CareSource®

Provider Manual

2022 | Georgia | D-SNP

CareSource Dual Advantage®
(Dual-Eligible Special Needs Plan)

This content has been reviewed; however, changes and/or revisions occur frequently. The provider should check the Provider Manual and Updates & Announcements pages on **CareSource.com** for the most up-to-date information.

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 Medicaid and other managed health care services since 1989. Since our first Medicaid managed care pilot in collaboration with community leaders and health care providers like yourself, we have continued to drive innovation and transformation of Medicaid. CareSource has a strong history of serving under-resourced populations with health and life services, maintaining a unique understanding of our members' needs.

CareSource offers a Dual-Eligible Special Needs Plan (D-SNP) that provides more coverage than original Medicare. CareSource Dual Advantage members have access to both Medicare and Medicaid benefits, plus prescription drug benefits and extra benefits not covered by Medicare, such as dental and vision.

This manual is a resource for working with our Georgia health plans. It communicates policies and programs across our Georgia plans 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. You can also find the most up-to-date information on the CareSource Provider Portal (Providerportal.caresource.com/GA/). In an effort to better support our providers and offer an immediate response to questions, concerns and inquiries, we offer claims, policy and appeals assistance through our call center at **1-833-230-2176** for DSNP.

To support our providers, we have dedicated Provider Services teams specialized with each plan to help assist with questions and concerns. Additionally, an external team of Provider Managers is 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®
Healthcare with Heart

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About This Manual

Format

This manual includes information for CareSource's Dual Advantage plan in Georgia:

- Dual Advantage (Dual-Eligible Special Needs plan, or D-SNP)

Navigation

In Part One, the following chapters contain information that is intended to familiarize you with CareSource:

Part One: Introduction to Working with CareSource

- About CareSource
- Communicating with CareSource
- Credentialing and Recredentialing
- Claim Submissions
- Utilization Management

Within these universal chapters, you will also find call-outs that speak to specific plans, designated contact information for each plan, or an "Additional Plan-Specific Details" section at the end of that chapter that provides more information on that topics specific to a plan.

In Part Two, each plan has its own chapter with the following sub-chapters included that speak to that plan only.

Part Two: CareSource Georgia Plans

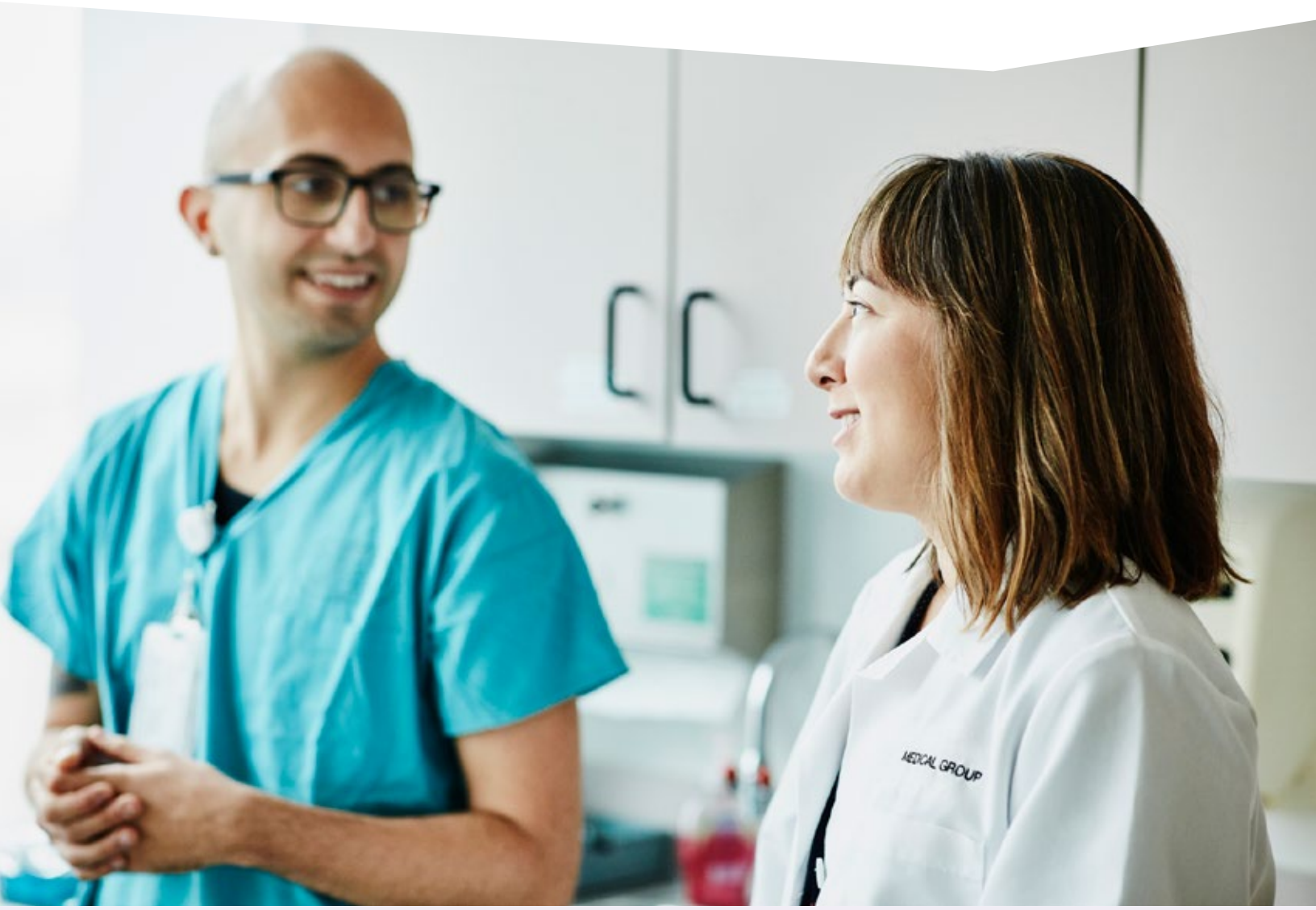
- Member Enrollment and Eligibility
- Covered Services and Exclusions
- Member Support Services and Benefits
- Member Grievance and Appeals
- Referrals and Prior Authorizations
- Pharmacy
- Provider Appeals Procedures

In Part Three, the following chapters contain all-plan information that is universal to all CareSource Georgia products:

Part Three: Your Role as a CareSource Provider

- CareSource Member Rights and Responsibilities
- Americans with Disabilities Act
- Health Equity Commitment
- Quality Improvement Program
- Primary Care Providers
- Key Contract Provisions
- Fraud, Waste and Abuse

You can easily find which plan chapter you are in by the color-coded header that appears at the top of the page.



About CareSource

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 together to facilitate a high level of care and a respectful experience for our members.

We are a nonprofit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. In Georgia, CareSource currently serves members and consumers of our Medicaid Dual-Eligible Special Needs (D-SNP) and 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 care organization (MCO), we improve the health of our members by utilizing a contracted network of high-quality participating providers. Primary care providers within the network provide a range of services to our members, and also coordinate patient care by referring them to specialists when needed, ensuring 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 and 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 with our benefit managers:
  - Pharmacy: ExpressScripts Inc. (ESI)
  - Dental: DentaQuest
  - Vision: EyeMed
  - Hearing: TruHearing
  - 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 (BH) and substance use disorder (SUD) management
- Collaboration with pharmacy and medication therapy management (MTM)

For more information on these programs across our various plans, see the "Member Support Services and Benefits" chapters for each plan included in this manual.

The CareSource Foundation

CareSource gets actively involved in the communities that we serve, from employees serving on hundreds of nonprofit boards to investing dollars back. We listen, we learn and we are driven to action. As a result, we launched the CareSource Foundation in 2006 to add another component to our professional services: community response. Focus areas of the CareSource Foundation are closely aligned with the greatest needs of

our member demographics. Areas of emphasis include children's health, special populations such as seniors and individuals with disabilities, the uninsured and life issues such as hunger, domestic violence, SUD and homelessness.

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 CareSource 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 and 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 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 Provider Services at:

- D-SNP: **1-833-230-2176**

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: 844-784-9583 or http://caresource.ethicspoint.com
- Compliance Officer: 937-487-5110 or CorporateComplianceOfficer@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 to 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 it 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 or ask you to share information with us. CareSource, like you, is a covered entity under HIPAA. Covered entities may 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.

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. Please reach out to our Provider Services department with any questions

Provider Services	
Monday to Friday	8 a.m. to 6 p.m. Eastern Standard Time (EST)

Member Services		
CareSource24®, nurse advice line for all plans)	Seven days a week, 365 days a year	24 hours a day
CareSource D-SNP	Monday to Friday	8 a.m. to 8 p.m. EST

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.

	D-SNP
Provider Services	1-833-230-2176
Prior Authorizations	1-833-230-2176
Claim Inquiries	1-833-230-2176
Credentialing	1-833-230-2176
Member Services	1-833-230-2020
CareSource24 – Nurse Advice Line	1-833-687-7301
Fraud, Waste and Abuse Hotline	1-844-679-7865
TTY for the Hearing Impaired	711

Fax

	D-SNP
Credentialing	937-396-3632
Care Management Referral	937-396-3688
Contract Implementation	937-396-3632
Fraud, Waste and Abuse	1-800-418-0248
Medical Prior Authorization Form	1-844-417-6157
Pharmacy Prior Authorization Form	1-877-251-5896
Pharmacy Prior Authorization Specialty Drug Form (Outpatient Drugs Only)	N/A
Provider Appeals	937-531-2398
Provider Maintenance	937-396-3076
Medicare Part D Formulary Exception/Prior Authorization Form	1-877-251-5896

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 network announcements, our Provider Manual, claims information, frequently asked questions, clinical and preventive guidelines and much more.

Provider Portal

URL: https://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

- Easy access to a secure online (encrypted) tool with time-saving services and critical information
- Available 24 hours a day, seven 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:

- **Payment history** – Search for payments by check number or claim number.
- **Claims features**
  - Claims status – Search for status of claims and claim appeals.
  - Claims attachments – Submit documentation needed for claims processing.
  - Submit claim – 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. For more information about submitting claims online, please visit the Claims Submissions section on page 21.
  - Rejected claims – Find claims that may have been rejected so that you can resubmit them.
  - Claim dispute and appeals – Search for the status of claims and claim appeals.
- **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.
- **Care management referrals** – Submit automated care management forms on our portal for efficiency in enrolling members.
- **Benefit limits** – Track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy and speech therapy.
- **Care treatment plans** – Providers can view care treatment plans.
- **Clinical Practice Registry (CPR)** – Filter patient data to identify opportunities for preventive health screenings.
- **Recovery letters** – View and download letters.
- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **Member financial status and information** – View member payment responsibilities (such as deductible, copay and coinsurance) and monthly premium payment status. Also view member's payment history.
- **File grievance**

Portal Registration

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

1. Visit **CareSource.com** > Providers > Georgia and click on "Provider Login."
2. Click on the "Register Now" button and complete the three-step registration process. You will need your Tax ID number and your CareSource Provider Number, located in your welcome letter.
3. Click the "Continue" button.
4. Note the username and password you create so that you can access the portal's many helpful tools.

If you do not remember your username/password, please call Provider Services:

- D-SNP: **1-833-230-2176**

Dental Providers

Please use the Providers > **Dental Provider Login** menu option of the Provider Portal to access capabilities specifically for dental providers.

Mail

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

	D-SNP
Provider Appeals	CareSource P.O. Box 1947 Dayton, OH 45401-1947
Member Appeals & Grievances	CareSource P.O. Box 1947 Dayton, OH 45401-1947
Medicare Pharmacy Appeals	Express Scripts P.O. Box 66588 St. Louis, MO 63166-66588 c/o Medicare Clinical Appeals
Medicare Pharmacy Grievances	CareSource P.O. Box 1947 Dayton, OH 45401-1947

Please Note: Provider appeals can only be mailed if supporting documentation is above 100 MBs where the Provider Portal will not allow submission.

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

Online

CareSource.com > Providers > Provider Portal Log-In

Email

ProviderMaintenance@caresource.com

Fax

937-396-3076

Mail

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

Credentialing and Recredentialing

CareSource credentials and recredentials all licensed independent practitioners including physicians, facilities and non-physicians with whom we contract and who fall within our scope of authority and action. Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners.

Credentialing Process

Council for Affordable Quality Healthcare Application

CareSource is a participating organization with the Council for Affordable Quality Healthcare (CAQH). Please make sure that we have access to your provider application prior to submitting your CAQH number:

1. Log onto the CAQH website at www.CAQH.org, utilizing your account information
2. Select the Authorization tab and ensure CareSource is listed as an authorized health plan (if not, please check the Authorized box to add)

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)
- Nurse Protocol Agreement (for nurses) and a Supervisory Agreement (for physician assistants)

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

Debarment and Criminal Conviction Attestation

CareSource verifies that our providers and the providers' employees have not been debarred or suspended by any state or federal agency. CareSource also requires that 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.

Providers must offer a list that identifies all of the provider employees, as defined above, along with the employee's tax identification (TIN) or social security numbers (SSN). 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 according to National Committee for Quality Assurance (NCQA) standards and the appropriate federal and individual state department of insurance requirements.

Providers 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 practitioner or group of providers
- Providers who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities
- Providers 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 providers who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits
- Covering providers (locum tenens)
- Medical directors of urgent care centers and ambulatory surgical centers
- Telemedicine

Providers Who Do Not Need Credentialed

- Providers who practice exclusively within the inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting
- Providers who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the CareSource Provider Directory
- Providers who do not provide care for members in a treatment setting (e.g. board-certified consultants)
- Waiver independent providers who provide personal care services in members' homes

Provider Selection Criteria

CareSource is committed to providing the highest level of quality of 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 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.

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 is 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 (PBM), Express Scripts.
- 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, provider is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body
- Liability insurance coverage is maintained
- CLIA certificates are current
- Completion of 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.

Provider Credentialing Rights

- Providers have the right to review information submitted from outside sources 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 by supplying corrections in writing to the credentialing department prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the provider will be notified and given the opportunity to correct this information prior to presenting to the credentialing committee.

- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the credentialing department.

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, 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, with the exception of 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 timeframe 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.
- 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 National Committee for Quality Assurance (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 Centers for Medicare & Medicaid Services (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
Attn: Vice President/Senior Medical Director
P.O. Box 8738
Dayton, OH 45401-8738

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 should be sent to:

CareSource
Attn: Vice President/Senior Medicaid 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.

Claim Submissions

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?

All claims may be submitted through the Provider Portal, including:

- Professional medical office claims
- Medical/surgical dental claims
- Institutional claims
- Behavioral health claims

Routine hearing and vision claims must be submitted to TruHearing and EyeMed respectively, through your relationship with the benefits manager.

Dental Providers

Dental claims other than those listed above must be submitted to DentaQuest through their provider web portal: https://govservices.dentaquest.com/.

Electronic Funds Transfer

CareSource offers electronic funds transfer (EFT) as a payment option. We work with ECHO Health Inc. as our claims 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*YARBORO*JUSTIN
- REF*6P*W246632770
- The NM1*PR (COB carrier), NM1* GB (other subscriber information from other payer) and REF*6P (other insurance group number)

To enroll in EFT, complete the enrollment form, available on **CareSource.com** > Providers > Claims, and fax it back to our payment processing vendor, ECHO Health Inc. Providers may also call ECHO support at 1-888-834-3511 for assistance with registration.

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.

Availity Clearinghouse

CareSource prefers electronic claim submission. To submit electronic claims, you may use the Provider Portal or our Availity clearinghouse.

You can reach Availity at 800-282-4548 or at www.availity.com.

Please provide the clearinghouse with the CareSource payer ID number: **31114**

File Format

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

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This was in preparation to implement ICD-10 CM codes on Oct.1, 2015. The new standard is the HIPAA 5010 format. 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:

- Medicaid: 2010AA Loop – Billing Provider Name
- Medicare: 2310B Loop – Rendering Provider Name
- 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 (Tax Identification Number) 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 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

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

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

Claims Payment Processing

CareSource has partnered with ECHO Health, Inc. to deliver provider payments. ECHO offers three payment options:

- Electronic funds transfer (EFT) – preferred
- Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
- Paper checks

*Payment processing fees are what you pay your bank and credit card processor for use of payment via credit card.

To register for claims payment, complete the ECHO enrollment form located on **CareSource.com** > Provider > Claims and fax, email, or mail it back to ECHO. You may call ECHO Customer Support at 1-888-834-3511 for assistance with your enrollment.

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 chapter, on page 22.

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
- CMS 1450 (UB-04), formerly UB92 form for Facilities

Paper claim submission must be done using the most current form version as designated by 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 – 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 (PA) number, where applicable – A number is needed to match the claim to corresponding PA information. This is only needed if the service provided required prior authorization.
- 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.

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All HCFA claims must have Box 27 completed in order for the claim to pay correctly.

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 Submitting Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. 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:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.
- If you submit paper claims, 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
Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401

Claim Submission Timely Filing

Claims must be submitted within 365 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.

For claim denials, providers must adhere to the following timeframes for submitting disputes and appeals:

If the claim is denied or the provider was denied authorization or reimbursement due to not obtaining prior authorization, then providers have 60 days from the date of discharge or the date of written determination to submit a dispute or appeal.

Claim Processing Guidelines

- Providers have 365 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after 365 calendar days, the claim will be denied for timely filing.
  - **D-SNP** Providers have 60 days to file a claim appeal.

- If you do not agree with the decision of the processed claim you will have 60 days from the date of discharge or the date of written determination to submit a dispute or appeal.
- If the claim is denied or the provider was denied authorization or reimbursement due to not obtaining prior authorization, then providers have 60 days from the date of discharge or the date of written determination to submit a dispute or appeal.
  - **D-SNP** Providers have 60 calendar days from the date of service or discharge.
- 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.

Please see "Provider Appeals Procedures" sections in each plan-specific chapters for more information on the claims dispute and appeals processes.

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Appeals filed past the timeframe will be dismissed unless a good cause is documented.

Searching for Claim Information Online

Claim statuses are updated daily on our 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 or claim or patient number.

Additional Claim Enhancements on the Provider Portal

- Claim history available up to 24 months from the date of service
- Submission of claim appeals
- Reasons for payment, denial, or adjustment
- Check for numbers and dates
- Procedure/diagnostic
- Claim payment date
- Dental claim information
- Submission of attachments for denied claims
- Easy submission for corrected claim when the claim was submitted online via the portal
- Accessibility to claim recovery letters

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 www.ama-assn.org/amaone/cpt-current-procedural-terminology.
- HCFA Common Procedure Coding System (HCPCS). Available at http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/ MedHCPCSGeninfo/ http://www.cms.hhs.gov/default.asp%20
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org.
- NDC: available at http://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.

CareSource 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) (also known as CCI) 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

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 (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.

Checking Claims Status

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.

Other Coverage

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:

- D-SNP: **1-833-230-2176**

You can check COB information for members who have been active with CareSource within the last 12 months. For providers enrolled in EFT, member-specific COB information is provided on the 835 remittance advice notification.

Claims involving COB will not be paid until an EOB or EDI payment information has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (zero balance) must still be submitted to CareSource for processing. This is due to regulatory requirements.

Coordination of Benefits Overpayment

If a provider receives a provider 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.

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 (PA), 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.

Utilization Management

	Phone	Fax	Email	Mail
D-SNP	1-833-230-2176	844-417-6157	MMMA@caresource.com	CareSource P.O. Box 3209 Dayton, OH 45401

On an annual basis, CareSource completes an assessment of satisfaction with the UM processes and identifies any areas for improvement opportunities.

Criteria

CareSource utilizes nationally recognized criteria, MCG, to determine medical necessity and appropriateness of services. 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 applicable criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available within five business days of decision 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 peer-to-peer scheduling line at 1-833-230-2168.

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 visit the Provider Portal at **CareSource.com** > Login > Provider Portal.

You can also request a PA by calling our Provider Services and selecting the option to request a PA. 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 the Provider Services lines listed above.

Access to Staff

Providers may call Provider Services to contact UM staff with any questions:

- D-SNP: **1-833-230-2176**

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 Standard Time (EST) 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 physical and behavioral health care providers.

Additional Plan-Specific Information

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Provider Appeals Procedure

If you are dissatisfied with a determination made by our UM department regarding a member's health care services or benefits, you may appeal the decision. Please see the "Provider Appeal Procedures" chapters for each plan in this manual for more information on how to file a clinical appeal.

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

Member Enrollment and Eligibility

CareSource Medicare plans and Dual-Eligible Special Needs Plans (D-SNP), are health care plans committed to helping members get the care they need.

Medicare Dual Advantage (D-SNP) is offered to members who are eligible for Medicare Parts A and B and Medicaid who live in our service area. The D-SNP plan offers full Medicaid benefits.

To be eligible to receive services through D-SNP, a person must:

- Be entitled to Medicare Part A and enrolled in Part B with full Medicaid benefits
- Live in our CareSource D-SNP service area
- Choose CareSource D-SNP during a valid election period
- Agree to the rules of the CareSource D-SNP plan

Member Eligibility Verification

Providers are expected to verify member eligibility each time a service is rendered. To verify member eligibility, please use one of the following methods:

- **Provider Portal**: Log on to **CareSource.com** and select Provider Portal from the menu options. You can check CareSource member eligibility up to 24 months after the date of service on our Provider Portal. You can search by date of service plus any one of the following: member name and date of birth, Medicare number or CareSource member ID number.
- **Phone**: Call Provider Services and follow the appropriate menu options to reach our automated member eligibility verification system 24 hours a day. The automated system will prompt you to enter the member ID number and the month of service to check eligibility.
  - D-SNP: **1-833-230-2176**

Primary Care Providers (PCPs) can obtain a monthly list of eligible members who have chosen them or were assigned to them from the CareSource Provider Portal. This list does not prove eligibility for benefits or guarantee coverage. Please use one of the above methods to verify member eligibility. Log onto our Provider Portal to view or print your list. All providers should always verify member eligibility before rendering services except in an emergency. This helps prevent unpaid claims.

Member ID Cards

Each new Medicare member receives a member ID card. An ID card for CareSource Medicare plans is issued when a member joins CareSource. Members can continuously use the same CareSource ID card as long as they maintain eligibility. CareSource will issue a new ID card only when the information on the card changes, if a member loses a card, or if a member requests an additional card. Because ID cards do not guarantee eligibility, providers must verify a member's eligibility on each date of service.

You can use our secure Provider Portal or call Provider Services and follow the prompt to check member eligibility.

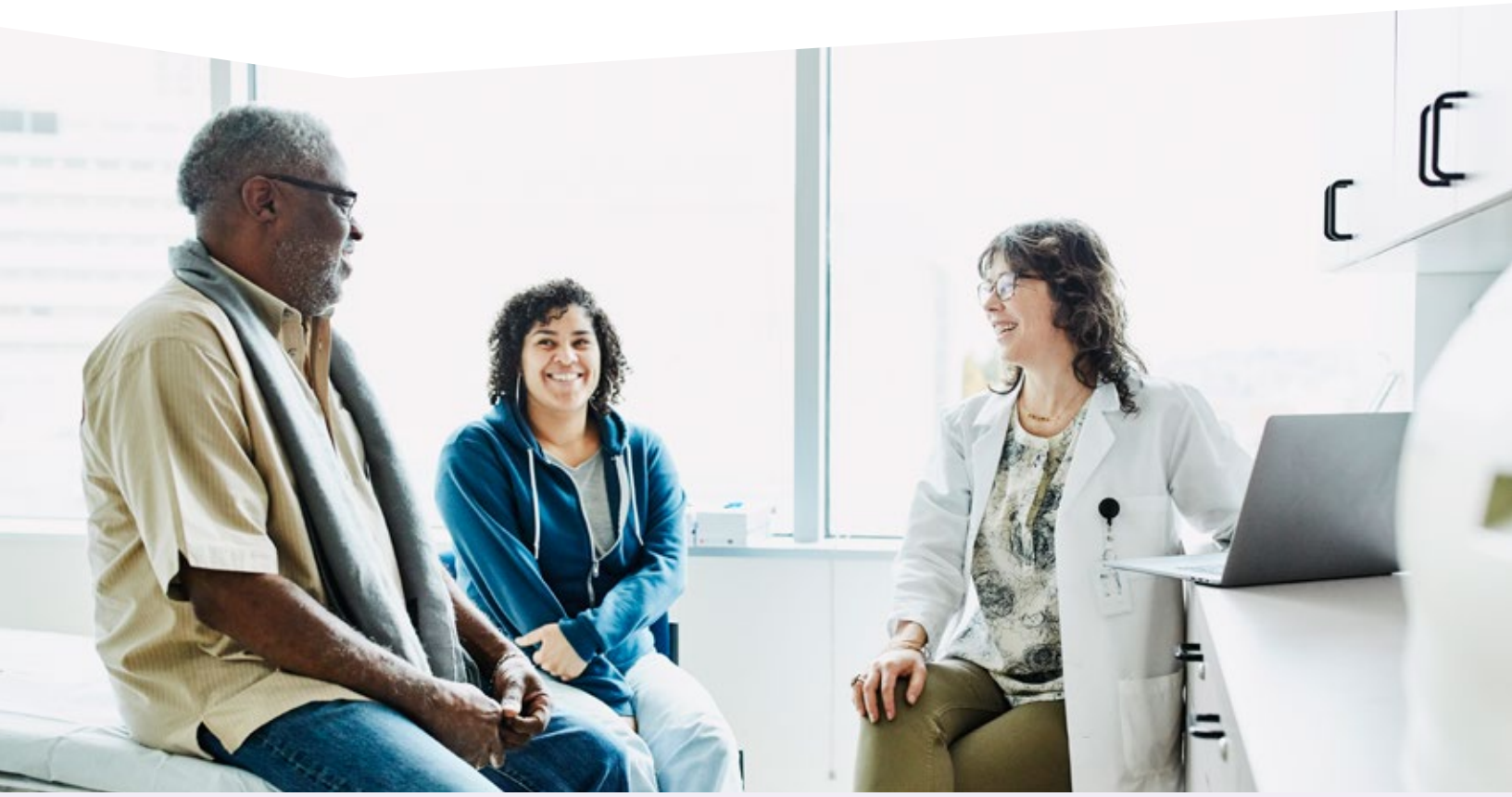
- D-SNP: **1-833-230-2176**

Members must be eligible for CareSource Medicare plans on the date of service in order for services to be covered.

Billing CareSource

CareSource members should not present their red, white and blue card for Original Medicare. If a CareSource member uses their red, white and blue Medicare card instead of their CareSource card and you bill the Medicare program instead of CareSource, the Medicare program will not pay for these services.

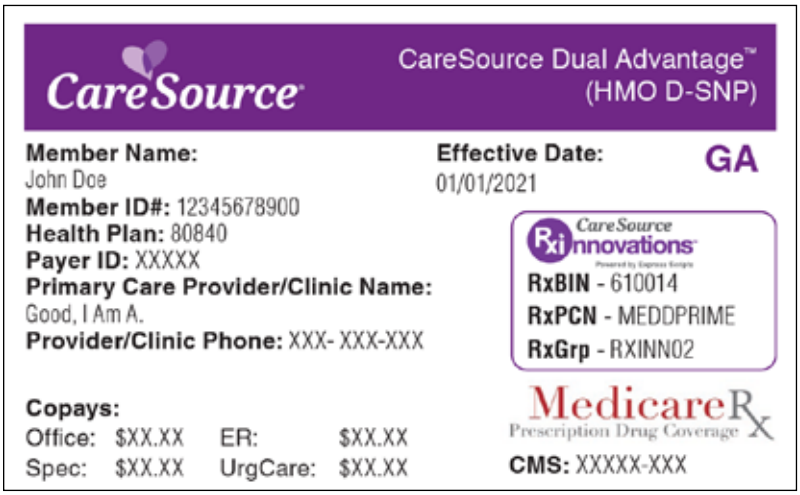
Members are asked to present a CareSource ID card each time services are accessed. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification. If you suspect fraud, please contact our Program Integrity department at **1-833-230-2176** and follow the appropriate menu options to report fraud.



Billing Georgia Medicaid for D-SNP

After receiving payment from CareSource for services provided to CareSource for services provided to a CareSource D-SNP member, **any remaining amount is not the responsibility of the CareSource member and he/she should not be billed by the provider.** Instead, the provider should bill the Georgia Medicaid program for the amount owed using the member's MMIS number.

Front of Georgia D-SNP Member ID Card


CareSource
CareSource Dual Advantage™ (HMO D-SNP)
Member Name: John Doe
Member ID#: 12345678900
Health Plan: 80840
Payer ID: XXXXX
Primary Care Provider/Clinic Name: Good, I Am A.
Provider/Clinic Phone: XXX- XXX-XXX
Effective Date: 01/01/2021
GA
CareSource Rxinnovations
RxBIN - 610014
RxPCN - MEDDPRIME
RxGrp - RXINN02
MedicareRx Prescription Drug Coverage
CMS: XXXXX-XXX
Copays:
Office: $XX.XX ER: $XX.XX
Spec: $XX.XX UrgCare: $XX.XX

Back of Georgia D-SNP Member ID Card


CareSource.com/Medicare
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, use the website or call:
MEMBERS: 1-833-230-2020 TTY: 711
24/7 Nurse Advice Line:
1-833-687-7301 (1-833-NURSE 01)
Vision Benefits:
EyeMed 1-866-299-1425
Hearing Benefits:
TruHearing 1-833-759-6826
Medical Claims:
CareSource
P.O. Box 8730
Dayton, OH 45401-8730
Providers:
1-833-230-2176
Dental Network:
DentaQuest 1-855-453-5284
Pharmacy:
1-877-891-5279
Pharmacy Claims:
Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

New Member Welcome Kits

Each household received a new member kit, a welcome letter, and an ID card for each person who has joined CareSource. The new member kits are mailed separately from the ID card and new member welcome letter.

New Member Kit Elements

- Welcome Letter
- Evidence of Coverage (EOC)
- Abridged formulary
- Information about finding doctors and pharmacies online, as well as a request card for a printed version of the provider and pharmacy directories
- Health risk assessment

Following the initial enrollment process, the member receives the following:

- Acknowledgment/confirmation letter
- Identification card

Member Disenrollment

A member may end their membership with CareSource only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the annual enrollment period (AEP) and during the annual disenrollment period. In certain situations, they may also be eligible to leave the plan at other times of the year. One situation is if the member moves out of the service area.

Please Note: All CareSource D-SNP members can move from plan to plan every three months while they are Medicaid-eligible.

Medicare Annual Enrollment Period

October 15-December 7

A member may request disenrollment by notifying CareSource. Refer members to the CareSource Medicare Member Services Department if they need information on disenrollment.

- D-SNP: **1-833-230-2020**

Members are advised to continue to use their CareSource ID card and to coordinate all services through their PCP until their disenrollment becomes effective.

If you learn that a member plans to disenroll, you may avoid payment delays by reminding the member to notify CareSource, and validating eligibility with CareSource on the date of each visit.

CareSource Involuntary Termination

Each member's enrollment is generally in effect as long as the member retains eligibility and chooses to stay with CareSource. The plan cannot and will not terminate a member because of the amount or cost of services.

CareSource can terminate members with CMS' approval for any of the following:

- If the member loses entitlement to Medicare Part B coverage
- If the member loses entitlement to Medicare Part A coverage
- If the member permanently moves or resides outside the service area
- If the member is temporarily absent from the service area for more than six consecutive months
- If the member is incarcerated
- If the member has committed fraud
- If the member has abused the CareSource plan beneficiary ID card and/or benefits
- If the member has demonstrated disruptive behavior that interfered with care for the member or others

Please notify CareSource if any of the situations listed above occur so we can discuss the disenrollment request with the member and, if necessary, initiate a request to CMS for member disenrollment. CMS will review all cases and determine whether or not the member should be disenrolled from CareSource, but members have the right to appeal the cancellation of coverage.

Procedures for Dismissing Non-Compliant Members

Participating providers can request that a CareSource member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include non-compliance with medication schedules, no-show office policies, or failure to modify behavior as requested. Any time a member misses three or more consecutive appointments, providers are expected to notify our care management department for assistance.

It is strongly recommended that your office make at least three attempts to educate the member about non-compliant behavior and document them in the patient's record. Please remember that CareSource's outreach staff can assist you in educating the member. After three attempts, providers may initiate the dismissal by following the guidelines below.

- The provider office must notify the member of the dismissal by certified letter.
- A copy of the letter must be sent to CareSource at the following address:
  CareSource
  Attn: Member Services Manager
  P.O. Box 8738
  Dayton, OH 45401-8738
  Fax: (937) 396-3095
- For PCPs only, the letter must contain specific language stating that:
  - The member must contact the Member Services department to choose another PCP.
  - The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal.

Please call Provider Services if you have questions about disenrollment reasons or procedures.

- D-SNP: **1-833-230-2176**

Member Enrollment and Provider Marketing

Although providers commonly inform their patients about their affiliations with managed care plans. However, advocating enrollment in a specific health plan is unacceptable according to the CMS Medicare Marketing Guidelines.

CMS allows providers to discuss participation under specified circumstances. CMS holds plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. The plan sponsor must ensure that any providers contracted (and its subcontractors, including providers or agents) with the plan sponsor comply with the requirements outlined in the Medicare Marketing Guidelines.

The plan sponsor must ensure that any providers contracted (including subcontractors or agents) with the plan sponsor to perform functions on their behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education, agree to the same restrictions and conditions that apply to the plan sponsor through its contract. In addition, the plan sponsor (and subcontractors, including providers or agents) are prohibited from steering, or attempting to steer an undecided potential enrollee toward a particular provider, or limited number of providers, offered either by the plan sponsor or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents). While conducting health screenings, providers may not distribute plan information to patients since both activities are prohibited marketing activities.

Provider Marketing

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers may not be fully aware of plan benefits and costs, and it's important that beneficiaries receive the right information needed to make an informed decision about their health care options.

It is inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms
- Accepting Medicare enrollment applications
- Making phone calls or directing, urging or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests
- Mailing marketing materials on behalf of plan sponsors
- Offering anything of value to induce plan enrollees to select them as their provider
- Offering inducements to persuade beneficiaries to enroll in a particular plan or organization
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities
- Distributing materials/applications within an exam room setting
- Health screening is a prohibited marketing activity

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions.

Providers contracted with plan sponsors (and their contractors) are permitted to do the following:

- Provide the names of plan sponsors with which they contract and/or participate
- Provide information and assistance in applying for the low income subsidy
- Make available and/or distribute plan marketing materials including provider affiliation materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials from all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials. Rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates. To that end, providers are permitted to:
  - Provide objective information on plan sponsors' specific plan formularies, based on a particular patient's medications and health care needs
  - Provide objective information regarding plan sponsors' plans, including information, such as covered benefits, cost sharing and utilization management tools
- Make available and/or distribute PDP enrollment applications, but not MA or MA-PD enrollment applications for all plans with which the provider participates
- Refer their patients to other sources of information, such as SHIPS, plan marketing representatives, their State Medicaid Office, local Social Security Office, the CMS website at http://www.medicare.gov or 1-800-MEDICARE

Please Note: The "Medicare and You" Handbook or "Medicare Options Compare" (from www.medicare.gov) may be distributed by providers without additional approvals.

There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plan sponsors and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plan sponsors should advise contracted providers of the provisions of these rules.

Please Note: Per guidance from CMS, a provider should not attempt to switch or steer plan enrollees or potential plan enrollees to a specific plan or group of plans to further the financial or other interests of the provider.

Covered Services and Exclusions

For the most up-to-date list of CareSource's D-SNP plan covered benefits, please visit **CareSource.com** > Georgia D-SNP > Benefits & Services.

You will find information on services, including dental services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Referrals and Prior Authorizations" section on page 50 of this manual for more information about referral and prior authorization (PA) procedures.

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.

- D-SNP: **1-833-230-2176**

This section describes the services and exclusions to benefits that are provided to our CareSource members. CareSource covers all medically necessary covered services for members. Covered services may require PA. Please visit **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization for the most up-to-date list of services that require PA. These requirements for members enrolled with CareSource are determined and enforced by CareSource.

Medical Necessity Standards and Practices

"Medically reasonable and necessary service" is a covered service that is required for the care of well-being of the member and is provided in accordance with generally accepted standards of medical or professional practice.

Some services require PA. CareSource reviews all service requests for Medicare members under the age of 21 (through the month of the member's 21st birthday) for medical necessity. If a request for authorization is submitted, CareSource will notify the provider and member in writing of the determination.

If a service cannot be covered, providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Provider Appeals Procedures" section on page 58 of this manual for information on how to file an appeal.

Covered services and exclusions for CareSource members can be found at **CareSource.com** > Benefits and Services (Filter the drop-down by state and plan).

Covered services and exclusions for CareSource D-SNP plans are also listed in the Evidence of Coverage (EOC). The EOC is located on our website at **CareSource.com** > D-SNP > Plan Documents.

Member Support Services and 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

CareSource Medicare members can access the Member Services department by calling our toll-free number and following the menu prompts:

Representatives are available by telephone Monday through Friday, except on the following holidays:

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

Members Services is available 8 a.m. to 8 p.m. Eastern Standard Time (EST) Monday through Friday and from Oct. 1 – Mar. 31 we are open the same hours 7 days a week. Please visit **CareSource.com** > About Us > Contact Us for more information on the holiday hours.

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. For improved care coordination with PCPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse gave.

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

Care Management/Outreach

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 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.

CareSource encourages you to take an active role in your patient's care management program. The profile provides information on pharmacy and emergency department (ED) utilization, scheduled or planned services. This information provides you with critical information necessary to make informed decisions pertaining to your patient. In addition, we invite and encourage you to direct and participate in the development of a care plan individualized to the needs of your patient. We believe communication and coordination are integral to ensure the best care for these patients.

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

- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Members with special health care needs
- Behavioral health needs

If you would like to contact one of our case managers please call us on our confidential voice mail line at **1-844-679-7867** or email us at MAcasemanagement@Caresource.com.

Care Management of Complex Members

CareSource provides a community-based care coordination model for our highest-risk members. Utilizing nurses, social workers and community health workers, this multi- disciplinary approach integrates the Case Management Society of America (CSMA) Standards of Practice utilizing "Community Health Workers" to help patients overcome health care access barriers. It also strengthens our provider and community resource partnerships through collaboration.

Our services include face-to-face meetings with our most at-risk members. Ideally, these are conducted at the point of care to ensure development of a treatment plan that is comprehensive and collaborative. Typical complex-risk members served by this model may have multiple medical issues, socioeconomic challenges and behavioral health care needs.

CareSource encourages you to take an active role in your patients' care coordination 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 program 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
- Newsletters with helpful tips and information to manage their disease.
- Coordination with outreach teams such as wellness advocates and health coaches
- One-to-one care management (if they qualify)

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

Benefits to Members and Providers

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

Disease Management Referrals

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

CareSource Rewards Programs

CareSource offers MyHealth Rewards for members over the age of 18 to take health assessments, set goals and track activities. Members can take online health training based on their needs. Members can also earn rewards, if applicable. Members can redeem rewards in MyHealth for gift cards to retailers including T.J. Maxx, Marshalls, Home Goods, Panera Bread, iTunes and more. Members can get started by signing on to their My.CareSource.com account and click on the MyHealth icon under My Plan.

Transportation

D-SNP Members

Transportation can be provided for CareSource members to covered appointments, Women, Infants and Children (WIC) appointments and Medicaid redetermination appointments with the County Department of Job and Family Services. The CareSource transportation benefit is limited to 30 round-trip visits (60 one-way trips) annually per member. Transportation is provided at no cost to the member. Members can arrange transportation by calling the Member Services phone number on their ID card and requesting transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

Member Grievance and Appeals Procedures

Any time a member informs us that they are dissatisfied with CareSource, or a provider, it is a grievance. A grievance may include any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which CareSource or our delegated entity provides health care services. An expedited grievance may also include a complaint that CareSource refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination, grievance, or reconsideration timeframe. In addition, grievances may include complaints regarding timeliness, appropriateness, access to, and/ or setting of a provided health service, procedure or item. Grievances may also include complaints that covered health service procedures or items during a course of treatment did not meet accepted standards of delivery or health care. CareSource investigates all grievances. If the grievance is about a provider, CareSource calls the provider's office to gather information and attempt a possible resolution. CareSource responds to member grievances in accordance with CMS timeframes.

Member, Provider or Provider Appealing on Behalf of a Member

The D-SNP EOC is located at **CareSource.com** > D-SNP > Plan Documents.

Providers who are not physicians and are submitting appeals on behalf of members must have a valid Authorization of Representative (AOR) on file or physician representatives.

Level 1: Appeal

Reconsideration

A member starts the appeal process by making an appeal. It is called the first level of appeal or a Level 1 Appeal.

The member contacts CareSource and makes the appeal. If their health requires a quick response, they must ask for a fast appeal. To start an appeal, the member, their representative, or in some cases their doctor, must contact CareSource. The representative must have a valid Authorization of Representative (AOR) form or other corresponding document on file with CareSource for the appeal to be processed.

An appeal request must be within 60 calendar days from the date on the written notice sent concerning a coverage decision. If the member misses this deadline and has a good reason for missing it, we may give more time to make the appeal. A request for a Good Cause Extension must be submitted in writing. Examples of good cause for missing the deadline may include if the member had a serious illness that prevented he/she from contacting us or if we provided the member with incorrect or incomplete information about the deadline for requesting an appeal. If the member wishes, their doctor may give additional information to support the appeal. A standard appeal must be in writing and must be completed within 30 calendar days after being received by CareSource.

If we are using the standard deadlines, we must give the member our answer within 30 calendar days after we receive the member's appeal, if their appeal is about coverage for services they have not yet received. We will give the member our decision sooner if their health condition requires us to. However, if the member asks for more time, or if we need to gather more information that may benefit the member, we can take up to 14 more calendar days. If the member believes we should not take extra days, the member can file a "fast complaint" about our decision to take extra days. When the member files a fast complaint, we will give the member an answer to their complaint within 24 hours.

If we do not give the member an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send the member's request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. If our answer is yes to part or all of what the member requested, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive the member's appeal. If our answer is no to part or all of what the member requested we will send the member a written denial notice informing you of our decision. We will also automatically send the member's appeal to the Independent Review Entity (IRE) for a Level 2 Appeal.

A fast appeal is also called an expedited appeal. An expedited appeal can be a verbal or written request and must be completed within 72 hours after being received by the CareSource Grievance and Appeals department. We can provide our answer sooner if the member's health requires us to do so. If a member asks for more time, or if we need to gather more information that may benefit the member, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell the member in writing. If our answer is yes to part or all of what the member requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive the member's appeal.

Level 2: Independent Review Entity (IRE)

If CareSource says no to the Level 1 Appeal, the case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the IRE reviews the decision made when we said no to the first appeal. This organization decides whether the decision we made should be changed.

The IRE is an outside independent organization that is hired by Medicare. This organization is not connected with CareSource and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the IRE. Medicare oversees its work. CareSource will send information about the appeal to this organization. This information is called the "case file." The member has the right to ask for a copy of the case file. The member has a right to give the IRE additional information to support their appeal. Reviewers at the IRE will take a careful look at all of the information related to the appeal.

If there was a "fast" appeal at Level 1, there will also be a "fast" appeal at Level 2. The IRE will tell the member its decision in writing and explain the reasons for it. If the review organization says yes to part or all of what you requested, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review. If the organization says no to part or all of your appeal, they will tell the member in writing if their case meets the requirements for continuing with the appeals process.

Level 3: Administrative Law Judge

The notice received from the IRE will tell the member in writing if the case meets the requirements for continuing with the appeals process. The written response will explain who to contact and what to do to ask for a Level 3 Appeal. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage being requested must meet a certain minimum. If the dollar value of the coverage being requested is too low, the member cannot make another appeal, which means that the decision at Level 2 is final.

If the Administrative Law Judge (ALJ) approves the appeal, the appeals process may or may not be over. CareSource will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (IRE), CareSource has the right to appeal a Level 3 decision that is favorable to the member. If CareSource does not appeal the judge's decision, we must authorize or provide the member with the service within 60 days after receiving the judge's decision. If we decide to appeal the judge's decision, we will send the member a copy of the Level 4 Appeal request with accompanying documents.

If the ALJ says no to the decision, the member can either accept the decision and end the appeals process, or the member can continue to the next level of the review process. The member will receive a notice that tells what to do next.

Level 4: The Medicare Appeals Council

The Medicare Appeals Council will review the member's appeal and give the member an answer. The Medicare Appeals Council works for the federal government.

If the member's Level 4 appeal is approved, or if the Medicare Appeals Council denies CareSource's request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over. CareSource will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (IRE), CareSource has the right to appeal a Level 4 decision that is favorable to the member. If CareSource decides not to appeal the decision, CareSource must authorize or provide the member with the service within 60 days after receiving the Appeals Council's decision.

If the member's Level 4 appeal is denied or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over.

If the member decides to accept this decision, the appeals process is over. If the member does not want to accept the decision, the member might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to the member's appeal, the notice the member receives will tell the member whether the rules allow the member to go on to a Level 5 Appeal. If the rules allow the member to go on, the written notice will also tell the member who to contact and what to do next if the member chooses to continue with the next level of review.

Level 5: A Judge at the Federal District Court

A judge at the Federal District Court will review your appeal if permitted based on the Level 4 response. This is the last stage of the appeals process.

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 (UM) team. There are specific criteria for obtaining prior authorization. Please visit the Provider Portal at **CareSource.com** for the most current information on prior authorization and referral requirements.

Please Note: Prior Authorization does not guarantee payment.

Referral Information

Generally, CareSource does not require referrals or PA 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.

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 PA for any services rendered to CareSource members.

You can also 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:

- D-SNP: **1-844-679-7865**

Referral Procedures

Medicare members are not required to obtain referrals from their PCP prior to obtaining services from specialists. However, PCPs are asked to assist members in obtaining specialty services. If you have difficulty finding a specialist for your CareSource member, please call Provider Services at **1-844-679-7865** and select the option to speak to someone in the UM Department.

Please Note: Medicare members may go to non-participating providers for: emergency care, out of area dialysis care, and out-of-area urgently needed care.

Prior Authorization Information

Prior Authorization Procedures

The Provider Portal is the preferred method to request prior authorizations for health care services. You get immediate approval or pend status, and can also check pending claim status. Email us at CiteAutoAssistance@caresource.com for portal login assistance.

Online

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

Alternate Submission Methods

Phone

- D-SNP: **1-844-679-7865**

Fax

844-417-6157

Mail

CareSource
P.O. Box 1307
Dayton, OH 45401

Copies of prior authorization forms can be found on **CareSource.com** > Providers > Forms.

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource Member ID number
- Provider name 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 PA 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 and procedure planned, clinical supporting the request 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 PA 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 PA as soon as it is known that the service is needed.

All services that require PA from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which PA is required, but not obtained by the provider. CareSource will notify you of PA determinations by fax. Lack of appropriate notification will result in a provider denial.

For all PA 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.

Services that Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. Please visit **CareSource.com** > Providers > Provider Portal > Prior Authorization and select your plan for the most up-to-date information of services that require PA.

Ordering physicians must obtain a PA for the following outpatient, non-emergent diagnostic imaging procedures:

- MRI/MRAs
- CT/CTA scans
- PET scans

These services require a PA from NIA Magellan. Providers can obtain PA from NIA Magellan for an imaging procedure in the following ways:

- Online – www.radmd.com
- By Phone – 1-800-424-5660 (follow the options to obtain a prior authorization and select the option for advanced radiology prior authorization), Monday through Friday, from 8 a.m. to 8 p.m. EST.

Authorization requests are approved at intake in most cases. If an approval cannot be issued during the initial intake, more information may be required.

Please Note: Imaging procedures performed during an inpatient admission, hospital observation stay or emergency room visit are not included in this program.

In addition, any provider who is not a participating provider with CareSource must obtain PA for all non-emergency services provided to a CareSource member.

CareSource does not require PA for unlisted procedure CPT codes. However, it requires a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code. Submission of clinical information does not guarantee payment.

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. To avoid claim denials providers need to submit supporting clinical documentation with the claim submission.

Please Note: Authorization is required for non-participating providers.

Determination Timeframes

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

Review Type	Time for plan to respond when all information is present	Time for plan to request additional information	Provider response time to submit additional information	Plan response time after receiving additional information
Inpatient Initial	72 Hours	24 Hours	N/A	N/A
Inpatient Continued Stay Review (CSR)	72 Hours	24 Hours	N/A	N/A
Outpatient/Elective Non-Urgent	within 14 calendar days	24 Hours	N/A	N/A
Outpatient/Elective URGENT	within 72 Hours	24 Hours	N/A	N/A
Retrospective	within 30 Days	24 Hours	N/A	N/A
Part B Drug	72 Hours	24 Hours	N/A	N/A
Urgent Part B Drug	24 Hours	N/A	N/A	N/A

Pharmacy

Prescription Drug Coverage

CareSource partners with Express Scripts, Inc. to process medication claims. Express Scripts, Inc. processes medication claims for all Georgia plans to provide continuity for provider offices and CareSource members.

Tiered Medications

Every drug covered on the CareSource drug formulary is in one of six cost-sharing tiers listed below.

Cost-Sharing Tier 1: Includes preferred generic drugs. This is the lowest tier. (May include select brand drugs).

Cost-Sharing Tier 2: Includes non-preferred generic drugs. (May include select brand drugs).

Cost-Sharing Tier 3: Includes preferred brand drugs. (May include select generic drugs).

Cost-Sharing Tier 4: Includes non-preferred brand drugs (May include select generic drugs).

Cost-Sharing Tier 5: Includes specialty brand and generic drugs.

Cost-Sharing Tier 6: Includes prescription drugs that are Select Care Drugs. (Drugs in this tier have a $0 copay).

D-SNP members' copayments may be based on their applicable Low-Income Subsidy (LIS).

To find out which cost-sharing tier your drug is in, look it up in the plan's drug list at **CareSource.com** > Providers > Tools & Resources > Drug Formulary.

Tiered Cost-Sharing Exceptions

In certain circumstances, a member may request a reduction in the copayment or co-insurance amount for a drug on the formulary. A member must meet appropriate medical necessity criteria before the tiered cost-sharing exceptions will be approved. To determine medical necessity, the CareSource plan pharmacy benefit manager (PBM) will verify, through the provider's supporting statement(s) and/or standards documented in clinical guidelines adopted by the plan, that all drugs in the lower preferred tiers:

- Would not be as effective for the member as the requested drug
- Would have adverse effects for the member
- Or both of the above

NOTE: Tiered cost-sharing exception requests will be processed through CareSource's PBM prior authorization (PA) review process.

Medicare Part D Phone Numbers for Coverage Determination (Prior Authorization)

CareSource currently uses a pharmacy partner to handle PA requests. All requests for pharmaceutical PAs should be directed to: **1-877-251-5896**. Please follow the prompts for Medicare PA.

For written requests, please send via fax: 877-251-5896 for oral medications and injectable/specialty medications, or visit **CareSource.com**.

Medicare Pharmacy Coverage Determination (Prior Authorization)

CareSource will process coverage determinations and exception requests in accordance with Medicare Part D regulations. Requests will be handled through the PA review process. PA requires a drug to be "pre-approved" in order for it to be covered under a benefit plan.

The PA staff will adhere to the Centers for Medicare & Medicaid Services (CMS) approved criteria. The PBM's National Pharmacy and Therapeutics Committee established clinical guidelines, and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines.

Providers can submit PA requests by phone or fax. Providers will be required to submit pertinent medical/drug history, prior treatment history, and any other necessary supporting clinical information with the request.

Standard requests will be reviewed and determinations will be made within 72 hours. An expedited coverage determination will be made within 24 hours.

Drug Formulary

CareSource uses a list of covered drugs, called a drug formulary. The drug formulary contains information about drugs covered, their cost share tiers and limitations of coverage (such as PAs, quantity limits and step therapy protocols). Drugs are listed by therapeutic class and 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, please visit our website's Pharmacy page at **CareSource.com** > Provider Overview > Education > Patient Care > Pharmacy.

CareSource updates the drug formulary regularly and communicates any updates online on the Drug Formulary Changes pages. 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.

The CareSource formulary was selected in consultation with a team of providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. CareSource Medicare Advantage will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a CareSource network pharmacy, and other plan rules are followed.

Quantity, Supply, Duration and Benefit Limits

Quantity limits and dosing limits are based on several factors such as the manufacturer's recommended dosing frequencies, long-term considerations, diagnosis and best practices, and/or Food & Drug Administration (FDA) recommendations. Limits on opioids or other substances with a high potential for abuse are based upon maximal 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 used to treat the same condition be tried and failed prior to the approval of a step two formulary medication.

Generic Substitution & Therapeutic Exchange

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

The formulary document is subject to state-specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness, and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drugs.
- Manufactured in the same strength and dosage form as the brand-name drugs.

Prior Authorization

To submit prior authorization (PA) requests please fax all documents to 877-328-9660, or to submit by phone, call the following number and use the prompts: **1-877-251-5896**.

CareSource processes Medicaid PA requests in accordance with Georgia Medicaid regulations. PA requires that a drug be preapproved in order for it to be covered under a health benefit. The PA staff will adhere to the Georgia Administrative Code (OAC) and determine medical necessity for formulary exception requests that will be reviewed based in drug-specific prior authorization criteria or standard non-formulary prescription request criteria. Providers will be required to submit pertinent medical or drug history, prior treatment history and any other necessary supporting clinical information with the request.

Medical Reasons for Exceptions

Providers may be asked to provide written clinical documentation as to why a member needs an exception. In determining whether an exception will be given, CareSource will consider whether the requested drug is clinically appropriate.

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 Pharmacies

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.

Provider Appeals Procedures

If in your capacity as a member's provider you file an appeal on behalf of a member, please refer to the procedures set forth in this manual. Please refer to the applicable plan's "Member Grievances and Appeals Procedures" sections for additional details.

Claim Dispute Process

If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You should not file a dispute or appeal.

Claim Dispute Process for Participating and Non-Participating Providers

- Claim disputes must be submitted in writing or by using the CareSource Provider Portal.
- The dispute must be submitted within 60 days after the provider's receipt of the written determination of the claim.
- Please be aware that Participating Providers do not have the appeal rights and must use the Claim Dispute process to address any payment issues.
- Please be aware that all non-participating providers must submit a valid Waiver of Liability (WOL) with their claim appeal in order for the appeal to be considered valid. Any claim appeal submitted without a valid WOL will be dismissed.

Appeals of Claims Denials or Adverse Decisions

If you do not agree with the decision of a processed claim or dispute, you will have 60 days from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required timeframe, the claim will not be considered and the appeal will be dismissed. If the appeal is denied, providers will be notified in writing. If the appeal is approved, payment will show on the provider's Explanation of Payment (EOP).

How to Submit Claim Appeals

Providers can submit claims online.

Online

CareSource.com > Login > Provider Portal

From the Providers menu, select Claims Appeals.

Appeals may be submitted electronically, by fax, or by mail. These submissions must be submitted on disc to the CareSource Appeals department at the following address:

CareSource Provider Appeals Department
P.O. Box 1947
Dayton, OH 45401-1947
Fax: 937-531-2398

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

- The member's name and CareSource member ID number
- The provider's name and ID 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

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 an appeal.

Provider Appeals/Clinical Appeals

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

An appeal is defined as a formal request by a member or provider, including facilities or other health care entities on behalf of a member or provider for a review of a determination or action.

Timeline for Clinical 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 – within 60 days from the date of service or notification of denial
- Provider on behalf of a member with a valid Authorization of Representative form – within 60 days of receipt
- Member– within 60 days from the date of notification of denial

Additional Details about Clinical Appeals

Timing for Medical Necessity Appeals

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 60 calendar days from the date of denial, date of discharge or date of service.

Appeals Filed on Behalf of the Member

Medical necessity appeals filed by members or providers on behalf of a member must be submitted to CareSource within 60 days and will be resolved within 30 calendar days of receipt or as expeditiously as the member's condition warrants. Appeals on behalf of the member must include a valid Authorization of Representative (AOR) form to appeal on their behalf for the specific service that is being appealed.

Expedited Appeals

An expedited appeal should be considered if the provider feels that the patient's life or health is at risk if a decision about care is not made in a timely manner.

Requests may be a verbal request and should be submitted to the Grievance and Appeals department by calling:

- D-SNP: **1-833-230-2176**

CareSource will make a determination within 24 hours of the expedited appeal request whether to expedite the appeal resolution. CareSource will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal resolution. This attempt will be made by phone. If the member is in a facility, the provider or facility will be notified on the same business day of the decision. The member will be informed of the limited time available for presentation of evidence and allegations of fact or law in person or in writing.

The member and provider will be notified in writing of the determination to process as a standard appeal within 24 hours of receipt of the appeal, including information that the member can grieve the decision. In the event that CareSource denies the request for an expedited appeal, the appeal will be resolved within 30 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

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

Notification of Resolution

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

Extending an Appeal

A member can verbally request that CareSource extend the timeframe to resolve a standard or expedited appeal up to 14 calendar days. CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days. CareSource must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

Dissatisfaction of Medical Necessity Appeals – One Level of Appeal

If you are dissatisfied with any medical necessity decision made by CareSource, you may use the Appeal Request Form on our website to submit your appeal. Visit **CareSource.com** > Provider Overview > Tools & Resources > Forms to access the Appeal Request Form.

Appeal Request Elements

- 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

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.

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days from the date of denial, date of discharge or date of service.

How to Submit Appeals

Appeals may be submitted online, by fax, or by mail.

Online

Visit **CareSource.com** > Login > Provider Portal

Fax

937-531-2398

Mail

CareSource
Attn: Provider Appeals – Clinical
P.O. Box 1947
Dayton, OH 45401-1947

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 dignity by CareSource personnel, network providers and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive.
- Participate with your doctor in making decisions about your health care.
- Candidly discuss with your doctor the appropriate or medically necessary treatment options for your 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 you wish to receive should you be unable to express your wishes.
- Be able to get a second opinion from a qualified provider. If a qualified network provider is not able to see you, CareSource will set up a visit with a provider not in our network.

Members of CareSource are also informed of the following responsibilities:

- Supply information needed, to the extent possible, that the organization and its doctors need in order to provide care.
- Follow the plans and instructions for care that you have agreed to with doctors.
- Understand your 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 and how they may file a complaint with the U.S. Dept. of Health and Human Services (HHS) Office for Civil Rights (OCR) related to their privacy. 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 HIPAA regulations as required for all covered entities 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.

MEDICARE PROVIDERS

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

- 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 (also known as the Evidence of Coverage). The list of our member's 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, as stated in the member handbook, are as follows:

- Our plan must honor your rights as a member of the plan. We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.) To get information from us in a way that works for you, please call Member Services. Our plan has people and free translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you. If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.
- We must treat you with recognition of your dignity, fairness and respect at all times. Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.
- If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY: 1-800-537-7697) or your local Office for Civil Rights. If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.
- We must ensure that you get timely access to your covered services and drugs. As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (The Evidence of Coverage explains more about this). Call Member Services to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.
- As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, the Evidence of Coverage tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, the Evidence of Coverage tells what you can do.)
- We must protect the privacy of your personal health information Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws:
  - Your "personal health information" includes the personal information you gave us when you enrolled in this plan, as well as your medical records and other medical and health information.
  - The laws that protect your privacy give you rights related to getting information and controlling how your health information is used.
  - We give you a written notice, called a "Notice of Privacy Practice" that tells about these rights and explains how we protect the privacy of your health information.

Members of CareSource are also informed of the following about protection of their privacy:

- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone who has legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law:
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.
- You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.
- If you ask us to do this, we will consider your request and decide whether the changes should be made. You have the right to know how your health information has been shared with others for any purposes that are not routine. If you have questions or concerns about the privacy of your personal health information, please call Member Services.
- We must give you information about the plan, its network of providers and your covered services. As a member of CareSource, you have the right to get several kinds of information from us. (As explained above, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.) If you want any of the following kinds of information, please call Member Services:
  - Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other health plans.
  - Information about our network providers, including our network pharmacies.
- You have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- For a list of the providers in the plan's network, see the Provider Directory.
- For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
- For more detailed information about our providers or pharmacies, you can call Member Services or visit **CareSource.com.**
- Information about your coverage and rules you must follow in using your coverage.
  - The Evidence of Coverage explains what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see the Evidence of Coverage plus the plan's List of Covered Drugs (Formulary).
  - These documents tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services.
- Information about why something is not covered and what you can do about it.
- We must support your right to make decisions about your care.
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network providers or pharmacy.

  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see the Evidence of Coverage. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (The Evidence of Coverage also tells about how to make a complaint about quality of care, waiting times and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see the Evidence of Coverage.
- We must support your right to make decisions about your care.
- You have the right to know your treatment options and participate in decisions about your health care. You have the right to get full information from your doctors and other providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.
- You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:
  - To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
  - To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
  - The right to say “no.” You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. The Evidence of Coverage tells how to ask the plan for a coverage decision.
- You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness.
- You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:
  - Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
  - Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.
- The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.
- If you want to use an “advance directive” to give your instructions, here is what to do:

  - Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
  - Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
  - Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members, as well. Be sure to keep a copy at home.
- If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital:
  - If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
  - If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.
- Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.
- What if your instructions are not followed? If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state department of insurance.
- You have the right to make complaints and to ask us to reconsider decisions we have made.
- If you have any problems or concerns about your covered services or care, the Evidence of Coverage tells what you can do. It gives the details about how to deal with all types of problems and complaints.
- As explained in the Evidence of Coverage, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.
- You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services.

Members of CareSource are also informed of actions they can take if they feel they are being treated unfairly or that their rights are not being respected:

If it is about discrimination, call the Office for Civil Rights. If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else? If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services.
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to the Evidence of Coverage.
- Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of the cost or benefit coverage.

You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

Members of CareSource are also informed of how to get more information:

- You can call Member Services.
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to your Evidence of Coverage.
- You can contact Medicare.
  - You can visit the Medicare website (http://www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections."
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Members of CareSource are also informed of the following responsibilities:

What are your responsibilities? Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services. We're here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services. Use the Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - The Evidence of Coverage gives the details about your medical services, including what is covered, what is not covered, rules to follow and what you pay.
  - The Evidence of Coverage gives the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services to let us know.
  - We are required to follow rules set by Medicare and Medicaid to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits.
- Tell your doctor and other providers that you are enrolled in our plan. Show your plan membership card and Medicaid card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors, other providers and your health plan give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over- the-counter drugs, vitamins and supplements
  - If you have any questions, be sure to ask. Your doctors and other providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

  - Participate in developing mutually agreed upon treatment goals, to the degree possible.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals and other offices.
- Supply information (to the extent possible). We expect you to provide needed information that the organization and its practitioners and providers need in order to provide care.
- Understand and be active in your care. You are responsible for making an effort to understand your health problems and participate in developing mutually agreed treatment goals, to the degree possible.
- Follow physician plans of care. In order to ensure the best care, you have a responsibility to follow the plans and instructions for care that you agree to with your practitioners/providers.
- Pay what you owe. As a plan member, you are responsible for these payments:
  - In order to be eligible for our plan, you must maintain your eligibility for Medicare Part A and Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The Evidence of Coverage tells what you must pay for your medical services. The Evidence of Coverage tells what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost. Or, if you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see the Evidence of Coverage for information about how to make an appeal.
  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must pay the extra amount directly to the government to remain a member of the plan.
  - If you did not join a Medicare drug plan when you first became eligible or if you had a continuous period of 63 days or more when you did not have creditable prescription drug coverage, you may be required to pay a late enrollment penalty (LEP). The late enrollment penalty is added to the plan's monthly premium. Your premium amount will be the monthly plan premium plus the amount of the late enrollment penalty.
- Tell us if you move. If you are going to move, it's important to tell us right away by calling Member Services.
  - If you move outside of our plan service area, you cannot remain a member of our plan. We can help you figure out whether you are moving outside our service area.
  - If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.
- Call Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are on the back cover of the Evidence of Coverage.
  - For more information on how to reach us, including our mailing address, please see the Evidence of Coverage.

Americans with Disabilities Act

Providers are required to comply with Americans with Disabilities Act (ADA) standards, including but not limited to:

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

The 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/.

CareSource Commitment to Health Equity & Cultural Competency

We are dedicated to the communities in which we serve and making a positive impact in the lives of our members by eliminating health disparities, supporting our organization's Health Equity initiatives, partnering with community stake holders to carry out this much needed work. Our Enterprise Life Services Department is dedicated to serving marginalized communities and making a positive impact in the lives of diverse member populations to eliminate health disparities

Enterprise Life Services is taking an integrated approach to Health Equity and embedding it across CareSource. As a result, we have developed our objectives based on Pillars of Life Services outlined below.

Workforce Development: promote long-term employment opportunities, financial literacy, connection to job training and increasing assets, such as home ownership

Housing: increase the quality of safe & affordable housing, enhanced financial tools to develop & preserve housing units & improved affordability of housing

Food & Nutrition: regular & consistent access to healthy foods, education on nutrition & overall health impacts, addressing food deserts and inequalities

Health Equity: pursuit of Health Equity for Black, Indigenous and People of Color (BIPOC), LGBTQIA, & complex populations, elimination of health disparities; partnerships with outside organizations; drive policy & advocate for change

We recognize language and cultural differences have a significant impact on member health care experience and outcomes. 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.

CLAS Standards: National Culturally & Linguistically Appropriate Standards

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 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.
- Network providers must identify limited English proficient members and offer, at no expense to the member, sign and other language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking proficiency, including TDD/TTY services to communicate with hearing impaired members.

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.

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).

Member Health, Safety & Welfare

A top priority for CareSource is ensuring the health, safety and welfare of our members. The purpose of the CareSource Health, Safety and Welfare initiative 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.

Quality Improvement Program

CareSource is committed to providing evidence-based care in a safe, member-centered, timely, efficient and equitable manner. Our CareSource quality improvement (QI) program is comprehensive and includes both clinical and non-clinical services.

CareSource monitors and evaluates the quality and safety of the care and service delivered to our members, encompassing the safety and service delivered to our members with an emphasis on accessibility to care, availability of services and practitioners, quality of care and member safety, medical and behavioral health services, and internal monitoring, including review and evaluation of program areas, such as Utilization Management, Care Management and Pharmacy.

Member satisfaction and health outcomes are monitored through quality improvement activities, routine health plan reporting, annual Health Effectiveness Data and Information Set (HEDIS)®, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, assessment of provider and member satisfaction, and review of accessibility and availability standards and utilization trends. Performance is assessed against goals and objectives that are in keeping with industry standards. Annually, CareSource completes an evaluation of our QI program.

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our Georgia Medicaid and Marketplace plans.

Program Scope

CareSource supports an active, ongoing and comprehensive quality improvement program across the enterprise. To maintain a robust QI program, our scope includes:

- Advocate for members across settings including review and resolution of quality of care issues
- Meet member access and availability needs for physical and behavioral health care
- Determine interventions for HEDIS overall rate improvement to improve preventive care scores and facilitate support of members' acute and chronic health conditions and other complex health, safety or welfare needs. CareSource uses the annual member CAHPS survey to capture member perspectives on health care quality and establishes interventions based on results to enrich member and provider experience
- Demonstrate enhanced care coordination and continuity across settings
- Meet members' cultural and linguistic needs, encompassing the social determinants of health
- Ensure CareSource is effectively serving members with complex health needs
- Assess member population characteristics and needs
- Assess geographic availability and accessibility of primary care providers and specialists
- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings
- Determine practitioner adherence to clinical practice guidelines
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies
- Ensure regulatory and accrediting agency compliance, including:
    - All federal requirements as outlined in 42CFR Part 438, Managed Care
    - Performing HEDIS compliance audit and performance measurement
    - Ensuring compliance with NCQA accreditation standards

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 for Healthcare Improvement (IHI) framework developed to optimize health system performance, as well as the Centers for Medicaid & Medicare Services' (CMS) National Quality Strategy, which is a national effort to align public and private sector stakeholders to achieve better health and health care.

Institute for Healthcare Improvement Triple Aim for Populations

CareSource aligns with the Institute for Healthcare Improvement (IHI) Triple Aim framework to:

- Improve the member experience of care (including clinical quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care

CareSource also utilizes Lean Six Sigma tools, when indicated, to focus on improving member experience, member safety and ensuring our processes consistently deliver the desired results.

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 programs to improve outcomes.

CareSource uses HEDIS to measure the quality of care delivered to our members. HEDIS is developed and maintained by 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 care and address the most significant areas of care. Potential quality measures include the following:

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer and chlamydia)
- Care for Older Adults
  - Functional status assessment
  - Medication review
  - Pain assessment
  - Advance care planning
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure
- Behavioral health
  - Follow-up after hospitalization for mental illness
  - Antidepressant medication management

- Safety
  - Use of imaging studies for low back pain

Patient Safety Program

CareSource recognizes that patient safety is the cornerstone of high-quality health care, contributing to the overall health and welfare of our members. Our CareSource Patient Safety Program evaluates patient safety trends with the goal of reducing avoidable harm. The program is developed in the context of our Population Health Management approach and includes regulatory/accreditation, training/implementation, continuous monitoring, program evaluation and improvement. The Safety Program recognizes the importance of identifying health, safety and welfare issues that may result from the social determinants of health (SDOH) which contribute to health disparities. SDOH may negatively impact member health status, ability to seek preventive services and manage chronic health conditions. Safety events are monitored through retrospective review of Quality of Care Concerns and real time reporting of claims data. Data analysis of our provider and health system network ensures situational risks can be identified in a timely manner, reviewed and mitigated by proactive corrective action or performance improvement steps.

Preventive Guidelines and Clinical Practice Guidelines

CareSource approves and adopts evidence-based nationally recognized standards and guidelines and promotes them to practitioners to help inform and guide clinical care provided to members. Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management topics. 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 (PAC) and also approved by the Enterprise PAC. The CareSource Quality Enterprise Committee (QEC) is notified of guideline approval. Topics for guidelines are identified through analysis of member population demographics and national or state priorities. Guidelines may include, but are not be limited to:

- Behavioral health (e.g., depression)
- Adult health (e.g., hypertension and diabetes)
- Population health (e.g., obesity and tobacco cessation)

Guidelines may be promoted to 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 other health information are made available to members via member newsletters, the CareSource member website, or upon request.

If you would like more information on CareSource Quality Improvement, please call Provider Services:

- D-SNP: **1-844-679-7865**

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

CareSource expects participating providers to have procedures in place to see patients within these timeframes and to offer office hours to their CareSource patients that are no less (in number of scope) than the hours of operation offered to non-Medicaid members. If a provider serves only Medicaid recipients, hours offered to Medicaid members must be comparable to those offered to Medicaid fee-for-service members.

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 hours
Regular and routine care	Not to exceed 6 weeks

Specialists

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

Behavioral Health

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 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 timeframe, 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.

Advanced 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.

Quality of Care Reviews

CareSource ensures the provision of safe and quality care to members by investigating and mitigating potential quality of care concerns, that include:

- Inappropriate or inconsistent treatment
- Delay in receipt of Care
- Compromising member health, safety or welfare
- Having the potential to limit functional abilities on a permanent or long-term basis

To properly assess quality of care concerns, CareSource Enterprise Quality Improvement initiates contact with providers to request medical records using established processes and timelines. As per our policies and provider contracts, we are authorized to ask for protected health information for health care operations, which includes quality issue reviews. Medical record requests are forwarded to providers via mail, e-mail or fax and may be returned to CareSource via these same mechanisms as detailed in the medical record request document.

All providers are expected to return medical record requests related to Quality of Care concerns within 14 days from initial receipt of the request, unless otherwise defined by program guidelines or state or federal law requirements. If a state, federal or regulatory agency, or if the health and safety of a member requires that medical records must be submitted under a shorter timeframe, providers are expected to comply with the shorter turnaround time. Providers and facilities that utilize third-party health information management vendors are responsible for providing medical records to CareSource or facilitating delivery of medical records to CareSource by the identified contractor. We are legally bound to interact with providers only and CareSource is not subject to any fees charged by health information management companies for medical record retrieval or submission.

Your health partner representative may contact you if medical records are not received within the 14-day timeframe to ensure you received the request. In addition, our market Chief Medical Officer may also be in contact to facilitate and ensure receipt of the required medical records to complete the Quality of Care reviews. Providers or facilities who repeatedly fail to return requested medical records are reported to the Credentialing Committee and may face other directed intervention or penalties up to and including contract termination.

How to Submit Changes to CareSource

Online

Visit **CareSource.com** > Login > Provider Portal

Email

ProviderMaintenance@caresource.com

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.

Primary Care Providers

Primary Care Provider Concept

The Centers for Medicare & Medicaid Services (CMS) requires D-SNP plans to provide initial and annual Model of Care (MOC) training to all network providers contracted to see dual-eligible members and all out-of-network providers seen by dual-eligible members routinely.

Providers are required by CMS to attest to completing the annual model of care training. To view and attest that you have completed the training and receive credit, please log on to the Provider Portal (link to this), which will prompt you to review and attest to completing the model of care training.

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 at a minimum, 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" sections for each plan included in this manual on how to refer members for case management.

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.

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

Immunization Schedule

"Immunizations are an important part of preventive care and should be administered as needed. CareSource endorses the immunization schedule recommended by the Centers for Disease Control and Prevention and approved by the Advisory Committee on Immunization Practices. The schedule is updated annually, and the most current updates can be found at www.cdc.gov/vaccines.

Clinical Practice Registry and Member Profile

Quick and easy to access on our secure Provider Portal, the CareSource Clinical Practice Registry helps PCPs improve patient health outcomes efficiently. The primary use of the Registry is to help PCPs manage their patient population.

PCPs can quickly sort their CareSource membership into actionable groups. The CareSource Clinical Practice Registry is a proactive approach to patient care and helps place emphasis on preventive care.

Key Benefits of the Registry

- The registry is color-coded, which provides easy identification of members in need of tests and/or screenings.
- The information can be downloaded as a PDF or in an Excel spreadsheet format (the Excel spreadsheet contains patient contact information).
- It provides direct access to the CareSource Member Profile feature for individual members of interest.

Information Included on the Registry

- Asthma
- Breast cancer screening
- Cervical cancer screening
- Diabetes (e.g. cholesterol, eye exam, hematology, kidney)
- Emergency room visits

The CareSource Clinical Practice Registry is located on our secure Provider Portal.

Member Profile

With its comprehensive view of patient medical and pharmacy data, our Member Profile can help you improve health outcomes for your CareSource patients. The Member Profile can also help you determine an accurate diagnosis more efficiently, reduce unnecessary diagnostic tests and minimize emergency room visits.

Key Benefits of the Member Profile

- Provides medical history
- Identifies potential prescription non-adherence or abuse
- Identifies duplication of services
- Introduces disease or care management options

Please Note: The Member Profile tool can be found on the Eligibility and Prior Authorization screens of the Provider Portal.

After-Hours Care

Telephone Arrangements

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 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 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.

Enhanced Reimbursement

CareSource can help you identify members from your primary care practice who are utilizing the emergency room frequently. We offer this service to help you manage your patients more easily, direct them to the appropriate setting for care and decrease inappropriate emergency room visits. We also offer enhanced reimbursement to primary care offices holding evening or weekend hours.

CPT Code	Days/Hours	Reimbursement
99050	Monday to Friday 5 p.m. to 10 p.m. Weekends and holidays: 8 a.m. to 10 p.m.	$16.50, plus office visit rate
99051	Seven days per week 10 p.m. to 8 a.m.	$22, plus office visit rate

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. This must be done 90 days prior to the date of the intended termination and submitted on your organization's letterhead.
  - 60-day 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.
- For Primary Care Providers (PCPs) only: 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 365 days of the date of service or discharge.
- Appeals must be filed within 365 days of the date of service or 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

- Paying 90 percent of clean claims within 30 days of receipt.
- 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 "Provider Appeals Procedures" sections for each plan in this manual.
- Offering a 24-hour Nurse Advice Line 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 Medicaid 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" chapter on page 43 of this manual.

Submitting Provider Changes

Type of Change	**Notice Required** Please notify CareSource of the change prior to the timeframes 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

Mail

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

Americans with Disabilities Act Standards

Additionally, providers will remain compliant with Americans with Disabilities Act (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
- Accessibility along public transportation routes and/or provide enough parking
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities
- 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.

MEDICARE PROVIDERS

Additional Provider Responsibilities & Standards

- Paying 90 percent of clean claims within 30 days of receipt. We adhere to both federal and state prompt pay guidelines
- 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 "Provider Appeals Procedures" chapter on page 58 of this manual.
- Offering a 24-hour Nurse Advice Line for members to reach a medical professional at any time with questions or concerns.
- When CareSource coordinates benefits with the primary carrier, the Carve- Out method is used. Carve-out involves subtracting the primary payment from the lesser of the primary carrier allowable or Medicaid allowable. If the primary payment is more than the determined allowable amount, then CareSource pays zero.
- 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. For example:
    - 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 the "Member Rights and Responsibilities" chapter on page 62 of this manual.

CareSource expects participating providers to verify member eligibility and ask for all of 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 Provider Portal from the menu options.

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.

CMS requires that specific terms and conditions be incorporated into the agreement between a organization or first tier entity and a first tier entity or downstream entity to comply with the Medicare laws, regulations, and CMS instructions.

The topics covered in these requirements are as follows:

- Record retention
- Privacy and accuracy of records
- Hold harmless
- Prompt payment
- Compliance with applicable Medicare laws and regulations

These provisions will be included in contracts with CareSource providers who serve CareSource members.

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 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 Program Integrity 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 sixty (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 Program Integrity 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 providermaintenance@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 or 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 Program Integrity department. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for Reporting Anonymously:

Call the Fraud Hotline at 1-844-415-1272 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

Or you may 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/index.asp.

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

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