CareSource®

Health Care with Heart

CareSource Marketplace Plans

# Health Partner Manual

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

# Dear CareSource Health Partner,

Thank you for your participation. CareSource values our relationships with our health partners and is actively working to make it easier for you to deliver quality care to our members.

CareSource has more than 25 years of history providing Medicaid, Medicare and other managed health care services. We also offer plans in the Health Insurance Marketplace.

Members enrolled in our Marketplace plans pay any premiums and cost-sharing amounts (deductibles, coinsurance, copayments, etc.) that apply to their coverage based on their level of income. **Since we have purposely focused on the uninsured, we designed our Marketplace plans with low copayments and deductibles to improve access and reduce uncompensated care.**

This manual is a resource for working with our health plan. The manual communicates policies and programs and outlines key information such as claims submission, reimbursement processes, authorizations, member benefits and more to make it more efficient for you to do business with us. CareSource communicates updates to our health partner network regularly on our secure Provider Portal. The most up-to-date information can be found on the CareSource Provider Portal at **https://providerportal.caresource.com/.**

To support our health partners in navigating our plan, we have a dedicated call center to assist with questions and concerns. Additionally, an external team of specialists are available to provide onsite training and work with our health partners in their communities.

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

Sincerely,

CareSource

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# About CareSource

## Welcome

Welcome and thank you for becoming a participating health partner with CareSource.

At CareSource, we call health care providers our **health partners**. A “health partner” is any health care provider who participates in CareSource’s provider network. You may find “health partner” and health care provider used interchangeably in our manual, agreements and website.

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 non-profit, community-based health plan that currently serves Ohio, Indiana, Kentucky and West Virginia consumers that are enrolled our plans on the Health Insurance Marketplace.

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

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

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

- New members
- Existing members
- New practitioners
- Existing practitioners

# 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 health partners.

## Vision and Mission

*Our vision is transforming lives through innovative health and life services.*

*Our mission is to make 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 Include:**

- Health partner relations
- Health partner 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 and a 24-hour nurse advice line

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
- Care Transitions – Bridge to Home® (discharge planning and transitional care support)
- Behavioral health and substance abuse
- Lock-in programs (targeted at members who are over-utilizing pharmacy benefits and locks them into key health partners to control inappropriate use)
- Collaboration with pharmacy and medication therapy management

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

**The CareSource Foundation**

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

To date, the CareSource Foundation has awarded grants totaling over $14 million. Grants focus on issues of the uninsured, critical trends in children's health and special populations. Several large signature grants were made specifically to address issues of access to coverage in the new health care reform landscape and elevating children from the cycle of poverty through the power of education.

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

# Compliance and Ethics

At CareSource, we serve a variety of audiences – members, health partners, 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 health partners, consultants and vendors.

**General Compliance and Ethics Expectations of Health Partners**

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

For questions about health partner expectations, please call your Health Partner Engagement Specialist or Health Partner Services:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

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 & Compliance Hotline: 877-LINKCSM (877-546-5276) or http://caresource.safe2say.info
- Compliance Officer: 937-531-2028 or Kurt.Lenhart@CareSource.com

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

The CareSource Corporate Compliance Plan is posted on the CareSource website at **CareSource.com** for your reference.

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

Here are a few important places to start:

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

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

## Accreditation

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

# Communicating with CareSource

CareSource communicates with our health partner network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSource.com** and network notifications.

## CareSource Hours of Operation

| | | |
|---|---|---|
| **Health Partner Services** | Monday to Friday | 8 a.m. to 6 p.m.<br>Eastern Standard Time |

| **Member Services** | | |
|---|---|---|
| CareSource24<br>(nurse advice line for all plans) | Seven days a week, 365 days a year | 24 hours a day |
| CareSource | Monday to Friday | 7 a.m. to 7 p.m.<br>Eastern Standard Time |

Please visit **CareSource.com** for the holiday schedule or contact Health Partner Services for more information.

# Phone

Our interactive voice response system, Katie, 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.

| | Indiana | Kentucky | Ohio | West Virginia |
|---|---|---|---|---|
| Health Partner Services | 1-866-286-9949 | 1-855-852-5558 | 1-800-488-0134 | 1-855-202-1091 |
| Prior Authorizations | 1-866-286-9949 | 1-855-852-5558 | 1-800-488-0134 | 1-855-202-1091 |
| Claims Inquiries | 1-866-286-9949 | 1-855-852-5558 | 1-800-488-0134 | 1-855-202-1091 |
| Credentialing | 1-866-286-9949 | 1-855-852-5558 | 1-800-488-0134 | 1-855-202-1091 |
| Member Services | 1-877-806-9284 | 1-888-815-6446 | 1-800-479-9502 | 1-855-202-0622 |
| CareSource24® – Nurse Advice Line | 1-866-206-7880 | 1-866-206-7879 | 1-866-206-4240 | 1-866-206-0701 |
| Fraud, Waste & Abuse Reporting | 1-866-286-9949 | 1-855-852-5558 | 1-800-488-0134 | 1-855-202-1091 |
| TTY for the Hearing Impaired | 1-800-743-3333 or 711 | 1-800-648-6056 or 711 | 1-800-750-0750 or 711 | 1-800-982-8771 or 711 |

| | Indiana | Kentucky | Ohio | West Virginia |
|---|---|---|---|---|
| Care Management Referral | 844-676-0364 | 877-946-2273 | 877-946-2273 | 866-582-0615 |
| Credentialing | 866-573-0018 | 866-573-0018 | 866-573-0018 | 866-573-0018 |
| Contract Implementation | 937-396-3632 | 937-396-3632 | 937-396-3632 | 937-396-3632 |
| Fraud, Waste and Abuse | 800-418-0248 | 800-418-0248 | 800-418-0248 | 800-418-0248 |
| Medical Prior Authorization Form | 877-716-9480 | 877-716-9480 | 888-752-0012 | 844-676-0367 |
| Pharmacy Prior Authorization Form | 866-930-0019 | 866-930-0019 | 866-930-0019 | 866-930-0019 |
| Partner Appeals | 937-531-2398 | 937-531-2398 | 937-531-2398 | 866-582-0370 |
| Partner Maintenance | 937-396-3076 | 937-396-3076 | 937-396-3076 | 866-582-0370 |

# Website/Online Provider Portal

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

**Provider Portal: https://providerportal.caresource.com**

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

***Provider Portal Benefits***

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

***Provider Portal – Value to You***

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

- **Payment history** – Search for payments by check number or claim number.
- **Claim status** – Search for status of claims and claim appeals.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior authorization** – Medical inpatient/outpatient, home health care and Synagis®.
- **Eligibility termination dates** – View the member's termination date (if applicable) under the eligibility tab.
- **Case management referrals** – The case management form is now automated on our Portal for efficiency in enrolling members.
- **Benefit limits** – Health partners can track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy and speech therapy.
- **Care treatment plans** – Health partners now have the option to view care treatment plans for their patients on our Provider Portal.
- **Claim history for vision benefits**
- **Submit claims** – Submit claims using online forms. Claim submission through the portal is available to traditional health partners, community partners, delegates and health homes. For more information about submitting claims online, please visit the Claim Submissions section on page 18.
- **Monthly membership lists** – PCPs can view and download current monthly membership lists.
- **Member financial status and information** – View member payment responsibilities (such as deductible, copay and coinsurance) and monthly premium payment status.

***Dental Health Partners*** – Please refer to **CareSource.com** for information about the Provider Portal capabilities specifically for dental health partners.

***Portal Registration***

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

1. 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.
2. Click the "Continue" button.
3. 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 Health Partner Services:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

# How to Communicate with CareSource by Mail

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

**Health Partner Appeals Mailing Address**

| Indiana | Kentucky | Ohio | West Virginia |
|---|---|---|---|
| CareSource<br>P.O. Box 2008<br>Dayton, OH 45401-2008 | CareSource<br>P.O. Box 804<br>Dayton, OH 45401 | CareSource<br>P.O. Box 1947<br>Dayton, OH 45401-1947 | CareSource<br>P.O. Box 804<br>Dayton, OH 45401 |

Please visit our website for more information on how appeals can be submitted online.

**Member Appeals & Grievances Mailing Addresses**

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

**Claims Mailing Address**

| Indiana | Kentucky | Ohio | West Virginia |
|---|---|---|---|
| CareSource<br>P.O. Box 3607<br>Dayton, OH 45401-3607 | CareSource<br>P.O. Box 824<br>Dayton, OH 45401-0824 | CareSource<br>P.O. Box 8730<br>Dayton, OH 45401-8730 | CareSource<br>P.O. Box 804<br>Dayton, OH 45401 |

**Fraud, Waste and Abuse Address**

CareSource
Attn: Special Investigations Unit
P.O. Box 1940
Dayton, OH 45401-1940

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

**Newsletters**

CareSource communicates with health partners in a variety of ways. Our health partner newsletter, produced and mailed three times a year, contains operational updates, clinical articles and new initiatives underway at CareSource.

**Network Notifications**

Network notifications are published for CareSource health partners to regularly communicate updates to policies and procedures. Network notifications are found on our website and the CareSource Provider Portal.

**Heath Partner Demographic Changes and Updates**

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

**Email:** ProviderMaintenance@caresource.com
**Mail:** CareSource
P.O. Box 8738
Dayton, OH 45401-8738
Attn: Provider Maintenance
**Fax:** 937-396-3076

# Fraud, Waste and Abuse

Health care fraud, waste and abuse hurts everyone, including members, health partners, taxpayers and CareSource. As a result, CareSource has a comprehensive fraud, waste and abuse program in our Special Investigations Unit. 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 health partner/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 health partners 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 health partners to get treatment, drugs, etc.

## Examples of Health Partner 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 Special Investigations Unit 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 health partner education
- Written corrective action plan
- Health partner termination with or without cause
- Health partner 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 health partner agreement provides specific information on each type of termination/suspension. The Fair Hearing Plan, available at **CareSource.com** (search “Fair Hearing Plan”), provides information on an appeal process for specific health partner terminations.

# 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:**

**A.** Knowingly* presents, or causes to be presented, a false or fraudulent claim for payment or approval
**B.** Knowingly* makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim
**C.** Conspires to commit a violation of any other section of the False Claims Act
**D.** 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
**E.** 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
**F.** 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
**G.** 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 health care partner, 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 Special Investigations Unit.

Additional information on the False Claims Act and our fraud, waste and abuse policies can be found on **CareSource.com.**

**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, health partners 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, health partner 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** utilizing the contact information in the reporting section below.

**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 using the contact information in the reporting section below.

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 Special Investigations Unit. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting anonymously:

- **Call** the appropriate number below and tell Katie, our interactive voice response system, that you are calling to report fraud:
  Indiana: 1-866-286-9949
  Kentucky: 1-855-852-5558
  Ohio: 1-800-488-0134
  West Virginia: 1-855-202-1091

Our fraud, waste and abuse hotline is available 24 hours a day.

- **Write:**
  CareSource
  Attn: Special Investigations Unit
  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**.

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 health partners 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.

# Claim Submissions

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

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

## Billing Methods

CareSource accepts claims in a variety of formats, including paper and electronic claims. We encourage health partners 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**

Health partners now have the option to submit claims through the secure, online Provider Portal. Online submission saves you money by eliminating the costs associated with printing and mailing paper claims.

In addition, CareSource offers this service via our portal at no cost. 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

**Who Can Submit Claims Via the Portal?**

CareSource's traditional health partners, community partners and delegates, and health homes all may submit claims through the Provider Portal.

**What Types of Claims Can Be Submitted?**

- Professional medical office claims
- Dental claims
- Institutional claims

**Electronic Funds Transfer**

CareSource offers electronic funds transfer (EFT) as a payment option. Visit the Provider Portal for additional information about the program and to enroll in EFT. Health partners who elect to receive EFT payment will receive an EDI 835 (Electronic Remittance Advice). Health partners 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 health partners.
- **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.

Simply complete the enrollment form, available on the "Claims Payment" page of **CareSource.com**, and fax it back to InstaMed, who will work directly with health partners to enroll in EFT. Free EFT training is also available to CareSource health partners through InstaMed during the enrollment process. You view the training by visiting www.instamed.com/aha-eraeft.

# Electronic Claims 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 health partners. Our EDI system complies with HIPAA standards for electronic claims submission.

**EDI Clearinghouses**

CareSource prefers electronic claim submission. To submit electronic claims, health partners may use any clearinghouse (trading partner), if it can be validated that the clearinghouse will send the claims to CareSource. If you do not currently use a clearinghouse, please contact the clearinghouse of your choice from our preferred list below or use our free Provider Portal.

Please provide the clearinghouse with the CareSource payer ID number.

- Indiana: INCS1
- Kentucky: KYCS1
- Ohio: 31114
- West Virginia: WVCSI

| Trading Partner | Phone | Website | IN | KY | OH | WV |
|---|---|---|---|---|---|---|
| Alveo | 1-800-327-1213 | http://alveohealth.com/ | ♥ | ♥ | ♥ | |
| Change Healthcare | 1-800-845-6592 | www.emdeon.com | ♥ | ♥ | ♥ | ♥ |
| Dyserv | 1-614-294-6078 | www.dyserv.com | | | ♥ | |
| Manacon | 1-937-746-6685 | N/A | | | ♥ | |
| Practice Insight | 1-832-476-9030 | www.practiceinsight.com | ♥ | ♥ | ♥ | ♥ |
| Quadax | 1-440-777-6305 | www.quadax.com | ♥ | ♥ | ♥ | ♥ |
| RealMed | 1-817-927-8000 | www.RealMed.com | ♥ | ♥ | ♥ | ♥ |
| RelayHealth | 1-866-735-2963 | www.relayhealth.com | ♥ | ♥ | ♥ | ♥ |
| ZirMed | 1-877-494-7633 | www.zirmed.com | ♥ | ♥ | ♥ | ♥ |
| **Dental Clearinghouses** | **Phone** | **Website** | **IN** | **KY** | **OH** | **WV** |
| Tesia | 1-800-724-7240 | www.tesia.com | ♥ | ♥ | | |
| Emdeon Dental (formerly CPS) | 1-888-255-7293 | www.cpsedi.com | ♥ | ♥ | ♥ | |

**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).

**NPI and Tax ID Numbers**

Your National Provider Identifier (NPI) number and Tax ID 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 Health Partner's NPI and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating Health Partner's NPI and (if applicable) Box 49 for the group NPI

**Location of Health Partner's NPI, TIN and Member ID Number on Professional Claims**

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

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

The Billing Health Partner TIN (Tax Identification Number) must be submitted as the secondary Health Partner 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 Health Partner TIN or SSN

**Institutional Claims**

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

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

The Billing Health Partner TIN (Tax Identification Number) must be submitted as the secondary Health Partner 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 Health Partner TIN or SSN

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

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

# Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. 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 the Centers for Medicare and Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA).

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

- CMS 1500 Form Instructions: www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf
- UB-04 Form Instructions: www.nucc.org

**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 health partner's NPI and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating health partner's NPI and (if applicable) Box 49 for the group NPI

**All claims (EDI and paper) must include the following information:**

- 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 member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service – Use standard CMS (HCFA) location codes.
- ICD-10 diagnosis code(s).
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable.
- Units, where applicable (anesthesia claims require minutes).
- Date of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain From/To formats. Please enter each date individually.
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information.
- Federal tax ID number or physician social security number – Every health partner practice (e.g., legal business entity) has a different tax ID number.
- Signature of physician or supplier – The health partner's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

**What to Include on Claims That Require NDC**

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

**Instructions for NDC 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:**

- EDI claims 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 at the following address:**

| Indiana | Kentucky | Ohio | West Virginia |
|---|---|---|---|
| CareSource<br>Attn: Claims Department<br>P.O. Box 3607<br>Dayton, OH 45401 | CareSource<br>Attn: Claims Department<br>P.O. Box 824<br>Dayton, OH 45401 | CareSource<br>Attn: Claims Department<br>P.O. Box 8730<br>Dayton, OH 45401 | CareSource<br>Attn: Claims Department<br>P.O. Box 804<br>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. If the claim is denied, then health partners have 365 calendar days from the date of service or discharge to file a claim appeal. If the health partner was denied authorization or reimbursement due to not obtaining a required prior authorization, then the health partner has one hundred eighty (180) days from the date of service or discharge to file a claim appeal.

**Claims Processing Guidelines**

- Health partners 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.
- If you do not agree with the decision of the processed claim, you will have 365 calendar days from the date of service or discharge to file a claim appeal.

- If the health partner was denied authorization or reimbursement due to not obtaining a required prior authorization, then the health partner has 180 days from the date of service or discharge to file a claim appeal.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a member has other insurance and CareSource is secondary, the health partner 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 health partner 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.

## Searching for Claims Information Online

Claims' 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 number.

**Additional Claims Enhancements on the Provider Portal**

- Claim history available up to 24 months from the date of service
- Submit claim appeal
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date
- Dental claim information
- Vision claim information

## 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 health care partners 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 http://www.amaassn.org/ama/pub/physician-resources/solutions-managing-your-practice/ coding-billing-insurance/cpt.page.

- 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.
- National Drug Codes (NDC). Available at http://www.fda.gov/.

**Procedures That Do Not Have a Corresponding CPT 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.
- Abortion Sterilization and Hysterectomy procedures
  - Consent forms must be attached (Please go to the "Forms" Section of **CareSource.com** for these forms).
- 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 health partner.

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

**CareSource Health Partner 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 health partner contract. Generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

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

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

CareSource seeks to apply fair and reasonable coding edits. We maintain a health partner appeals function that will review, upon request, any claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review will take into consideration all the previously mentioned CCI and national commercial standards when considering the appeal. In order to ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the CareSource appeals team to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current CareSource claim logic and other established coding benchmarks. Any consideration of a health partner'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 (EOP)

Explanation of Payments (EOPs) are statements of the current status of your 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. Health partners who receive EFT payments will receive an Electronic Remittance Advice (ERA) and can access a "human readable" version on the Provider Portal.

**Information Included on EOPs**

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 health partner's responsibility to resubmit claims with the correct or completed information needed for processing.

## Check Claim Status Online

Pended claims are claims that have been entered into our system, but have not yet been processed completely.

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

## Explanation of Benefits

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

## Other Coverage – Coordination of Benefits (COB)

**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.

**COB Overpayment**

If a health partner receives a payment from another carrier after receiving payment from CareSource for the same items or services and it is determined the other carrier is primary, this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the health partner, or health partners can issue refund checks to CareSource for any overpayments. Health partners 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 health partner 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 health partner for all covered services. Then, we will pursue recovery from any third parties involved.

**Member Financial Liability and Grace Period**

A member must first pay an annual deductible before being entitled to covered services. In addition to the deductible, copayments or coinsurance are also applicable for most covered services. It is up to the health partner to collect these amounts at the time of service. If a member overpays his or her coinsurance, the health partner must refund the overpayment to the member.

CareSource is required to provide a 90-calendar day grace period to members for non-payment of their premium. During those 90 calendar days, CareSource will continue to process medical claims and pay health partners accordingly.

If the member is terminated for non-payment of premium, CareSource will retroactively terminate the member and all monies for months two and three of delinquency will be recovered from the health partner.

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

# Covered Services and Exclusions

## Covered Services

Please visit the CareSource website at **CareSource.com** for 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 of this manual for more information about referral and prior authorization 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 Health Partner Services:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

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 prior authorization. Please visit the Provider Portal at **CareSource.com** for the most up-to-date list of services that require prior authorization.

# Medical Necessity Determinations

Some services require prior authorization. When request for authorization is submitted, CareSource will notify the health partner and member in writing of the determination. If a service cannot be covered, the letter will from CareSource will include the reason that the service cannot be covered and how to request an appeal if necessary.

Health partners and members may have the right to appeal the decision. Please see the "Appeal Procedures" section of this manual for information on how to file an appeal.

Covered services and exclusions for CareSource's Marketplace members can be found at **CareSource.com.**

**CareSource Dental & Vision**

CareSource members can choose additional dental and vision coverage through CareSource Dental & Vision. Dental benefits include routine (cleanings and exams), basic (X-rays and fillings) and some major dental services. Adult members age nineteen years or older are eligible for CareSource Dental & Vision*. CareSource members ages 18 and under have some vision services covered under the basic plan**. Please visit **CareSource.com** for more information regarding this plan and the covered services.

*For Kentucky: Adult members age twenty or older are eligible for CareSource Dental & Vision.
**For Kentucky: CareSource members ages 19 and under have some vision services covered under the basic plan

# Credentialing and Recredentialing

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

**CAQH Application**

CareSource is a participating organization with CAQH. Please make sure that we have access to your health partner 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 sure CareSource is listed as an authorized health plan (if not, please check the Authorized box to add)

Please submit a complete Council for Affordable Quality Healthcare (CAQH) application or CAQH number and National Provider Identifier (NPI) number via one of three vehicles:

- **Email:** Contract.Implement@caresource.com
- **Fax:** 937-396-3632
- **Mail:** Send by certified mail with return receipt to:
  CareSource
  P.O. Box 8738
  Dayton, OH 45401-8738
  Attn: Contract Implement

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

Please also include copies of the following documents:

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

**Debarred Health Partner Employee Attestation**

CareSource verifies that its health partners and the health partners' employees have not been debarred or suspended by any state or federal agency. CareSource also requires that its health partners and the health partners' employees disclose any criminal convictions related to federal health care programs. "Health partner employee" is defined as directors, officers, partners, managing employees or persons with beneficial ownership of more than 5 percent of the entity's equity.

**CareSource Debarment/Criminal Conviction Attestation**

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

**Contracted Health Partners Listed in the Provider Directory and the Following Are Credentialed:**

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

**The Following Health Partners Listed in the Provider Directory Do Not Need to Be Credentialed:**

- Practitioners who practice exclusively within the inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting.

- Practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the CareSource Provider Directory.
- Pharmacists who work for a pharmacy benefit management (PBM) organization.
- Practitioners who do not provide care for members in a treatment setting (e.g. board-certified consultants).

**Health Partner Selection Criteria**

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

Quality of care delivery, as defined by the Institute of Medicine, states: "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 health partner 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 health partner types in a nondiscriminatory manner.

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

**Selection Criteria:**

**A.** Active and unrestricted license in the State issued by the appropriate licensing board.
**B.** Current DEA certificate (if applicable).
**C.** Successful completion of all required education.
**D.** Successful completion of all training programs pertinent to one's practice.
**E.** For MDs and DOs, successful completion of residency training pertinent to the requested practice type.
**F.** For dentists and other health partner where special training is required or expected for services being requested, successful completion of training.
**G.** Board Certification is not required for primary care specialties. PCPs who are approved by the CareSource Credentialing Committee will appear in CareSource Provider Directories.
**H.** Health partners 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.
**I.** Education, training, work history and experience are current and appropriate to the scope of practice requested.
**J.** Malpractice insurance at specified limits established for all practitioners by the credentialing policy.
**K.** Good standing with Medicaid and Medicare.
**L.** Quality of care and practice history as judged by:
    i. Medical malpractice history
    ii. Hospital medical staff performance
    iii. Licensure or specialty board actions or other disciplinary actions, medical or civil

iv. 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
v. Other quality of care measurements/activities
vi. Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
vii. Lack of issues on HHS-OIG, SAM/ EPLS, or state site for sanctions or terminations (fraud and abuse)

**M.** Signed, accurate credentialing application and contractual documents.
**N.** Participation with Care Management, Quality Improvement and Credentialing programs.
**O.** Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
**P.** Agreement to comply with plan formulary requirements or acceptance of Plan Preferred Drug List as administered through the Pharmacy Benefit Manager.
**Q.** Agreement to access and availability standards established by the health plan.
**R.** Compliance with service requirements outlined in the health partner agreement and CareSource Health Partner Manual.

**Indiana:**

An advanced practice nurse (APN) may be credentialed as a Primary Care Providers if that APN maintains compliance with the rules set forth by the Indiana State Board of Nursing defined in "Compilation of the Indiana Code and Indiana Administrative Code, 2013 Edition." The APN is expected to be familiar with these rules. "Advanced practice nurse" means a registered nurse holding a current license in Indiana who:

**A.** Has obtained additional knowledge and skill through a formal, organized program of study and clinical experience, or its equivalent, as determined by the board
**B.** Functions in an expanded role of nursing at a specialized level through the application of advanced knowledge and skills to provide healthcare to individuals, families, or groups in a variety of settings

**Kentucky:**

Advanced practice nurse (APN) may be credentialed as a Primary Care Provider

**Ohio:**

**A.** A certified nurse practitioner may be credentialed as a Primary Care Provider if that nurse practitioner:
i. Holds a valid certificate of authority issued by the Ohio Board of Nursing in accordance with section 4723.42 of the Revised Code
i. Is certified by a national certifying organization approved by the Ohio Board of Nursing
iii. Holds a current "certificate to prescribe"
iv. Has a signed standard care arrangement with a collaborating health partner who is a participating health partner with CareSource
v. Requests designation as a PCP via a letter to CareSource. vi. Practices within a provider-based practice as defined by OAC 5101:3-8-22
**B.** A certified nurse practitioner may be credentialed as a PCP and as an "independent practitioner" if the above criteria (i) through (vi) are met and the nurse practitioner's practice type is independent as defined by OAC 5101:3-8-22.

**West Virginia:**

An advanced practice registered nurse (APRN) may be credentialed as a Primary Care Provider if that APRN maintains compliance with the rules set forth by the West Virginia RN Board and West Virginia Code,

Chapter 30, Article, 7. The APRN is expected to be familiar with these rules. “Advanced practice nurse” means a registered nurse holding a current license in West Virginia as defined:

**A.** The practice of “advanced practice registered nurse” is a registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advance practice registered nurse which shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner.

**Organizational Credentialing and Recredentialing** – The following organizational health partners 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 health partners are also credentialed:**

- Hospice health partners
- Urgent care facilities, free-standing and not part of a hospital campus
- Dialysis centers
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- 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 health partner responsible for medical services will be credentialed using the standard credentialing and recredentialing processes.

**The following elements are assessed for organizational health partners:**

- Health partner is in good standing with state and federal regulatory bodies
- Health partner has been reviewed and approved by an accrediting body
- Every three years 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

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

# Practitioner Rights

- Practitioners have the right to review information submitted to support their credentialing application upon request to the CareSource Credentialing Department. CareSource keeps all submitted information locked and confidential.
- Practitioners 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 practitioner will be notified and given the opportunity to correct this information prior to presenting to the credentialing committee.
- Practitioners have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing Department.

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

**Board Certification Requirements**

Effective Jan. 1, 2003, physicians applying to become participating health partners 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 time frame specified by their respective board. Failure to become certified may result in termination as a participating health partner.

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. At the time of recredentialing, if board certification status has expired, a letter will be sent to the physician to request explanation. If the response indicates quality concerns as a reason, the VP, Senior Medical Director, or designated Medical Director will contact the physician and investigate directly.

To be credentialed as a subspecialist physicians must:

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

**Delegation of Credentialing/Recredentialing**

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

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

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

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

CareSource may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited CVO. Health partners 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 health partner 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 health partner will be notified in writing. Reconsideration and appeal opportunities are available unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan. To submit a request, the following steps apply:

**Step 1** – Submit to the Vice President/Senior Medical Director a reconsideration request in writing, along with any other supporting documentation.

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

All reconsideration requests must be received by CareSource within 30 calendar days of the date the health partner 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 health partner 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 health partner is notified of the reconsideration decision.

**Appeals may be sent to:**

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

Applying health partners may submit additional documents for reconsideration by the credentialing committee to the address above. An application rejection due to the health partner'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 see our website at **CareSource.com**. Search "Fair Hearing".

## Health Partner Disputes

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

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

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

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

## Summary Suspensions

CareSource reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating health partner 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 health partner 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.

# 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.

**Participating health partners are responsible for:**

- Providing CareSource with advance written notice of any intent to terminate an agreement with us. In terminations without cause, written notice must be done 120 calendar days prior to the date of the intended termination and submitted on your organization's letterhead.
  - **60 calendar days' notice is required if you plan to close your practice to new patients.** If we are not notified within this time period, you will be required to continue accepting CareSource members for a 60 calendar day period following notification.
- **For PCPs only:** Providing 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or a taped message used after-hours, patients should be given the means to contact their PCP or a back-up health partner to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up health partner and only recommends emergency room use for after hours.
- Submission of claims or corrected claims should be submitted within 365 calendar days of the date of service or discharge.
- Appeals must be filed within 365 calendar days of the date of service or discharge. An appeal in which the health partner was denied authorization or reimbursement due to not obtaining a required prior authorization must be filed within 180 days from the date of service or from the date of discharge.
- Health partners should keep all demographic and practice information up to date. Send email updates to ProviderMaintenance@caresource.com.

**Our agreement also indicates that CareSource is responsible for:**

- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the appeals section of this manual.
- Offering a 24-hour nurse advice line service for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance which involves subtracting the primary payment from the lessor of the primary carrier allowable or the CareSource allowable. If the member's primary insurer pays a health partner 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 health partners to follow standard practice procedures even though they may not be spelled out in our health partner agreement.

**For example:**

- Participating health partners, 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 health partners are expected to treat members with respect. CareSource members should not be treated any differently than patients with any other health care insurance. Please reference member rights in the "Member Support Services and Benefits" section of this manual.

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

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

**Timeline of Health Partner Changes**

| **Type of Change** | **Notice Required** (Please notify CareSource of the change **prior to** the time frames listed below.) |
|---|---|
| New health partners or deleting a health partner | Immediate |
| Health partner leaves the practice | Immediately upon Health Partner notice |
| Phone number change | 10 calendar days |
| Address change | 60 calendar days |
| Change in capacity to accept members | 60 calendar days |
| Health partners 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 Health Partner Directories are up-to-date and reduces unnecessary calls to your practice.

**How to submit changes to CareSource:**

**Email:** ProviderMaintenance@caresource.com
**Fax:** 937-396-3076
**Mail:** CareSource
P.O. Box 8738
Dayton, OH 45401-8738
Attn: Provider Maintenance

## Americans with Disabilities Act (ADA) standards

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

**A.** Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities,
**B.** Providing accessibility along public transportation routes and/or enough parking,
**C.** Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities, and
**D.** 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.

# Member Enrollment and Eligibility

## Member Enrollment

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

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

## Member ID Cards

The member ID card is used to identify a CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their previous ID card. Therefore, it is important to verify member eligibility prior to each service rendered.
Health partners may use our secure Provider Portal on our website or call Health Partner Services to check member eligibility.

**Provider Portal:** https://providerportal.caresource.com/

Click on "Member Eligibility" on the left, which is the first tab.

### Health Partner Services:

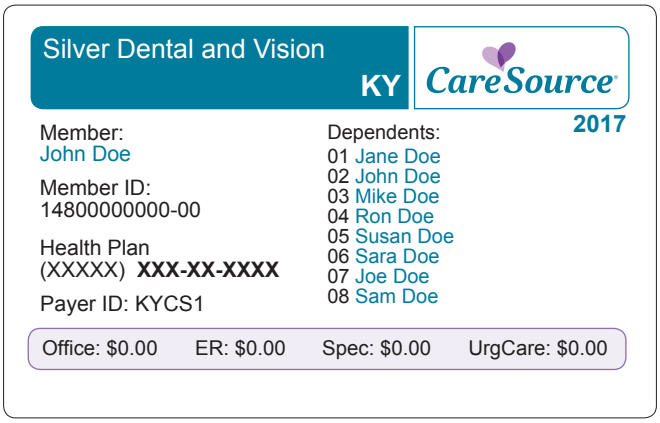
- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

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

### Indiana ID Artwork Sample

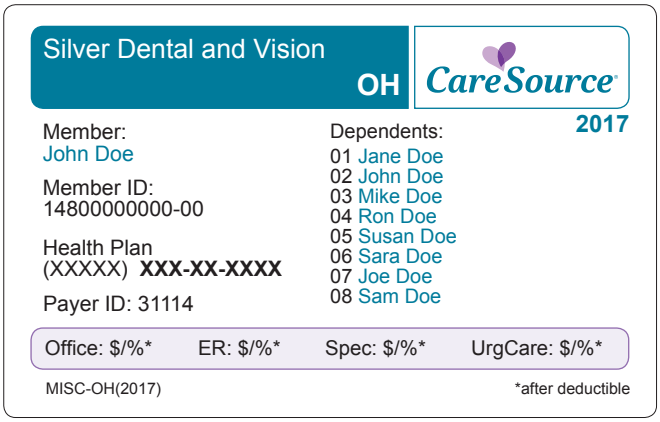

### Indiana Hoosier Choice ID Artwork Sample

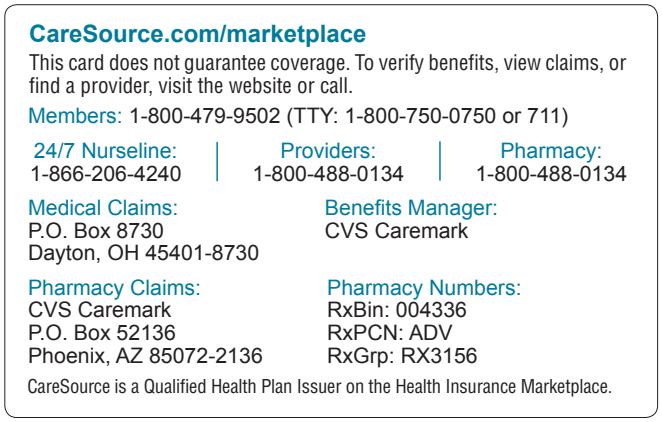
## Kentucky ID Artwork Sample


Silver Dental and Vision
KY
CareSource
2017
Member:
John Doe
Member ID:
14800000000-00
Health Plan
(XXXXX) **XXX-XX-XXXX**
Payer ID: KYCS1
Dependents:
01 Jane Doe
02 John Doe
03 Mike Doe
04 Ron Doe
05 Susan Doe
06 Sara Doe
07 Joe Doe
08 Sam Doe
Office: $0.00 ER: $0.00 Spec: $0.00 UrgCare: $0.00

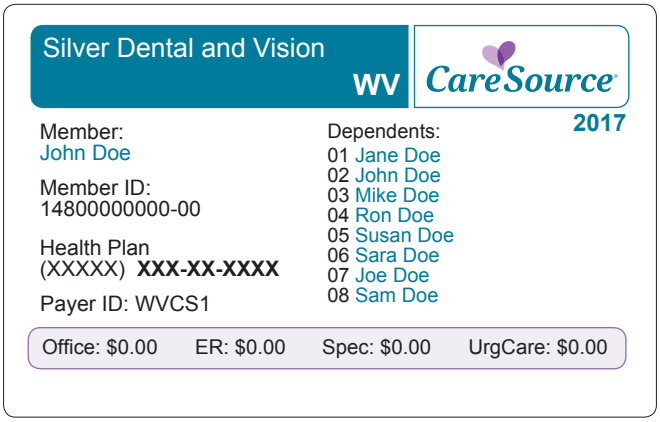

**CareSource.com/marketplace**
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the website or call.
Members: 1-888-815-6446 (TTY: 1-800-648-6056 or 711)
24/7 Nurseline: 1-866-206-7879
Providers: 1-855-852-5558
Pharmacy: 1-855-852-5558
Medical Claims:
P.O. Box 824
Dayton, OH 45401-0824
Benefits Manager:
CVS Caremark
Pharmacy Claims:
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136
Pharmacy Numbers:
RxBin: 004336
RxPCN: ADV
RxGrp: RX3158
CareSource is a Qualified Health Plan Issuer on the Health Insurance Marketplace.

## Ohio ID Artwork Sample


Silver Dental and Vision
OH
CareSource
2017
Member:
John Doe
Member ID:
14800000000-00
Health Plan
(XXXXX) **XXX-XX-XXXX**
Payer ID: 31114
Dependents:
01 Jane Doe
02 John Doe
03 Mike Doe
04 Ron Doe
05 Susan Doe
06 Sara Doe
07 Joe Doe
08 Sam Doe
Office: $/%* ER: $/%* Spec: $/%* UrgCare: $/%*
MISC-OH(2017)
*after deductible


**CareSource.com/marketplace**
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the website or call.
Members: 1-800-479-9502 (TTY: 1-800-750-0750 or 711)
24/7 Nurseline: 1-866-206-4240
Providers: 1-800-488-0134
Pharmacy: 1-800-488-0134
Medical Claims:
P.O. Box 8730
Dayton, OH 45401-8730
Benefits Manager:
CVS Caremark
Pharmacy Claims:
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136
Pharmacy Numbers:
RxBin: 004336
RxPCN: ADV
RxGrp: RX3156
CareSource is a Qualified Health Plan Issuer on the Health Insurance Marketplace.

## West Virginia ID Artwork Sample


Silver Dental and Vision
WV
CareSource
2017
Member:
John Doe
Member ID:
14800000000-00
Health Plan
(XXXXX) **XXX-XX-XXXX**
Payer ID: WVCS1
Dependents:
01 Jane Doe
02 John Doe
03 Mike Doe
04 Ron Doe
05 Susan Doe
06 Sara Doe
07 Joe Doe
08 Sam Doe
Office: $0.00 ER: $0.00 Spec: $0.00 UrgCare: $0.00


**CareSource.com/marketplace**
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the website or call.
Members: 1-855-202-0622 (TTY: 1-800-982-8771 or 711)
24/7 Nurseline: 1-866-206-0701
Providers: 1-855-202-1091
Pharmacy: 1-855-202-1091
Medical Claims:
P.O. Box 804
Dayton, OH 45401-0804
Benefits Manager:
CVS Caremark
Pharmacy Claims:
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136
Pharmacy Numbers:
RxBin: 004336
RxPCN: ADV
RxGrp: RX3174
CareSource is a Qualified Health Plan Issuer on the Health Insurance Marketplace.

**The CareSource member ID card contains the following:**

- Member plan – Members may choose a plan with dental and vision coverage, indicated in this area. Please visit **CareSource.com** for more information regarding this plan and the covered services.
- Member name
- Member ID number – This is the ID number of the plan holder.
- Health plan number
- Payer ID number
- Copay amounts for office, emergency room, specialist and urgent care visits
- Dependents – Please ensure that you include the dependent suffix when submitting your claims. Dependents will be listed on the front of the card if the subscriber has a family plan.
- Member Services phone number
- 24/7 nurse advice line
- Pharmacy phone number
- Address to submit medical claims
- Address to submit pharmacy claims
- Pharmacy numbers

## Member disenrollment

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

**Involuntary member disenrollment:**

CareSource is required to provide a 90 calendar day grace period to members for non-payment of their premium. During those 90 days, CareSource will continue to process medical claims and pay health partners accordingly.

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

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

# Member Support Services 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 New Member Identification Cards and Kits

Each new member household receives a new member kit, a welcome letter and two ID cards that include each family member who has joined CareSource. The new member kits are mailed separately from the ID card and new member welcome letter.

**New Member Kit Contains:**

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

Members are referred to the Provider Directory, which lists health care partners and facilities participating with CareSource. A current list of health partners can be found at any time on CareSource's website, **CareSource.com**, using our Find a Doctor/Provider tool.

# CareSource Member Services

Representatives are available by telephone Monday through Friday, except on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the day after, Christmas Eve and Christmas Day.

Members access Member Services by calling our toll-free number 7 a.m. to 7 p.m. Eastern Standard Time (EST), and telling Katie, our interactive voice response system, what their question is regarding:

- Indiana: 1-877-806-9284
- Kentucky: 1-888-815-6446
- Ohio: 1-800-479-9502
- West Virginia: 1-855-202-0622

# CareSource24, Nurse Advice Line

Members can call our nurse advice line 24 hours a day, seven days a week. With CareSource24, members have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions. Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is the "Gold Standard" in telephone triage, offering evidence-based triage protocols and decision support. CareSource24 nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the Primary Care Provider (PCP) by explaining the importance of their role in coordinating the member's care.

Key features of this service include nurses who:

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

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

# Care Management/Outreach

CareSource provides the services of care management physical and behavioral health nurses, social workers and outreach specialists to provide one-on-one, personal interaction with patients. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team. Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging non-compliant patients, reinforcing medical instructions and assessing social needs,

as well as educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many chronic diseases. You can refer a member to Care Management by calling:

- Indiana: 1-855-202-0415
- Kentucky: 1-855-202-0385
- Ohio: 1-844-280-5463
- West Virginia: 1-866-286-9738

**Care Management Services**

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

We offer individualized education and support for many conditions and needs, including:

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

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

**CareSource Disease Management Program**

CareSource members with chronic conditions, including asthma and diabetes, will be automatically enrolled into CareSource's enhanced disease management program.

Members enrolled in the program will receive free information to help them better manage their asthma or diabetes. Information sent to members will include care options for them to discuss with their health partner.

Each member identified as high risk will have a nurse assigned to his or her case. The nurse will help educate, coordinate and provide resources and tools to assist the member in reaching health care goals.

**How to Refer Members to Disease Management**

If you have a CareSource patient with asthma or diabetes who you believe would benefit from this program and is not already enrolled, call:

- Indiana: 1-855-202-0415
- Kentucky: 1-855-202-0385
- Ohio: 1-877-365-9412
- West Virginia: 1-866-286-9738

# Emergency Department Diversion Program

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

We instruct members to call their PCP or the CareSource24 nurse advice line if they are unsure if they need to go to an ER. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. We also offer enhanced reimbursement to PCP offices for holding evening or weekend hours to help ensure that our members have alternatives other than the ER available to them when they need medical care outside of normal business hours. Please see the "Primary Care Providers" section of this manual for more information.

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

**Perinatal Care Management**

CareSource has a program for perinatal and neonatal care management utilizing a staff of specialized nurses. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with health partners and members. This outreach program is offered in partnership with community agencies to target members at greatest risk for preterm birth or complication. The expertise offered by the staff includes a focus on patient education and support and involves direct telephone contact with members and health partners. We encourage our prenatal care health partners to notify our Care Management Department when a member with a high-risk pregnancy has been identified.

**Eyeglass Frames**

Adult members of our health plan (age 19 and over) who have selected our enhanced benefit option (CareSource Dental & Vision) can choose from a selection of eyeglass frames for a $25 copay up to $150 per year. These frames must be ordered through one of CareSource's contracted optical labs. Please refer to **CareSource.com** for additional information about vision services.

Children (members up to the age of 19) may receive one set of prescription eyeglasses per year at no cost. Contact lenses are limited to a single purchase of up to a three-month supply of daily disposables, or a six-month supply of nondaily disposables, once per year in any 12-month period.

**Interpreter Services — Non Hospital Health Partners**

CareSource offers language interpreters for members who need assistance to communicate with CareSource. We can also provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services are available at no cost to the member. As a health partner, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately.

**Interpreter Services — Hospital Health Partners**

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

# Immunization Schedule

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

**Immunization Codes**

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

You can also get CMS coding guidelines at https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf.

# Health Education

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

# Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, health care partners 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, health partners' diagnostic equipment must accommodate individuals with disabilities.

Please see the following pages for information about the ADA. More information on this subject may be obtained at www.cdihp.org.

**Q. Which health care partners are covered under the ADA?**

**A.** Private hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists and health clinics are among the health care partners covered by the Title III of the ADA. Title III applies to all private health care partners, regardless of size. It applies to health partners of both physical and mental health care. If a professional office is located in a private home, the portion of the home used for public purposes is covered by the ADA.

Hospitals and other health care facilities that are operated by state or local governments are covered by Title II of the ADA.

Health care partners that offer training sessions, health education, or conferences to the general public must make these events accessible to individuals with disabilities.

**Policies and Procedures**

Health care partners are required to modify policies and procedures when necessary to serve a person with a disability. The ADA, however, does not require health partners to make changes that would fundamentally alter the nature of their service.

**Q. What kinds of modifications to policies or procedures might be required?**

**A.** Modifying standard policies, practices or procedures can be an inexpensive but effective way to provide access to health care services. This may mean taking extra time to explain a procedure to a patient who is blind or ensuring that a patient with a mobility impairment has access to an accessible exam room.

**Effective Communication, Auxiliary Aids & Services**

Health care partners must find appropriate ways to communicate effectively with persons who have disabilities affecting their ability to communicate. Various auxiliary aids and services such as interpreters, written notes, readers, large print or Braille text can be used depending on the circumstance and the individual.

**Q. Why are auxiliary aids and services so important in the medical setting?**

**A.** Auxiliary aids and services are often needed to provide safe and effective medical treatment. Without these aids and services, medical staff runs the risk of not understanding the patient's symptoms, misdiagnosing the patient's medical problem and prescribing inappropriate treatment. Similarly, patients may not understand medical instructions or warnings that may have a serious impact on their health.

**Q. How does a health care partner determine which auxiliary aid or service is best for a patient?**
**A.** The health care partner can choose among various alternatives consulting with the person and carefully considering his or her expressed communication needs in order to achieve an effective result.

**Q. Can a patient be charged for part or all of the costs of receiving an auxiliary aid or service?**
**A.** No. A health care partner cannot charge a patient for the costs of auxiliary aids and services, either directly or through the patient's insurance carrier.

**Q. In what medical situations should a health care partner obtain a sign language interpreter?**
**A.** If a patient or responsible family member usually communicates in Sign Language, an interpreter should be present in all situations in which the information exchanged is lengthy or complex (for example, discussing a patient's medical history, conducting psychotherapy, communicating before or after major medical procedures and providing complex instructions regarding medication).

If the information to be communicated is simple and straightforward, such as prescribing an X-ray or a blood test, the physician may be able to communicate with the patient by using pen and paper.

**Existing Facilities / Barrier Removal**

**Q. When must private medical facilities eliminate architectural and communication barriers that are structural in nature from existing facilities?**
**A.** When the removal of those barriers is readily achievable, meaning easy to accomplish, without much difficulty or expense. Like undue burden, readily achievable is determined on a case-by-case basis in light of the resources available to an individual health partner.

**Q. How does one remove "communication barriers that are structural in nature"?**
**A.** For instance, install permanent signs, flashing alarm systems, visual doorbells and other notification devices, volume control telephones, assistive listening systems and raised character and Braille elevator controls.

**Complaints**

**Q. What if a patient thinks that a health care health partner is not in compliance with the ADA?**
**A.** If a health care health partner cannot satisfactorily work out a patient's concerns, various means of dispute resolution including arbitration, mediation, or negotiation are available. Patients also have the right to file an independent lawsuit in federal court and to file a formal complaint with the U.S. Department of Justice.

*Excerpted from and based on "ADA Q and A's" by Deborah Leuchovius, ADA Specialist, PACER (Parent Advocacy Coalition for Educational Rights), 8161 Normandale Blvd., Bloomington, MN 55437.*

**Telephone Arrangements/24-Hour Access**

CareSource 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 health partner's office phone must be answered during normal business hours.
- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.

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

# CareSource Member Rights and Responsibilities

As a CareSource health partner, 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.

You have the right to:

- Receive information about CareSource, our services, our network health partners and member rights and responsibilities.
- Be treated with respect and dignity by CareSource personnel, network health partners 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 health partner. If a qualified network health partner is not able to see you, CareSource will set up a visit with a health partner not in our network.

You have the responsibility to:

- Provide information needed, to the extent possible, in order to receive 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 health partners and network pharmacies.
- Show your ID card to make sure you receive full benefits under the plan.

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

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

Please remember that disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the HIPAA regulation 45 CFR 164. For example, health care partners 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.

# Pharmacy

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

## Details of Prescription Drug Coverage

**Copayment Requirements**

Members may be required to pay a copayment for prescription drugs. Some plans offer lower co-pays for less costly drugs. For example, there may be a lower charge for a generic drug, a higher copay for a preferred brand-name drug and a still higher copay for a non-preferred drug.

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

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

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

For a complete list of drugs available, visit **CareSource.com/marketplace.**

**Tiered Medications**

Every drug on the plan's Preferred Drug List is in one of the tiers below. In general, the higher the cost-sharing tier number, the higher the cost for the drug:

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

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

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

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

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

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

All specialty medications will require the use of CVS Caremark specialty pharmacy. Please visit our website at **CareSource.com** if you have questions about the specialty medications.

## Preferred Drug List (Formulary)

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

CareSource uses a Preferred Drug List (PDL) or formulary. The PDL contains information about prior authorizations, quantity limits and step therapy protocols and therapeutic interchanges for most drug classes. To learn more about how to use our pharmaceutical management procedures, look in the introduction section of the PDL. The most up-to-date formulary may be found online at **CareSource.com**.

## Quantity Limits & Quotas

Quantity limits, limits on how much of a drug can be given at one time, are based on normal manufacturers' recommended dosing frequencies and safety considerations.

# Step Therapy, Therapeutic Interchange & Generic Substitution

Certain medications on the Preferred Drug List are covered if utilization criteria are met. Step therapy is one such utilization technique that requires using a formulary medication before the non-formulary medication would be approved for use.

Generic substitution occurs when a pharmacy dispenses a generic version rather than a prescribed brand-name product. Generic drugs are usually priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Members and health partners can expect the generic to produce the same effect and have the same safety profile as the brand-name drug. If a brand name product is requested when a generic equivalent is available, a prior authorization request will need to be submitted.

Additionally, if a member would have a drug allergy or intolerance, or a certain drug might not be effective and a non-formulary agent is requested, referred to as therapeutic interchange, a prior authorization request would be required.

# Prior Authorizations

To submit prior authorization requests by phone, call the appropriate number below and follow the prompts, or fax to 866-930-0019:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

**Tell Us the Medical Reasons for Exceptions**

Typically, our Preferred Drug List includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

CareSource has an exception process that allows the member, the member's representative or the prescribing physician to make a request for an exception. Reasons for exceptions may include intolerance or allergies to drugs, or inadequate or inappropriate responses to drugs listed on the PDL. The member, member's representative or prescribing physician must initiate the request by calling Member Services. CareSource then reaches out to the health partner to obtain the appropriate documentation.

CareSource will provide a decision no later than 72 hours after the request is received, or within 24 hours if the member is suffering from a serious health condition. Health partners 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. If the initial exception request is denied, health partners have the right to request an external review by an Independent Review Organization (IRO). The external review process is outlined in the Grievances and Appeals chapters of this manual.

**Other Medical Supplies and Durable Medical Equipment (DME)**

To support member access and convenience, other medical supplies, such as wound care supplies and enteral feeds, can continue to be filled by the CareSource pharmacy benefit manager (PBM) through the retail pharmacy as previously done for a limited period of time until a DME health partner can be contacted.

**Medications Administered in the Health Partner's Setting**

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

## Medication Therapy Management Program

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

## Network Pharmacy

Our Pharmacy Directory gives members a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website for a complete list of network pharmacies at **CareSource.com**.

## Questions?

For questions pertaining to prior authorization requests, please contact us at:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

# Primary Care Providers

## Primary Care Provider (PCP) Concept

All CareSource members may choose a 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 health plan's online Provider Directory. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling Member Services.

## PCP Roles and Responsibilities

PCP care coordination responsibilities include the following:

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

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

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

**PCPs are Responsible For:**

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

**Prenatal and Postpartum Care Documentation**

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

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

**Immunization Schedule**

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

# Health Partner Appeals Procedures

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

## Appeal of Claim Denials

If you do not agree with the decision of the processed claim, you will have 365 calendar days from the date of service or discharge to file a claim appeal. Health partners have 180 days from the date of service or the date of discharge, whichever is later, to request a medical necessity appeal. If the appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied. If the appeal is denied, health care partners will be notified in writing. If the appeal is approved, payment will show on the health partner's Explanation of Payment (EOP).

**Note**: If you believe the claim processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim; you do not need to file an appeal. Health partners have 365 calendar days from the date of service or discharge to submit a corrected claim.

**How to Submit Appeals**

Health partners can submit claims through our secure Provider Portal, or in writing:

**Provider Portal**: https://providerportal.caresource.com/

Under the Provider Portal, click on the "Claims Appeals" tab on the left. This is the preferred method of appeal submission.

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

- The member's name, CareSource member ID number.
- The health partner's name and ID number, located in your provider welcome number.
- The code(s) and reason why the determination should be reconsidered.
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or electronic data information (EDI) for reconsideration.
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.

**Health Partner Claim Submissions**

| | Indiana | Kentucky | Ohio | West Virginia |
|---|---|---|---|---|
| Fax: | 855-475-3161 | 855-475-3161 | 855-795-0088 | Toll-Free Fax Line:<br>855-475-3161<br>Fax Line:<br>937-487-0702 |

**Health Partner Claim Appeals**

| | Indiana | Kentucky | Ohio | West Virginia |
|---|---|---|---|---|
| Fax: | Toll-Free Fax Line:<br>855-795-0088<br>Fax Line:<br>937-531-2398 | Toll-Free Fax Line: 855-795-0088<br>Fax Line:<br>937-531-2398 | 937-531-2398 | 866-582-0370 |
| Mail: | CareSource<br>Attn: Claim Appeals<br>P.O. Box 2008<br>Dayton, OH 45401 | CareSource<br>Attn: Claim Appeals<br>P.O. Box 2008<br>Dayton, OH 45401 | CareSource<br>Attn: Claim Appeals<br>P.O. Box 2008<br>Dayton, OH 45401 | CareSource<br>Attn: Health Partner Appeals<br>P.O. Box 804<br>Dayton OH 45401 |

# CareSource Health Partner Medical Necessity Appeals

**Health Partner 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 health partner, including facilities or other health care entities on behalf of a member for a review of an Adverse Benefit Determination.

### Timeline for Medical Necessity Appeals

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

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

### Appeals Filed on Behalf of the Member

Medical necessity appeals filed by members or health partners on behalf of a member must be submitted to CareSource within 180 calendar days and will be resolved within 30 calendar days of receipt or as expeditiously as the member's condition warrants for pre-service appeals and 30 calendar days for post-service appeals. Appeals on behalf of the member must include written authorization to appeal on the member's behalf.

### Expedited Appeals

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

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

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

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

Expedited review of an internal appeal may be started orally, in writing, or by other reasonable means available. We will complete expedited review of an appeal as soon as possible given the medical needs but no later than seventy-two (72) hours after our receipt of the request or as expeditiously as the medical condition requires unless the resolution time frame is extended.

### Notification of Resolution

CareSource will communicate our decision by telephone to the attending physician or the ordering health partner. We will also provide written notice of our determination to the member, attending physician or ordering health partner and the facility rendering the service.

### Extending an Appeal

A member can verbally request that CareSource extend the time frame to resolve a standard or expedited appeal up to 15 calendar days only if more time is needed due to circumstances beyond their control. CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 15 calendar days only if more time is needed due to circumstances beyond our control.

**Dissatisfaction of Medical Necessity Appeals – Member External Reviews**

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

**Opportunity for External Review**

For Kentucky only: An External Review will be conducted by an IRE assigned by the Kentucky Department of Insurance. The member will be assessed a filing fee of $25 to be paid to the IRE. This fee may be waived if the IRE determines that the fee creates a financial hardship on the member. The fee shall be refunded if the IRE finds in favor of the member. There is no minimum cost of Health Care Services denied in order to qualify for an External Review; however, the member must generally exhaust CareSource's internal appeal process before seeking an External Review. Any exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

You may use the "**Health Partner Appeal Request Form**" on **CareSource.com** to submit your appeal, but this form is not required.

Appeal requests should include:

- The member's name, CareSource member ID number and date of birth
- The health partner's name and CareSource health partner 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
- Written authorization from the member allowing you to file the appeal on their behalf

The Appeals Department may request additional information from you to document medical necessity.

All appeal requests and associated information are reviewed by clinicians previously uninvolved with the case. You will be notified in writing of the outcome of your appeal request.

**How to Submit Medical Necessity Appeals**

There are three ways to submit appeals: through our Provider Portal, by fax or in writing:

**Provider Portal:** https://providerportal.caresource.com
**Fax:** 937-531-2398 (For West Virginia: 866-582-0370)
**Writing:** CareSource
Attn: Health Partner Appeals – Clinical
P.O. Box 1947
Dayton, OH 45401-1947

# Quality Improvement Program

CareSource is committed to providing care that is safe, effective, member-centered, timely, efficient and equitable. The scope of the CareSource quality improvement (QI) program is comprehensive and includes both clinical and non-clinical services. CareSource monitors and evaluates quality of care, safety and service delivered to our members, with emphasis on accessibility to care, availability of services and physical and behavioral healthcare delivered by network practitioners and health partners. CareSource also monitors member services through practitioners, health partners, hospital, utilization management, care management and pharmacy programs. Member satisfaction and health outcomes are monitored through routine health plan reporting, annual HEDIS and Qualified Health Plan (QHP) Enrollee Experience Survey scores, assessment of health partner and member satisfaction and review of accessibility and availability standards, utilization trends and quality improvement activities. 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 Ohio Medicaid plan and our Ohio, Kentucky and Indiana Marketplace plans. CareSource's Marketplace plan in West Virginia currently holds Interim Accreditation status. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement.

## Program Scope

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

- Advocate for members across settings
- Meet member access and availability needs for physical and behavioral health care

- Determine interventions for HEDIS overall rate improvement that increase preventive care rates and facilitate support of members' acute and chronic health conditions and complex needs
- Determine interventions for QHP Enrollee Survey rate improvement that enrich member and health partner experience and satisfaction
- Demonstrate enhanced care coordination and continuity across settings
- Meet members' cultural and linguistic needs
- Monitor important aspects of care to ensure the safety of members across health care settings
- Determine practitioner adherence to clinical practice guidelines
- Support member self-management efforts
- Partner collaboratively with network partners, practitioners, regulatory agencies and community agencies
- Ensure regulatory and accrediting agency compliance

## 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 the HEDIS to measure the quality of care delivered to members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by The National Committee for Quality Assurance (NCQA). The HEDIS tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence-based care and address the most pressing areas of care. Potential quality measures for the Health Insurance Marketplace are:

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer and chlamydia)
  - Well-child care
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure
- Behavioral health
  - Follow-up after hospitalization for mental illness
  - Antidepressant medication management
  - Follow-up for children prescribed attention deficit/hyperactivity disorder (ADHD) medication
- Safety
  - Use of imaging studies for low back pain

CareSource uses the annual member survey, QHP Enrollee Survey, to capture member perspectives on health care quality. The QHP Enrollee Survey is a consumer experience survey that assesses enrollee experience with QHPs offered through Marketplaces. The survey includes a set of core questions that address key areas of care and service Preventive Guidelines and Clinical Practice Guidelines

CareSource approves and adopts nationally accepted standards and guidelines and promotes them to practitioners and members to help inform and guide clinical care provided to members. Guidelines are reviewed at least every two years or more often as appropriate, and updated as necessary. They may be

found at the Health Care Links page on **CareSource.com/providers** under your plan. The use of these guidelines allows CareSource to measure the impact of the guidelines on outcomes of care. Review and approval of the guidelines are completed by the CareSource Clinical Advisory Committee every two years or more often as appropriate. The guidelines are then presented to the CareSource Quality Enterprise Committee. Topics for guidelines are identified through analysis of Marketplace plan members. Guidelines may include, but are not be limited to:

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

Guidelines are promoted to health through newsletters, our website, direct mailings, health partner manual, and through focused meetings with CareSource Health Partner Engagement Specialists. Information about clinical practice guidelines and 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 Health Partner Services at:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

*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 health partners. Participating health partners are expected to have procedures in place to see patients within these time frames and to offer office hours to their CareSource patients that are at least the equivalent of those offered to any other patient.

Please keep in mind the following access standards for differing levels of care. Thank you for adhering to these standards.

**Primary Care Providers (PCPs)**

| 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 |

**Non-PCP Specialists**

| 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 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 14 calendar 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 health partner is unable to see the member within the appropriate time frame, CareSource will facilitate an appointment with a participating health partner or a non-participating health partner, if necessary.

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

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a health partner 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.

**How to Submit Changes to CareSource:**

**Email:** ProviderMaintenance@caresource.com
**Fax:** 937-396-3076
**Mail:** CareSource
Attn: Health Partner Maintenance
P.O. Box 8738
Dayton, OH 45401-8738

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

# Referrals and Prior Authorizations

This section describes the referral and prior authorization processes and requirements for services provided to CareSource members. Please visit our Provider Portal at CareSource.com for the most current information on prior authorization (PA) and referral requirements.

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

## Access to Staff

Health partners may call our toll free number to contact Medical Management staff with any UM questions:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

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 Utilization Management (UM) issues.

- Staff members can receive inbound communication regarding UM issues after normal business hours. Health partners may leave voice mail messages on these telephone lines after business hours, 24 hours a day, seven days a week. A dedicated fax line, email and Provider Portal for medical necessity determination requests is also available 24 hours a day, seven days a week.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

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

# Confidentiality

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

**Health Partner Performance and Profiling**

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

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

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

# Referrals

If you have questions about referrals and prior authorizations, please call Medical Management at:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

To find network health partners, use our online Find a Doctor/Provider tool at **CareSource.com** under "Quick Links."

**Services That Do Not Require a Referral**

CareSource does not require referrals or prior authorization before members can see in-network specialty physicians. However, some health partners require referrals before they will schedule new patients. Also, prior authorizations are needed before CareSource will pay for services from out-of-network health partners, 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 prior authorization for any services rendered to CareSource members. You can request a prior authorization by calling our Medical Management Department and selecting the option to request a prior authorization:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

Or you can submit a request online at **CareSource.com** and select the Provider Portal option from the menu. If you have difficulty finding a specialist for your CareSource Member, please use our online Find a Doctor/ Provider tool at CareSource.com under "Quick Links," or call Health Partner Services at:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

**Steps to Make a Referral to a Specialist**

**Referring doctor** – Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to our health plan, but you must notify the specialist of your referral.

**Specialist** – Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure.

**Referrals to an out-of-plan health partner** – A member may be referred to out of-plan health partner if the member needs medical care that can only be received from a doctor or other health care partner who is not participating with our health plan. Treating health partners must get prior authorization from our health plan before sending a member to an out-of-plan health partner.

**Referrals for second opinions** – A second opinion is not required for surgery or other medical services. However, health care partners or members may request a second opinion.

The following criteria should be used when selecting a health partner for a second opinion:

- The health partner must be a participating health partner. If not, prior authorization must be obtained to send the patient to a non-participating health partner.
- The health partner must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The health partner must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the health partner giving the second opinion.

# Prior Authorization Procedures

Prior authorizations for health care services can be obtained by contacting the Medical Management Department online, by email, phone, fax or mail:

**Online: CareSource.com** and select the Provider Portal option from the menu
**Email:** MMHIX-Just4Me@caresource.com
**Fax:** Please fax the prior authorization form to the number below. Copies of prior authorization forms can be found on **CareSource.com**.

| Indiana | Kentucky | Ohio | West Virginia |
|---|---|---|---|
| 877-716-9480 | 877-716-9480 | 888-752-0012 | 844-676-0367 |

**Mail:** Send prior authorization requests to:
CareSource
P.O. Box 1307
Dayton, OH 45401-1307

**Phone:**
- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

Tell Katie, our interactive voice response system, that you need to submit an authorization request.

**When requesting an authorization, please provide the following information:**

- Member/patient name and CareSource Member ID number
- Health partner name and NPI
- 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 health partner, if applicable
- Clinical information to support the medical necessity for the service

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

If the request is for **inpatient admission** (whether it is elective, urgent or emergency), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

If **inpatient surgery** is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, any appropriate clinical and anticipated discharge needs.

If the request is for **outpatient surgery**, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs.

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Health partners must verify eligibility on the date of service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the health partner. CareSource will notify you of prior authorization determinations by a letter mailed to the health partner's address on file.

For all prior authorization decisions (standard or urgent), CareSource provides notice to the health partner 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.

# Determination Timeframes

CareSource's timeframes to make authorization determinations vary depending upon the member's health condition, completeness of submission information and state requirements. Please reference the appropriate table below to find determination time frames for the member's state:

| | Indiana | | | |
|---|---|---|---|---|
| **Review Category** | **Timeframe for CareSource to respond when all information is present** | **Timeframe for CareSource to request additional information** | **Health partner response time to submit additional information** | **CareSource response time after receiving additional information** |
| **Inpatient notification** (submitted only with patient demographics, not clinical information) | N/A | 24 hours | 48 hours | 24 hours |
| **Inpatient – Initial** | 24 hours | 24 hours | 48 hours | 24 hours |
| **Inpatient – Continued Stay Review (CSR)** | 24 hours | 24 hours | 48 hours | 24 hours |
| **Outpatient/Elective – Non-Urgent** | 2 business days | 24 hours | 45 days | 2 business days |
| **Outpatient/Elective – Urgent** | 2 business days or 72 hours whichever is less | 24 hours | 48 hours | 48 hours |
| **Retrospective** | 2 business days | 2 business days | 45 days | 20 business days |

| | Kentucky | | | |
|---|---|---|---|---|
| **Review Category** | **Timeframe for CareSource to respond when all information is present** | **Timeframe for CareSource to request additional information** | **Health partner response time to submit additional information** | **CareSource response time after receiving additional information** |
| **Inpatient notification** (submitted only with patient demographics, not clinical information) | N/A | 24 hours | 48 hours | 24 hours |
| **Inpatient – Initial** | 24 hours | 24 hours | 48 hours | 24 hours |
| **Inpatient – Continued Stay Review (CSR)** | 24 hours | 24 hours | 48 hours | 24 hours |
| **Outpatient/Elective – Non-Urgent** | 15 calendar days | 15 calendar days | 45 days | Within 15 calendar days |
| **Outpatient/Elective – Urgent** | 72 hours | 24 hours | 48 hours | 48 hours |
| **Retrospective** | 30 calendar days | 30 calendar days | 45 days | 30 calendar days |

| | Ohio | | | |
|---|---|---|---|---|
| **Review Category** | **Timeframe for CareSource to respond when all information is present** | **Timeframe for CareSource to request additional information** | **Health partner response time to submit additional information** | **CareSource response time after receiving additional information** |
| **Inpatient notification** (submitted only with patient demographics, not clinical information) | N/A | 24 hours | 48 hours | 24 hours |
| **Inpatient – Initial** | 24 hours | 24 hours | 48 hours | 24 hours |
| **Inpatient – Continued Stay Review (CSR)** | 24 hours | 24 hours | 48 hours | 24 hours |
| **Outpatient/Elective – Non-Urgent** | 2 business days | 24 hours | 45 days | 2 business days |
| **Outpatient/Elective – Urgent** | 72 hours | 24 hours | 48 hours | 48 hours |
| **Retrospective** | 30 calendar days | 30 calendar days | 45 days | 30 calendar days |

| | West Virginia | | | |
|---|---|---|---|---|
| **Review Category** | **Timeframe for CareSource to respond when all information is present** | **Timeframe for CareSource to request additional information** | **Health partner response time to submit additional information** | **CareSource response time after receiving additional information** |
| **Inpatient notification** (submitted only with patient demographics, not clinical information) | N/A | 24 hours | 48 hours | 24 hours |
| **Inpatient – Initial** | 24 hours | 24 hours | 48 hours | 24 hours |
| **Inpatient – Continued Stay Review (CSR)** | 24 hours | 24 hours | 48 hours | 24 hours |
| **Outpatient/Elective – Non-Urgent** | 15 calendar days | 15 calendar days | 45 days | Within 15 calendar days |
| **Outpatient/Elective – Urgent** | 72 hours | 24 hours | 48 hours | 48 hours |
| **Retrospective** | 30 calendar days | 30 calendar days | 45 days | 30 calendar days |

# Utilization Management (UM)

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The Medical Management department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources.

We also monitor the coordination of medical care to ensure its continuity. Referrals to the CareSource case management team are made, if needed. CareSource makes it's UM criteria available in writing by mail, fax or email and via the web.

**Mail:** CareSource
P.O. Box 1307
Dayton, OH 45401-1307
**Fax:** 877-716-9480
**Email:** MMHIX-Just4Me@caresource.com

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

### Confidentiality

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

### Health Partner Performance and Profiling

As a function of medical management oversight responsibilities, CareSource monitors over and underutilization of medical services. Health partner profiling is done periodically to measure utilization of common inpatient and outpatient services as preventive services. Healthcare Effectiveness Data and Information Set (HEDIS®) clinical performance measures and pharmacy utilization. Summary reports for these measures are available to individual health partners upon request, and routine periodic reporting is under development.

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

### Criteria

CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. These criteria are designed

to assist health care partners 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 a medical policy developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available to discuss individual cases with attending physicians upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health care partners 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 Medical Management Department. If you would like to discuss an adverse decision with CareSource's physician reviewer, please call the Medical Management Department within five business days of the determination at:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

**Post Stabilization Services**

Please call CareSource with any questions related to post-stabilization service:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

The definition of "Post-Stabilization Care Services" is 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. Prior Authorization 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 health partner. To request prior authorization for observation services as a non-participating health partner or to request authorization for an inpatient admission, please call Health Partner Services:

- Indiana: 1-866-286-9949
- Kentucky: 1-855-852-5558
- Ohio: 1-800-488-0134
- West Virginia: 1-855-202-1091

When calling, tell Katie, our interactive voice response system, that you are requesting post-stabilization. During regular business hours, your call will be answered by our Medical Management Department. If calling after regular business hours, the call will be answered by CareSource24, our nurse triage line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

# Member Grievances and Appeals

Grievances and appeals procedures vary depending on the member's state of residence. Therefore, to ensure clarity, this information is organized by state in the following chapters. Please refer to the applicable chapter as based upon the state listed on the member's ID card, not the state where the health partner is located.

# Indiana Member Grievances and Appeals Procedures

**Note:** If a health partner files an Appeal related to a member's Adverse Benefit Determination, then the member appeals procedures below apply. In order for a health partner to file an Appeal regarding an Adverse Benefit Determination, written consent from the member is required. **Please see the Health Partner Appeals Procedures section for more information on submitting an appeal related to a claim.**

Members may contact Member Services at **1-877-806-9284** with any questions they have about Benefits, including any questions about coverage and Benefit levels; Annual Deductibles, Coinsurance Copayment, and Annual Out-of-Pocket Maximum amounts; specific claims or services they have received; our Network; and our authorization requirements.

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

## The Grievance Process

Pursuant to we have put in place a Grievance Process for the quick resolution of Grievances members submit to us that are unrelated to Benefits, Benefit denials, and/or Health Care Services generally. For

purposes of this Grievance Process, we define a Grievance as any dissatisfaction expressed, orally or in writing, by the member or their Authorized representative regarding:

1. The availability, delivery, appropriateness, or quality of Health Care Services;
2. The Handling of payment of claims for Health Care Services;
3. Matters pertaining to the contractual relationship between CareSource and the member; or
4. CareSource's decision to rescind member coverage under the Plan.

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

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

Members may also submit a Grievance by calling us at **1-877-806-9284** (TTY: 1-800-743-3333 or 711). They may arrange to meet with us in-person to discuss their Grievance.

We will acknowledge all Grievances submitted by the member or their Authorized Representative, orally or in writing, within three (3) business days of our receipt of the Grievance.

We will investigate, resolve, and make a decision regarding the Grievance within not more than thirty (30) business days after the Grievance was filed by the member. We will send the member and/or their Authorized Representative a letter explaining the Plan's resolution of the Grievance within five (5) business days after completing our investigation.

If the member or their Authorized Representative is unsatisfied with our decision regarding the Grievance, the member or their Authorized Representative may Appeal of our Grievance decision, orally or in writing, within 180 days of receiving notice of our Grievance decision. We will acknowledge receipt of the Appeal within three (3) business days after receiving the Appeal request. The Appeal will be resolved not later than forty-five (45) days after the Appeal is filed, and we will send the member and/or their Authorized Representative written notice of the resolution of the Appeal within five (5) business days after completing the investigation.

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

**CareSource Managed Care**

In processing claims, CareSource reviews requests for Prior Authorization, Predetermination and Medical Review for purposes of determining whether requested Health Care Services are Covered Services. This managed care process is described below. Members with questions regarding the information contained in this section may call Member Services at 1-877-806-9284 (TTY: 1-800-743-3333 or 711).

**The following define the categories of Prior Authorization, Predetermination and Medical Requests:**

**Prior Authorization** – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date pursuant to the terms of this Plan.

**Predetermination** – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. We will review your EOC to determine if there is an Exclusion for the Health Care Service. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the Health Care Service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

**Medical Review** – Medical Reviews occur for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Most Network health partners know which services require Prior Authorization and will obtain any required Prior Authorization or request a Predetermination if they feel it is necessary. The ordering Network health partner will contact us to request Prior Authorization or a Predetermination review. We will work directly with Network health partners regarding such Prior Authorization request.

We will utilize our clinical coverage guidelines in determining whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

Members are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact Member Services at **1-877-806-9284**.

- **Review Request for a Claim Involving Emergent Care** – a request for Prior Authorization or Predetermination that in the opinion of the treating health partner with knowledge of the Covered Person's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function or subject the Covered Person to severe pain that cannot be adequately managed without such care or treatment. If a review request for a claim involving emergent care is not approved, the Covered Person may proceed with an Expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.
- **Prospective Review Request** – a request for Prior Authorization or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent Review Request** – a request for Prior Authorization or Predetermination that is conducted during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an Expedited External Review while simultaneously pursuing an Internal Appeal, the procedures for which are described below.
- **Post-Service Claim Review Request** – a request for Prior Authorization that is conducted after the service, treatment or admission has occurred. The review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

**Timing of Decisions and Notifications**

We will issue our benefit decisions and related notifications within the timeframes set forth below. Please call Member Services at **1-877-806-9284** (TTY: 1-800-743-3333 or 711) with any questions.

| Review Request Category | Timeframe for Notice of Decision |
|---|---|
| Urgent Care Claims* | As soon as possible, but not later than two (2) Business Days after receipt of request that includes all necessary information or seventy-two (72) hours from the receipt of request, whichever is less. |
| Prospective Care Claims** | Two (2) Business Days after receipt of request that includes all necessary information or fifteen (15) calendar days from the receipt of request, whichever is less. |
| Concurrent Care for a Claim Involving Emergent Care when request is received at least 24 hours before the expiration of the previous authorization or no previous authorization exists* | Within twenty-four (24) hours from the receipt of the request. |
| Concurrent Care for a Claim Involving Emergent Care when request is received less than twenty-four (24) hours before the expiration of the previous authorization or no previous authorization exists* | As soon as possible, but not later than two (2) Business Days after receipt of request that includes all necessary information or seventy-two (72) hours from the receipt of request, whichever is less. |
| Concurrent Care Claims | As soon as possible, but not later than two (2) Business Days after receipt of request that includes all necessary information or seventy-two (72) hours from the receipt of request, whichever is less. |
| Retrospective Care Claim*** | Two (2) Business Days after receipt of request that includes all necessary information or twenty (20) Business Days from the receipt of the request, whichever is less. |

*** Urgent Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan. If the Plan needs more information before we can make a decision, then the Plan will notify you of the information we need within twenty-four (24) hours of our receipt of your request. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Plan will notify you of our final decision as soon as possible, but in no case later than forty-eight (48) hours after the earlier of: (a) our receipt of the specified information, or (b) the end of time period afforded to you to provide the specified additional information.

**** Prospective Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

***** Retrospective Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

If we do not receive the specific information requested or if the information is not complete by the applicable timeframe identified above and in the written notification, a decision will be made based upon the information in our possession.

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- **Verbal:** oral notification given to the requesting health partner via telephone or via electronic means if agreed to by the health partner.
- **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting health partner and the Covered Person or his or her Authorized Representative.

If we do not approve the Benefits, we will provide the member or their Authorized Representative a notice of an Adverse Benefit Determination. The notification will include our decision, the reasons, policies and procedures that served as the basis for our decision; a description of any additional material or information necessary for the member or their Authorized Representative to perfect the claim for Benefits; notice of the member's right to appeal the decision; and the department, address, and telephone number through which the member may contact a qualified representative to obtain more information about our decision or the member's right to appeal.

Members or their Authorized Representatives have 180 calendar days after they receive the notice of an Adverse Benefit Determination to file an Appeal with us. The Appeal may be filed orally or in writing, and may be submitted by the member or their Authorized Representative. Authorized Representatives must obtain written approval from the member to file appeals. The timing of decisions and notifications related to such Appeals are provided directly below.

**Adverse Benefit Determination Appeals**

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

If a member or their Authorized Representative wishes to Appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, they or their Authorized Representative must submit an Appeal orally or in writing within one hundred eighty (180) calendar days of receiving the Adverse Benefit Determination notice. The member or their Authorized Representative not need submit Appeals for Claims Involving Emergent Care in writing.

The Appeal request should include:

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

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

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

They member or their Authorized Representative may also submit an Adverse Benefit Determination Appeal by calling us at **1-877-806-9284** (TTY: 1-800-743-3333 or 711).

For Appeals for Claims Involving Emergent Care, the member or their Authorized Representative can call the Plan at **1-877-806-9284** to request an Appeal.

The Plan offers one (1) level of appeal. Within three (3) business days after we receive an oral or written Appeal of an Adverse Benefit Determination, we will acknowledge to the appealing party, orally or in writing, the date the Plan received the Appeal of the Adverse Benefit Determination Notice. The Plan has twenty (20) business days after receiving the Appeal for a pre-service denial or forty-five (45) days after receiving the post-service denial Appeal to complete the Appeal process. We will send the member and/or their Authorized Representative written notice of the resolution of the Appeal within five (5) business days after completing the investigation. The Appeal will be reviewed by a panel of qualified individuals who were not involved in the matter giving rise to the Appeal or in the initial investigation of the Appeal.

The member and/or their Authorized Representative have the right to review your claim file and present evidence and testimony as part of the Appeal process. We will provide member and/or their Authorized Representative, free of charge, with all documents relevant to their claim and Appeal and with any new or additional evidence considered, relied upon, or generated by the panel in connection with the claim;

such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of the our decision is to be provided in order to give you a reasonable opportunity to respond prior to that date.

Before we may issue our final decision regarding the member's Appeal based on new or additional rationale, member and/or their Authorized Representative will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of our decision is required to be provided in order to give member and/or their Authorized Representative a reasonable opportunity to respond prior to that date.

We will provide continued coverage to the member pending the outcome of the Appeal. For Appeals concerning Concurrent Care Claims, benefits for an ongoing course of treatment will not be reduced of terminated without providing advance notice to the member and/or their Authorized Representative and an opportunity for advance review.

Separate schedules apply to the timing of claims Appeals, depending on the type of claim being appealed.

**The time frames which you and CareSource are required to follow are provided below.**

## Review Request for a Claim Involving Emergent Care

Appeals concerning decisions related to a Review Request for a Claim Involving Emergent Care are referred directly to an Expedited Appeal review process for investigation and resolution. See the "**Expedited Review of Internal Appeals**" section below for additional information concerning the timing of the resolution of such Appeals.

Members and/or their Authorized Representatives do not need to submit an Appeal of an Adverse Benefit Determination related to Emergent Care in writing. Members and/or their Authorized Representatives should call CareSource as soon as possible to Appeal a decision related to a Claim Involving Emergent Care.

## Pre-Service Request for Benefit

Members and/or their Authorized Representatives must Appeal an Adverse Benefit Determination related to Pre-Service Requests for Benefits no later than 180 calendar days after receiving the Adverse Benefit Determination notice. We must notify the member and/or their Authorized Representative of our benefit determination within 15 calendar days after receiving the request for Appeal.

## Post-Service Claims

Members and/or their Authorized Representatives must appeal an Adverse Benefit Determination related to Post-Service Requests for Benefits no later than 180 calendar days after receiving the Adverse Benefit Determination notice. We must notify the member and/or their Authorized Representatives of our benefit determination within 45 calendar days after receiving your request for the Appeal.

## Concurrent Services Requests

Appeals relating to ongoing emergencies or denials of continued hospital stays (Concurrent Care Claims Involving Emergent Care) are referred directly to an expedited Appeal process for investigation and resolution. See the "**Expedited Review of Internal Appeals**" section below for additional information concerning the timing of the resolution of such Appeals. Appeals for Concurrent Care Claims (Non-Emergent) will be concluded in accordance with the medical or dental immediacy of the case.

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

## Expedited Review of Appeal

Expedited Review of an Appeal may be started orally, in writing, or by other reasonable means available to the member and/or their Authorized Representative. All necessary information, including our decision, will be transmitted by telephone, facsimile, or other available similarly expeditious method. We will complete the expedited review of your Appeal as soon as possible given the medical needs, but no later than seventy-two (72) hours after our receipt of the request. We will communicate our decision by telephone to the member and/or their Authorized Representative, attending physician or ordering health partner, and the facility rendering the service.

Members and/or their Authorized Representatives may request an expedited review of their Appeal for:

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

## Exhaustion of Internal Appeals Process

The internal Appeal process must be exhausted prior to initiating an External Review except in the following instances:

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

## External Reviews

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

## Opportunity for External Review

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

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

The following determinations made by us or our agent regarding a service proposed by a treating physician:

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

There are two (2) types of IRO reviews: standard and expedited.

**Standard External Review.** Standard External Reviews and external investigation/experimental reviews are normally completed within fifteen (15) business days after the External Review is filed. The IRO will notify us and member of its determination of a standard External Review within seventy-two (72) hours after making the determination.

**Expedited External Review.** An expedited review for urgent medical situations is normally completed within seventy-two (72) hours after the expedited External Review is filed. The IRO will notify us and member of its determination of an expedited External Review within twenty-four (24) hours after making the determination. An External Review is considered an urgent medical situation and qualifies for expedited External Review if the External Review is related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the member's:

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

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

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

*NOTE:* Upon receipt of new information from the member that is relevant to our resolution of our Adverse Benefit Determination and was not considered by us, we shall reconsider our Adverse Benefit Determination and the IRO shall cease the External Review process until the reconsideration is complete. If the information submitted to us for reconsideration is related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the member's life or health or the ability to reach and maintain maximum function, we will render a decision within seventy-two (72) hours after the information is submitted or if the information submitted to us for reconsideration is not related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the member's life or health or the ability to reach and maintain maximum function, we will render a decision with fifteen (15) days after the information is submitted. If our reconsideration is still adverse to the member, the member may request the IRO resume the External Review process.

*NOTE:* If the member has the right to an External Review under Medicare (42 U.S.C. 1395, et seq.), then the member may not request an External Review of an Adverse Benefit Determination under the procedures outlined in the Plan.

## IRO Review and Decision

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

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

The IRO will make its decision within fifteen (15) days after a standard External Review request is filed or within seventy-two (72) hours of after an expedited External Review request is filed. The IRO will provide the member and us with written notice of its decision within seventy-two (72) hours after making its determination for a standard External Review and within twenty-four (24) hours after making its determination for an expedited External Review.

## Request for External Review

The member or their Authorized Representative must request an External Review through us within one hundred eighty (180) days of the date of Final Adverse Benefit Determination notice. All requests must be in writing, except for a request for an expedited External Review. Expedited External Reviews may be requested electronically or orally.

## IRO Assignment

When we initiate an External Review by an IRO, we will select an IRO from a list of IROs that are certified by the Indiana Department of Insurance. We select a different IRO for each request for external review filed and rotate the choice of IRO among all certified IROs before repeating a selection. The IRO will assign a medical review professional who is board certified in the applicable specialty for resolution of the External Review. An IRO that has a material professional, familial, financial, or other affiliation, or conflict of interest with us, our management, the member, you, the proposed drug, therapy or device, or the Facility will not be selected to conduct the review.

## Binding Nature of External Review Decision

An External Review decision by the IRO is binding on us. The decision is also binding on the member except to the extent that the member may have other remedies available under applicable state or federal law. The member may file not more than one (1) External Review request of our Adverse Benefit Determination.

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

## If You Have Questions about Your Rights or Need Assistance

Members may contact Member Services at:

CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401
877-806-9284
(TTY: 1-800-743-3333 or 711)

# Definitions

*Definitions.* For purposes of this section, the following definitions apply—

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

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

**A Claim Involving Emergent or Urgent Care means:**

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

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

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

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

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

# Kentucky Member Complaints & Appeals Procedures

Members may contact Member Services at **1-888-815-6446** with any questions they have about Benefits, including any questions about coverage and Benefit levels; Annual Deductibles, Coinsurance Copayment, and Annual Out-of-Pocket Maximum amounts; specific claims or services they have received; our Network; and our authorization requirements.

We have implemented the Complaint Process and the Internal and External Appeals procedures to provide fair, reasonable, and timely solutions to complaints that members may have concerning the Plan, Benefit determinations, coverage and eligibility issues, or the quality of care rendered by Network health partners.

## The Complaint Process

We have put in place a Complaint Process for the quick resolution of Complaints members submit to us that are unrelated to Benefits or Benefit denials. For purposes of this Complaint Process, we define a Complaint as an expression of unhappiness or dissatisfaction, orally or in writing, concerning any matter relating to any aspect of the Plan's operation. If members have a Complaint concerning the Plan, they may contact us by sending a letter at the following address:

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

They may also submit a Complaint by calling us at **1-888-815-6446**. They may arrange to meet with us in-person to discuss the Complaint.

Within thirty (30) calendar days of our receipt of a Complaint, we will investigate, resolve, and respond to the Complaint and send a letter explaining the Plan's resolution of the Complaint.

Please note that the Adverse Benefit Determination Appeal Process below addresses issues related to Benefits, Benefits denials, or other Adverse Benefit Determinations.

## CareSource Managed Care

In processing claims, CareSource reviews requests for Prior Authorization, Predetermination and Medical Review for purposes of determining whether requested Health Care Services are Covered Services. This managed care process is described below. Members with questions regarding the information contained in this section may call Member Services at **1-888-815-6446**.

Most Network health partners know which services require Prior Authorization and will obtain any required Prior Authorization or request a Predetermination if they feel it is necessary. The ordering Network health partner will contact us to request Prior Authorization or a Predetermination review. We will work directly with Network health partner regarding such Prior Authorization request. However, they may designate an Authorized Representative to act on their behalf for a specific request.

We will utilize our clinical coverage guidelines in determining whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

Members are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact Member Services.

**The following define the categories of Prior Authorization, Predetermination and Medical Requests:**

- **Prior Authorization** – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date, pursuant to the terms of this Plan.
- **Predetermination** – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. We will review your EOC to determine if there is an Exclusion for the Health Care Service. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the Health Care Service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.
- **Medical Review** – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Prior Authorization and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which we have a related clinical coverage guideline, and are typically initiated by us.
- **Urgent Review Request** – A request for Prior Authorization or Predetermination that in the opinion of the treating health partner with knowledge of the Covered Person's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Covered Person or the ability of the

Covered Person to regain maximum function or subject the Covered Person to severe pain that cannot be adequately managed without such care or treatment. If an urgent care review request is not approved, the Covered Person may proceed with an Expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.

- **Prospective Review Request** – A request for Prior Authorization or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent Review Request** – A request for Prior Authorization or Predetermination that is conducted during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.
- **Retrospective Review Request** – A request for Prior Authorization that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

**Timing of Decisions and Notifications**

We will issue our benefit decisions and related notifications within the timeframes set forth below. Please call Member Services at **1-888-815-6446** with any questions.

| Review Request Category | Timeframe for Making Decision |
|---|---|
| Urgent Care Claims* | As soon as possible taking into account the medical exigencies but within seventy-two (72) hours of our receipt of your request. |
| Prospective Care Claims** | Within fifteen (15) calendar days of our receipt of your request. |
| Concurrent Care Claims* | Within twenty-four (24) hours of our receipt of your request. |
| Retrospective Care Claims*** | Within thirty (30) calendar days of our receipt of your request. |

*** Urgent Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan. If the Plan needs more information before we can make a decision, we will notify you of the information we need within twenty-four (24) hours of our receipt of your request. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Plan will notify you of our final decision as soon as possible, but in no case later than forty-eight (48) hours after the earlier of: (a) our receipt of the specified information, or (b) the end of time period afforded to you to provide the specified additional information.

**** Prospective Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration

of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

***** Retrospective Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- **Verbal:** oral notification given to the requesting health partner via telephone or via electronic means if agreed to by the health partner.
- **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting health partner and the Covered Person or his or her Authorized Representative.

If we do not approve the Benefits, we will provide members with a Notice of an Adverse Benefit Determination. The Notice of an Adverse Benefit Determination will include the specific reason or reasons for the Adverse Benefit Determination; the reference to the specific Plan provisions on which the Adverse Benefit Determination is based; a description of any additional material or information necessary for the member or health care partner to perfect the claim for Benefits; and a description of our review procedures and the time limits applicable to such procedures.

Members have 180 calendar days after receiving the Notice of an Adverse Benefit Determination to file an Appeal with us.

**Adverse Benefit Determination Appeals**

If we make an Adverse Benefit Determination, we will provide the member or Authorized Representative with a Notice of an Adverse Benefit Determination, as described above. An Adverse Benefit Determination is a decision by us to deny Benefits because services are not covered, are excluded, or limited under the Plan, or because the member is not eligible to receive the Benefit. The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

For Adverse Benefit Determinations related to Concurrent Service Requests or Prospective Service Requests, members or their Authorized Representatives may request that we reconsider the Adverse Benefit Determination. We will reconsider the Adverse Benefit Determination within three (3) business days after the request for reconsideration. The reconsideration must be conducted between the health partner rendering the Health Care Service and the reviewer who made the Adverse Benefit Determination; provided, however, that if the Plan's reviewer is not available, such review may designate another reviewer. For requests for reconsideration related to an Urgent Care Service Request, the Plan shall review such request in a timeframe

that takes into account the medical exigencies. Reconsideration is not a prerequisite to an internal or External Review of an Adverse Benefit Determination.

If a member wishes to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, the member or Authorized Representative must submit an appeal in writing within one hundred eighty (180) calendar days of receiving the Adverse Benefit Determination. They do not need to submit Urgent Care appeals in writing. This communication should include:

**1.** The Covered Person's name and identification number as shown on the ID card;
**2.** The health partner's name;
**3.** The date of the medical service;
**4.** The reason the member or Authorized Representative disagree with the denial; and
**5.** Any documentation or other written information to support the request.

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

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

The member or Authorized Representative may also submit An Adverse Benefit Determination Appeal by calling us at **1-888-815-6446.**

For Urgent Care requests for Benefits that have been denied, members or their health partner can call the Plan at **1-888-815-6446** to request an appeal.

The Plan offers one (1) level of appeal. The Plan must notify the members of the appeal determination within fifteen (15) calendar days after receiving the completed appeal for a pre-service denial and thirty (30) days after receiving the completed post-service appeal.

Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. CareSource will review all claims in accordance with the rules established by the Superintendent and the United States Department of Labor. In life-threatening circumstances, members are entitled to an immediate appeal to an Independent Review Entity ("IRE").

CareSource's decision after exhaustion of this internal appeal process will be final and considered the Final Internal Adverse Benefit Determination.

When a member, a person acting on the member's behalf, or the member's health partner of record expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, CareSource or a utilization review agent will treat that expression as an appeal of an Adverse Benefit Determination.

Within five (5) business days after we receive an appeal of an Adverse Benefit Determination, we will send to the appealing party a letter acknowledging the date the Plan received the appeal and a list of documents the appealing party must submit. If the appeal was oral, the Plan will enclose a one-page appeal form clearly stating that the form must be returned to CareSource for prompt resolution. The Plan has thirty (30) calendar days from receipt of a written appeal of Adverse Benefit Determination or the appeal form to complete the

appeal process and provide written notice of the appeal decision to the appealing party. The appeal will be reviewed by a health partner not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure, or treatment under review.

Notice of our Final Internal Adverse Benefit Decision on the appeal will include the dental, medical, and contractual reasons for the resolution; clinical basis for the decision and the specialization of health partner consulted. A denial will also include notice of the member's right to have an IRE review the denial and the procedures to obtain a review.

Separate schedules apply to the timing of claims appeals, depending on the type of claim. The types of claims are:

**Urgent Care Services Requests for Benefits** – A request for Benefits provided in connection with Urgent Care Services, as defined in Section 13 "Glossary"

**Prospective Service Requests for Benefits or Pre-Service Requests** – A request for Benefits which the Plan must approve or in which you must notify us before non-Urgent Care Services are provided; and

**Post-Service** – A claim for reimbursement of the cost of non-Urgent Care Services that have already been provided.

**Concurrent Service Requests for Benefits** – A request for Benefits during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.

## Expedited Review of Internal Appeal

Expedited Review of an internal appeal may be started orally, in writing, or by other reasonable means available to the member or health partner. We will complete expedited review of an appeal within 24 hours but no later than seventy-two (72) hours after our receipt of the request and will communicate our decision by telephone to your attending Physician or the ordering health partner. We will also provide written notice of our determination to the member, attending Physician or ordering health partner, and the Facility rendering the service. We maintain records of requests for External Review for a minimum of three (3) years.

Members may request an expedited review for:

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

# Exhaustion of Internal Appeals Process

The internal Appeal process must be exhausted prior to initiating an External Review except in the following instances:

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

**External Reviews**

Pursuant to KRS 304.17A-600 to 304.17A-633, CareSource, as a health plan, must provide a process that allows the members the right to request an independent External Review of an Adverse Benefit Determination.

An External Review will be conducted by an Independent Review Entity (IRE) assigned by the Kentucky Department of Insurance. The member will be assessed a filing fee of $25 to be paid to the IRE. This fee may be waived if the IRE determines that the fee creates a financial hardship on the member. The fee shall be refunded if the IRE finds in favor of the member. There is no minimum cost of Health Care Services denied in order to qualify for an External Review; however, you must generally exhaust CareSource's internal appeal process before seeking an External Review. Any exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

Members are entitled to an External Review by an IRE in the following instances:

- The internal appeal process was completed or jointly waived by the member and CareSource, or CareSource failed to make a determination within 30 days of receiving the written appeal or within 72 hours of receiving the request for an expedited appeal; and
- The member was covered on the date of service or, if a prospective denial, the member was eligible to receive benefits on the date the proposed service was requested.
- There are three (3) types of IRE reviews: standard, expedited, and external investigation/experimental. Standard reviews and external investigation/experimental reviews are normally completed within thirty (30) calendar days. An expedited review for urgent medical situations must be complete within 24 hours from receipt of all required information, unless the member and CareSource agree to a 24-hour extension, and can be requested if the member is hospitalized, or if, in the opinion of the treating health partners, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:
  - Placing the health of the member or, with respect to a pregnant woman, the health of the member or her unborn child in serious jeopardy;
  - Subjecting the member to severe pain that cannot be adequately managed;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of a bodily organ.

A member may also request an External Review of an Adverse Benefit Determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care

service is explicitly listed as an excluded benefit under the Plan. To be eligible for an External Review under this section, the treating physician shall certify that one of the following situations is applicable:

- Standard health care services have not been effective in improving the condition.
- Standard health care services are not medically appropriate for the member.
- There is no available standard health care service covered by the health plan issuer that is more beneficial than the requested health care service.

Additionally, the member may request orally or by electronic means an expedited review under this section if the treating physician certifies that the requested health care service in question would be significantly less effective if not promptly initiated.

*Notes:*
- An expedited External Review is not available for retrospective Final Internal Adverse Benefit Determinations (meaning the Health Care Service has already been provided to the member.)
- Upon receipt of new information from the IRE, we may reconsider our Adverse Benefit Determination and provide coverage. If we make such reconsideration, we will notify the member, the IRE, and the Kentucky Department of Insurance of our decision within five (5) Business Days.

## Request for External Review

The member or the member's authorized representative must request an External Review through us within four (4) months of receiving CareSource's written decision rendered under the internal appeals process. All requests must be in writing, except for a request for an expedited External Review. Expedited External Reviews may be requested electronically or orally.

If the member's request is complete, we will initiate the External Review and notify the member or the member's authorized representative in writing, or immediately in the case of an expedited review, that the request is complete and eligible for External Review. The notice will include the name and contact information for the assigned IRE for the purpose of submitting additional information.

We will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRE. If a request for expedited review is complete, we will immediately provide or transmit all necessary documents and information regarding the Adverse Benefit Determination to the Kentucky Department of Insurance.

If the request is not complete, we will inform the member or the member's authorized representative in writing and specify what information is needed to make the request complete. If we determine that the Adverse Benefit Determination is not eligible for External Review, we must notify the member or the member's representative in writing and provide the member or the member's representative with the reason for the denial and indicate that the denial may be appealed to the Kentucky Department of Insurance.

The Kentucky Department of Insurance may determine that the request is eligible for External Review regardless of the decision by us and require that the request be referred for External Review. The Department's decision will be made in accordance with the terms of the Plan and all applicable provisions of the law.

IREs are assigned by the Kentucky Department of Insurance on a rotating basis so that CareSource does not have the same IRE for two consecutive external reviews.

## IRE Review and Decision

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

The IRE will provide a written notice of its decision within twenty-one (21) calendar days for a standard review or twenty-four (24) hours for an expedited review of receipt of all required information. For a standard review, an extension of up to fourteen (14) days may be allowed if agreed to by the member and CareSource. For an expedited review, an extension of up to twenty-four (24) hours may be allowed if agreed to by the member and CareSource. This notice will be sent to the member, the treating health partner, us and the Kentucky Department of Insurance, and must include the following information:

- The findings for either us or the member regarding each issue under review;
- The proposed service, treatment, drug, device, or supply for which the review was performed;
- The relevant provisions in the Policy and how applied; and
- The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

## Binding Nature of External Review Decision

An External Review decision is binding on us and the member except to the extent there are other remedies available under state or federal law. Subject to the foregoing, upon receipt of notice by an IRE to reverse an Adverse Benefit Determination, we will immediately provide coverage for the Heath Care Service in question. Members may not file a subsequent request for an External Review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to us. A decision issued by the IRE will be admissible in any civil action related to our coverage decision. The IRE's decision is presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

## If You Have Questions about These Rights or Need Assistance

Health partners may contact us by mail, fax, or phone. Please call Health Partner Services at **1-855-852-5558**. Health partners may also contact the Kentucky Department of Insurance at:

Kentucky Department of Insurance
ATTN: Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602-0517

Toll free (KY only) 1-800-595-6053 or 502-564-3630
Deaf/hard-of-hearing 1-800-648-6056
http://insurance.ky.gov

To file a Consumer Complaint, members may go to http://insurance.ky.gov/online_complaint.aspx?MenuID=3&Div?id=4.

## Definitions

For purposes of this section, the following definitions apply:

**Adverse Benefit Determination** means our denial, reduction, or termination of a Health Care Service, in whole or in part, based on any of the following:

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

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

**External Review** means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted by an Independent Review Entity (IRE).

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

**Independent review entity (IRE)** means an entity that conducts independent External Reviews of Adverse Benefit Determinations pursuant to this Section.

# Ohio Member Complaints & Appeals Procedures

Members may contact Member Services at **1-800-479-9502** with any questions they have about benefits, including any questions about coverage and benefit levels; annual deductibles, coinsurance copayment, and annual out-of-pocket maximum amounts; specific claims or services they have received; our network; and our authorization requirements.

We have implemented the Complaint Process and the Internal and External Appeals procedures to provide fair, reasonable, and timely solutions to complaints that members may have concerning the Plan, benefit determinations, coverage and eligibility issues, or the quality of care rendered by network health partners.

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## The Complaint Process

Pursuant to Ohio Revised Code 1751.19, we have put in place a Complaint Process for the quick resolution of Complaints members submit to us that are unrelated to benefits or benefit denials. For purposes of this Complaint Process, we define a complaint as an expression of unhappiness or dissatisfaction, orally or in writing, concerning any matter relating to any aspect of the Plan's operation. If members have a complaint concerning the Plan, they may contact us by sending a letter to the following address:

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

They may also submit a complaint by calling us at **1-800-479-9502**. They may arrange to meet with us in-person to discuss the Complaint.

Within thirty (30) calendar days of our receipt of a complaint, we will investigate, resolve, and respond to the complaint and send a letter explaining the Plan's resolution of the complaint. Please note that the Adverse Benefit Determination Appeal Process below addresses issues related to benefits, benefits denials, or other adverse benefit determinations.

***CareSource Managed Care***

In processing claims, CareSource reviews requests for Prior Authorization, Predetermination and Medical Review for purposes of determining whether requested Health Care Services are Covered Services. This managed care process is described below. Members with questions regarding the information contained in this section may call Member Services at **1-800-479-9502**.

**Prior Authorization** – A required review of a service, treatment or admission for a benefit coverage determination, which must be obtained prior to the service, treatment or admission start date, pursuant to the terms of this Plan.

**Predetermination** – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. We will review your EOC to determine if there is an Exclusion for the Health Care Service. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the Health Care Service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

**Medical Review** – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Prior Authorization and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which we have a related clinical coverage guideline, and are typically initiated by us.

Most network health partners know which services require Prior Authorization and will obtain any required Prior Authorization or request a Predetermination if they feel it is necessary. The ordering network health partners will contact us to request Prior Authorization or a Predetermination review. We will work directly with network health partners regarding such Prior Authorization request. However, they may designate an Authorized Representative to act on their behalf for a specific request.

We will utilize our clinical coverage guidelines in determining whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

Members are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact Member Services.

**The following define the categories of Prior Authorization, Predetermination and Medical Requests:**

- **Urgent Review Request** – A request for Prior Authorization or Predetermination that in the opinion of the treating health partner with knowledge of the Covered Person's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function or subject the Covered Person to severe pain that cannot be adequately managed without such care or treatment. If an urgent care review request is not approved, the Covered Person may proceed with an Expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.
- **Prospective Review Request** – A request for Prior Authorization or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent Review Request** – A request for Prior Authorization or Predetermination that is conducted during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.
- **Retrospective Review Request** – A request for Prior Authorization that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

***Timing of Decisions and Notifications***

We will issue our benefit decisions and related notifications within the timeframes set forth below. Please call Member Services at **1-800-479-9502** with any questions.

| Review Request Category | Timeframe for Making Decision |
|---|---|
| Urgent Care Claims* | As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours from the receipt of request. |
| Prospective Care Claims** | Within two (2) Business Days after receiving all necessary information, or fifteen (15) calendar days from the receipt of the request, whichever is less. |
| Concurrent Urgent Care Claims when request is received at least twenty-four (24) hours before the expiration of the previous authorization or no previous authorization exists | Within twenty-four (24) hours from the receipt of the request, taking into account the medical exigencies. |
| Concurrent Urgent Care Claims when request is received less than twenty-four (24) hours before the expiration of the previous authorization or no previous authorization exists | As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours from the receipt of request, whichever is less. |
| Concurrent Care Claim | Within one (1) Business Day after receiving all necessary information. |
| Retrospective*** | Thirty (30) calendar days from the receipt of the request. |

*** Urgent Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan. If the Plan needs more information before we can make a decision, we will notify you of the information we need within twenty-four (24) hours of our receipt of your request. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Plan will notify you of our final decision as soon as possible, but in no case later than forty-eight (48) hours after the earlier of: (a) our receipt of the specified information, or (b) the end of time period afforded to you to provide the specified additional information.

**** Prospective Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.
This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

***** Retrospective Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- **Verbal:** oral notification given to the requesting health partner via telephone or via electronic means if agreed to by the health partner.
- **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting health partner and the Covered Person or his or her Authorized Representative.

If we do not approve the Benefits, we will provide members with a Notice of an Adverse Benefit Determination. The Notice of an Adverse Benefit Determination will include the specific reason or reasons for the Adverse Benefit Determination; the reference to the specific Plan provisions on which the Adverse Benefit Determination is based; a description of any additional material or information necessary for the member or health partner to perfect the claim for Benefits; and a description of our review procedures and the time limits applicable to such procedures.

Members have 180 calendar days after they receive the Notice of an Adverse Benefit Determination to file an Appeal with us.

**Adverse Benefit Determination Appeals**

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

***Health partners must have member written consent to file pre-service appeals.***

For Adverse Benefit Determinations related to Concurrent Service Requests or Prospective Service Requests, members or their Authorized Representative may request that we reconsider the Adverse Benefit Determination. We will reconsider the Adverse Benefit Determination within three (3) business days after the request for reconsideration. The reconsideration must be conducted between the health partner rendering the Health Care Service and the reviewer who made the Adverse Benefit Determination; provided, however, that if the Plan's reviewer is not available, such review may designate another reviewer. For requests for reconsideration related to an Urgent Care Service Request, the Plan shall review such request in a timeframe that takes into account the medical exigencies. Reconsideration is not a prerequisite to an internal or External Review of an Adverse Benefit Determination.

If a member wishes to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, the member or his/her Authorized Representative must submit an appeal in writing within one hundred eighty (180) calendar days of receiving the Adverse Benefit Determination. They do not need to submit Urgent Care appeals in writing. This communication should include:

**1.** The Covered Person's name and identification number as shown on the ID card;
**2.** The health partner's name;
**3.** The date of the medical service;
**4.** The reason the member or their Authorized Representative disagrees with the denial; and
**5.** Any documentation or other written information to support the request.

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

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

They may also submit an Adverse Benefit Determination Appeal by calling us at **1-800-479-9502**.

For Urgent Care requests for Benefits that have been denied, members or their health partner can call the Plan at **1-800-479-9502** to request an appeal.

The Plan offers one (1) level of appeal. The Plan must notify the members of the appeal determination within fifteen (15) calendar days after receiving the completed appeal for a pre-service denial and thirty (30) days after receiving the completed post-service appeal.

Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. CareSource will review all claims in accordance with the rules established by the Superintendent and the United States Department of Labor. In life-threatening circumstances, members are entitled to an immediate appeal to an Independent Review Organization (IRO).

CareSource's decision after exhaustion of this internal appeal process will be final and considered the Final Internal Adverse Benefit Determination.

When a member, a person acting on their behalf, or their health partner of record expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, CareSource or a utilization review agent will treat that expression as an appeal of an Adverse Benefit Determination.

Within five (5) business days after we receive an appeal of an Adverse Benefit Determination, we will send to the appealing party a letter acknowledging the date the Plan received the appeal and a list of documents the appealing party must submit. If the appeal was oral, the Plan will enclose a one-page appeal form clearly stating that the form must be returned to CareSource for prompt resolution. The Plan has thirty (30) calendar days from receipt of a written appeal of Adverse Benefit Determination or the appeal form to complete the appeal process and provide written notice of the appeal decision to the appealing party. The appeal will be reviewed by a health partner not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure, or treatment under review.

Notice of our Final Internal Adverse Benefit Decision on the appeal will include the dental, medical, and contractual reasons for the resolution; clinical basis for the decision and the specialization of health partner consulted. A denial will also include notice of the member's right to have an IRO review the denial and the procedures to obtain a review.

Separate schedules apply to the timing of claims appeals, depending on the type of claim. The types of claims are:

**Urgent Care Services Requests for Benefits** – A request for Benefits provided in connection with Urgent Care Services, as defined in Section 13 "Glossary" in the member's Evidence of Individual Coverage and Health Insurance Contract (EOC).

**Prospective Service Requests for Benefits or Pre-Service Requests** – A request for Benefits which the Plan must approve or in which you must notify us before non-Urgent Care Services are provided; and

**Retrospective Post-Service** – A claim for reimbursement of the cost of non-Urgent Care Services that have already been provided.

**Concurrent Service Requests for Benefits** – A request for Benefits during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.

The time frames which the member or the member's Authorized Representative and CareSource are required to follow are provided below.

## Urgent Care Request for Benefits*

If we deny the member's request for Urgent Care Services, we must notify the member or his/her Authorized Representative of our benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receiving the request for the appeal.

Urgent Care appeals do not need to be submitted in writing. The member or his/her Authorized Representative should call CareSource as soon as possible to appeal an Urgent Care request for Benefits.

## Pre-Service Request for Benefits

The member or his/her Authorized Representative must appeal an Adverse Benefit Determination related to Pre-Service Requests for Benefits no later than 180 calendar days after receiving the Adverse Benefit Determination. We must notify the member or his/her Authorized Representative of our benefit determination within 15 calendar days after receiving the request for the appeal. We may require a one-time extension of no more than 15 calendar days only if more time is needed due to circumstances beyond CareSource's control.

## Post-Service Claims

The member or his/her Authorized Representative must appeal an Adverse Benefit Determination related to Post-Service Requests for Benefits no later than 180 calendar days after receiving the Adverse Benefit Determination. We must notify the member or his/her Authorized Representative of our benefit determination within 60 calendar days after receiving the request for the appeal. We may be entitled to a one-time extension of no more than 15 calendar days only if more time is needed due to circumstances beyond CareSource's control.

## Concurrent Services Requests

Appeals relating to ongoing emergencies or denials of continued hospital stays are referred directly to an expedited appeal process for investigation and resolution. They will be concluded in accordance with the medical or dental immediacy of the case but in no event will exceed one working day from the date all information necessary to complete the appeal is received. Initial notice of the decision may be delivered orally if followed by written notice of the decision within three (3) business days.

The appeal will be reviewed by a health care partner not involved in the initial decision, which is in the same or similar specialty that typically manages the medical or dental condition, procedure, or treatment under review. The Physician or health partner reviewing the appeal may interview the patient or patient's designated representative.

## Expedited Review of Internal Appeal

Expedited Review of an internal appeal may be started orally, in writing, or by other reasonable means available to the member or health partner. We will complete expedited review of an appeal as soon as possible given the medical needs but no later than seventy-two (72) hours after our receipt of the request and will communicate our decision by telephone to the member's attending Physician or the ordering health partner. We will also provide written notice of our determination to the member, attending Physician or

ordering health partner, and the Facility rendering the service. We maintain records of requests for External Review for a minimum of three (3) years.

Members may request an expedited review for:

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

## Exhaustion of Internal Appeals Process

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

- We agree to waive the exhaustion requirement;
- The member did not receive a written decision of our internal appeal within the required time frame;
- We failed to meet all requirements of the internal appeal process unless the failure:
  - Was minor;
  - Does not cause or is not likely to cause prejudice or harm to the member;
  - Was for good cause and beyond our control;
  - Is not reflective of a pattern or practice of non-compliance; or
  - An expedited External Review is sought simultaneously with an expedited internal review.

## External Reviews

Under Chapter 3922 of the Ohio Revised Code, CareSource, as a health plan, must provide a process that allows the members the right to request an independent External Review of an Adverse Benefit Determination. An Adverse Benefit Determination is a decision by us to deny Benefits because services are not covered, are excluded, or limited under the Plan, or because the member is not eligible to receive the Benefit. The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

# Opportunity for External Review

An External Review may be conducted by an IRO or by the Ohio Department of Insurance. The member will not pay for the External Review. There is no minimum cost of Health Care Services denied in order to qualify for an External Review; however, the member must generally exhaust CareSource's internal appeal process before seeking an External Review. Any exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

Members are entitled to an External Review by an IRO in the following instances:

- The Adverse Benefit Determination involves a medical judgment or is based on any medical information.
- The Adverse Benefit Determination indicates the requested service is Experimental or Investigational, the requested Health Care Service is not explicitly excluded from the Plan and the member's treating Physician certifies at least one of the following:
  - Standard Health Care Services have not been effective in improving the member's condition.
  - Standard Health Care Services are not medically appropriate for the member.
  - No available standard Health Care Service covered by us is more beneficial than the requested Health Care Service.

There are three (3) types of IRO reviews: standard, expedited, and external investigation/experimental. Standard reviews and external investigation/experimental reviews are normally completed within thirty (30) calendar days. An expedited review for urgent medical situations is normally completed within seventy-two (72) hours and can be requested if any of the following applies:

- The member's treating Physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the member's life or health or would jeopardize the member's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The member's treating Physician certifies that the Final Internal Adverse Benefit Determination involves a medical condition that could seriously jeopardize the member's life or health or would jeopardize the member's ability to regain maximum function if treatment is delayed until after the time frame of a standard External Review.
- The Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or Health Care Service for which the member received Emergency Health Services, but has not yet been discharged from a Facility.
- An expedited internal appeal is already in progress for an Adverse Benefit Determination of Experimental or Investigational treatment and the member's treating Physician certifies in writing that the recommended Health Care Service or treatment would be significantly less effective if not promptly initiated.

The member may also request an External Review of an Adverse Benefit Determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit under the member's Plan. To be eligible for an External Review under this section, the member's treating physician shall certify that one of the following situations is applicable:

- Standard health care services have not been effective in improving the member's condition.
- Standard health care services are not medically appropriate for the member.
- There is no available standard health care service covered by the health plan issuer that is more beneficial than the requested health care service.

Additionally, the member may request orally or by electronic means an expedited review under this section if the member's treating physician certifies that the requested health care service in question would be significantly less effective if not promptly initiated.

**Notes:**

- An expedited External Review is not available for retrospective Final Internal Adverse Benefit Determinations (meaning the Health Care Service has already been provided to the member.
- Upon receipt of new information from the IRO, we may reconsider our Adverse Benefit Determination and provide coverage. If we make such reconsideration, we will notify the member, the IRO, and the Ohio Department of Insurance of our decision within one (1) Business Day.

**External Review by the Ohio Department of Insurance**

The member is entitled to an External Review by the Department in either of the following instances:

- The Adverse Benefit Determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The Adverse Benefit Determination for an Emergency indicates that the medical condition did not meet the definition of Emergency AND our decision has already been upheld through an External Review by an IRO.

## Request for External Review

Regardless of whether the External Review case is to be reviewed by an IRO or the Department of Insurance, the member or his/her Authorized Representative must request an External Review through us within one hundred eighty (180) calendar days of the date of the notice of Final Internal Adverse Benefit Determination issued by us. All requests must be in writing, except for a request for an expedited External Review. Expedited External Reviews may be requested electronically or orally.

If the member's request is complete, we will initiate the External Review and notify the member in writing, or immediately in the case of an expedited review, that the request is complete and eligible for External Review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the member that, within ten (10) Business Days after receipt of the notice, the member may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review.

We will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable). If a request for expedited review is complete, we will immediately provide or transmit all necessary documents and information regarding the Adverse Benefit Determination to the Ohio Department of Insurance.

If the request is not complete, we will inform the member in writing and specify what information is needed to make the request complete. If we determine that the Adverse Benefit Determination is not eligible for External Review, we must notify the member in writing and provide the member with the reason for the denial and inform the member that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine that the member's request is eligible for External Review regardless of the decision by us and require that the request be referred for External Review. The Department's decision will be made in accordance with the terms of the Plan and all applicable provisions of the law.

## IRO Assignment

When we initiate an External Review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of Health Care Service. An IRO that has a conflict of interest with us, the member, the member's health partner, or the Facility will not be selected to conduct the review.

## IRO Review and Decision

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

The IRO will provide a written notice of its decision within thirty (30) calendar days of receipt by us of a request for a standard review or within forty-eight (48) hours of receipt by us of a request for an expedited review. This notice will be sent to the member, us and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for External Review.
- The date the IRO was assigned by the Ohio Department of Insurance to conduct the External Review.
- The dates over which the External Review was conducted.
- The date on which the IRO's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards that were used or considered in reaching its decision.

**Note**: Written decisions of an IRO concerning an Adverse Benefit Determination that involves a health care treatment or service that is stated to be Experimental or Investigational also include the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation. In the event the Department of Insurance determines that, due to facts and circumstances, a second External Review is required, we will pay the costs of such second External Review.

## Binding Nature of External Review Decision

An External Review decision is binding on us except to the extent we have other remedies available under state or federal law or unless the Superintendent determines that, due to facts and circumstances of an External Review, a second External Review is required. Subject to the foregoing, upon receipt of notice by an IRO to reverse an Adverse Benefit Determination, we will immediately provide coverage for the Heath Care Service in question. The decision is also binding on the member except to the extent the member has other remedies available under applicable state or federal law or unless the Superintendent determines that, due to facts and circumstances of an External Review, a second External Review is required. Members may not file a subsequent request for an External Review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to us. A decision issued by the IRO will be admissible in any civil action related to our coverage decision. The IRO's decision is presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

## If Members Have Questions about Their Rights or Need Assistance

Members may contact us by mail, fax, or phone. Please call Member Services.

**Members may also contact the Ohio Department of Insurance at:**

Ohio Department of Insurance
Attn: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

To file a Consumer Complaint, members may go to:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

## Definitions

For purposes of this section, the following definitions apply:

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

- A determination that the Health Care Service does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;

- A determination of a member's eligibility for Benefits under the Plan;
- A determination that a Health Care Service is not a Covered Service;
- The imposition of an Exclusion or other limitation on Benefits that would otherwise be covered;
- A determination not to issue coverage to a member, if applicable to this Plan; or
- A determination to rescind coverage under the Plan regardless of whether there is an adverse effect on any particular Benefit at that time.

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

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

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

I**ndependent review organization (or IRO)** means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to this Section.

# West Virginia Member Grievances and Appeals Procedures

***NOTE:***
If a health partner files an Appeal related to a member's Adverse Benefit Determination, then the member appeals procedures below apply. In order for a health partner to file an Appeal regarding an Adverse Benefit Determination, written consent from the member is required. **Please see the Health Partner Appeals Procedures section for more information on submitting an appeal related to a claim.**

Members may contact Member Services at **1-855-202-0622** with any questions they have about Benefits, including any questions about coverage and Benefit levels, Annual Deductibles, Coinsurance Copayment and Annual Out-of-Pocket Maximum amounts, specific claims or services they have received, our Network, and our authorization requirements.

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

## The Grievance Process

We have put in place a Grievance Process for the quick resolution of Grievances submitted by the member to the Plan that are unrelated to Benefits or Benefit denials. For purposes of this Grievances Process, we define a Grievance as an expression of unhappiness or dissatisfaction, orally or in writing, concerning any

matter relating to any aspect of the Plan's operation. If the member has a Grievance concerning the Plan, then the member may contact us.

The member may submit their Grievance by sending a letter to us at the following address:

CareSource
Attention: West Virginia Member Appeals
P.O. Box 1947
Dayton, OH 45401

The member may also submit a Grievance by calling us at **1-800-479-9502**. The member may also arrange to meet with us in-person to discuss their Grievance.

Within twenty (20) working days of our receipt of the member's Grievance, we will investigate, resolve and respond to the Grievance and send the member a letter explaining the Plan's resolution of the Grievance. We may take up to an additional ten (10) working days to issue a decision in some cases.

**NOTE:** The Adverse Benefit Determination Appeal Process below addresses issues related to Benefits, Benefits denials, or other Adverse Benefit Determinations. The Adverse Benefit Determination Appeal Process, described below, is separate and distinct from the Grievance Process.

**Initial Benefit Determinations**

In processing claims, the Plan reviews requests for (1) Prior Authorization, (2) Predetermination and (3) Retrospective Medical Review to determine whether requested Health Care Services are Covered Services. This managed care process is described below. If the member has any questions regarding the information contained in this section, then the member may call Member Services at **1-888-815-6446**.

For purposes of this Section, the following definitions apply:

**Authorization** – A determination by us that a Health Care Service has been reviewed and, based upon the information provided to us, are Covered Services.

**Prior Authorization** – An Authorization that must be obtained prior to the member receiving a Health Care Service.

**Predetermination** – An Authorization that the member voluntarily request prior to or during the course of receiving a Health Care Service. We will review the EOC to determine if there is an Exclusion for the Health Care Service. If there is a related clinical coverage guideline, then the benefit coverage review will include a review to determine whether the Health Care Service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

**Retrospective Medical Review** – A review of whether a Health Care Service that has already been received by a member is a Covered Service. A review may only be deemed a Retrospective Medical Review if our Prior Authorization was not required and a Predetermination review was not performed. Retrospective Medical Reviews are typically initiated by us. Retrospective Medical Reviews do not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

Health Partners should know which services require Prior Authorization and should obtain any required Prior Authorization or request a Predetermination if they feel it is necessary. The ordering Health Partner must contact us to request Prior Authorization or a Predetermination review. We will work directly with Health Partners regarding such Prior Authorization request. However, the member may designate an Authorized Representative to act on their behalf for a specific request.

We will utilize our clinical coverage guidelines in determining whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

The member is entitled to receive, upon request and free of charge, reasonable access to any documents relevant to their request.

**Types of requests for Prior Authorization, Predetermination and Retrospective Medical Review:**

**Urgent Review Request** – A request for review of any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a Physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care of treatment that is subject of the review. Urgent care shall also include all requests for hospitalization and outpatient surgery. In addition, a claim involving urgent care also includes any claim that a Physician with knowledge of the member's condition determines is claim involving urgent care.

**Prospective Review Request** – A request for Prior Authorization or a Predetermination that is submitted prior to the member receiving a Health Care Service.

**Concurrent Review Request** – A request for Prior Authorization or Predetermination that is submitted prior to or during the course of receiving a Health Care Service.

**Retrospective Review Request** – A request for Medical Review that is submitted after the Health Care Service has been received.

**Timing of Initial Benefit Determinations**

We will make our benefit decisions within the timeframes set forth on the next page. Please call Member Services at **1-888-815-6446** with any questions.

| Review Request Category | Timeframe for Making Decision |
|---|---|
| Urgent Care Claims* | As soon as possible but not later than seventy-two (72) hours from the receipt of request. |
| Prospective Care Claims** | With fifteen (15) calendar days of our receipt of the members request. |
| Concurrent Urgent Care Claims when request is received at least twenty-four (24) hours before the expiration of the previous authorization or no previous autho¬rization exists | Within twenty-four (24) hours from the receipt of the request. |
| Concurrent Urgent Care Claims when request is received less than twenty-four (24) hours before the expiration of the previous authorization or no previous authorization exists | As soon as possible, but not later than seventy-two (72) hours from the receipt of request. |
| Concurrent Care Claim (non-urgent) | As soon as possible, but not later than seventy-two (72) hours from the receipt of request |
| Retrospective*** | Thirty (30) calendar days from the receipt of the request. |

*** Urgent Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan. If the Plan needs more information before we can make a decision, we will notify the member of the information we need within twenty-four (24) hours of our receipt of the request. The member will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Plan will notify the member of our final decision as soon as possible, but in no case later than forty-eight (48) hours after the earlier of: (a) our receipt of the specified information, or (b) the end of time period afforded to the member to provide the specified additional information.

**** Prospective Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify the member. The notice will specifically describe the required information, and the member will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notification is made to the member, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision.

***** Retrospective Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify the member. The notice will specifically describe the required information, and the member will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notification is made to the member, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision.

**Notification of Initial Benefit Determination**

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- **Verbal:** Oral notification given to the Covered Person via telephone (for Urgent Care Claims only), followed by written notification.
- **Written:** Mailed letter or electronic means (including email and fax) given to, at a minimum, the requesting health partner and the Covered Person or his or her Authorized Representative.

If we approve the member's request for Benefits or Health Care Services, then we will provide the member with notice of our decision. However, even if the Plan gives prior authorization for a Health Care Service, such Prior Authorization does not guarantee that the Plan will provide Benefits for such Health Care Service. In order for the Plan to provide Benefits for the Health Care Service at issue:

- The member must be eligible for coverage under the Plan;
- The Health Care Service must be a Covered Service;
- The member may not have exceeded any applicable limits described in this EOC; and
- The Health Care Service may not be subject to an Exclusion under the Plan.

If we deny the request for Benefits or Health Care Services, then we will provide the member or their Authorized Representative with an Adverse Benefit Determination notice.

# Internal Appeal Process

**Adverse Benefit Determination Appeals**

The Plan offers one (1) level of Internal Appeal.

If the member or their Authorized Representative wish to appeal an Adverse Determination, then the member or their Authorized Representative must submit the member's Internal Appeal to us within one hundred eighty (180) days of receiving the Adverse Determination. All Internal Appeal requests must be in writing, except for an Internal Appeal request involving Urgent Care, which may be requested in writing, orally, or electronically. The member or their Authorized Representative may send a written request for an Internal Appeal of Adverse Determination to:

CareSource
Attention: West Virginia Member Appeals
P.O. Box 1947
Dayton, OH 45401

If the member or their Authorized Representative would like to appeal an Adverse Determination involving an Urgent Care Claim or Adverse Determination involving an admission, availability of care, continued stay or health care service where the member received emergency services, but have not been discharged from a facility, then the member may also submit the member's Internal Appeal orally by calling 1-800-479-9502.

This communication, whether done in writing or orally, must include the following information:

1. The Covered Person's name and identification number as shown on the ID card;
2. The health partner's name;
3. The date of the medical service;
4. The reason the member disagrees with the Coverage Denial; and
5. Any documentation or other written information to support the member's request.

**Note:** If the Internal Appeal request of an Adverse Determination was done orally, except for Urgent Care Claim Appeals, the Internal Appeal must be followed up in writing before the Plan will begin to process the Internal Appeal of an Adverse Determination.

## First Level Review of Internal Appeal Involving an Adverse Determination

The Internal Appeal of an Adverse Determination will be reviewed by a health partner not involved in the initial decision and not a subordinate of the original decision maker. The health partner will be in the same or similar specialty that typically manages the medical condition, procedure, or treatment under review. The health partner reviewing the Internal Appeal may interview the patient or patient's designated representative.

We may need additional information to process a request for an Internal Appeal. If additional information is needed, then we may send to the member or their Authorized Representative a letter acknowledging the date the Plan received the request for an Internal Appeal and a list of documents, if any, the member or their Authorized Representative must submit.

The Plan must notify the member of the Final Adverse Benefit Determination within thirty (30) days after receiving the completed Internal Appeal of Adverse Determination involving a Prospective Review Request and sixty (60) days after receiving the completed Internal Appeal of an Adverse Determination involving a Retrospective Review Request.

If the Plan denies the member's Internal Appeal of an Adverse Determination, then the Plan will notify the member via a Final Adverse Determination notice. If we approve the member's request for benefits, then we will provide the member, their attending Physician, or ordering health partner with the appropriate notice.

## Expedited Review of Internal Appeal Involving an Adverse Determination

The member may request an expedited Internal Appeal of an Adverse Determination for:

- Any claim for Health Care Services or treatment with respect to which the application of the time periods for making non-Urgent Care Claim determinations:
  - Could seriously jeopardize the members life or health or their ability to regain maximum function, or,

  - In the opinion of a Physician with knowledge of the members medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
    - Except as provided below, whether a claim meets the above conditions in order to be eligible for expedited Internal Appeal will be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of the member's medical condition determines is a claim involving Urgent Care Services.
- Any Adverse Determination involving an admission, availability of care, continued stay or health care service where the member received emergency services, but have not been discharged from a facility.

We will complete an expedited review of an Internal Appeal of an Adverse Determination as soon as possible given the member's medical needs, but not later than seventy-two (72) hours after our receipt of the request.

We will communicate our decision and all other necessary information in writing, electronically, or orally. If notice is provided orally, then we will also provide written or electronic notice of the notice within three (3) days following the oral notification.

## Standard Review of Decisions Not Involving an Adverse Determination

The member may also request review of any decision involving any of the following that is adverse to the member, but that does not involve an Adverse Determination:

1. The availability, delivery, or quality of Health Care Services, including a complaint regarding an Adverse Determination made pursuant to utilization review;
2. Claims, payments, handling or reimbursement for Health Care Services; or
3. Matters pertaining to the contractual relationship between the member and the Plan.

The decision will be reviewed by a person or persons who were not involved in the initial decision or were subordinates of the original decision maker(s). We will notify the member, in writing, of our decision within twenty (20) Business Days after the date of receipt of the member's request for a review of a decision not involving an Adverse Determination.

## Exhaustion of the Internal Appeals Process

The Internal Appeal of an Adverse Determination process must be exhausted prior to initiating an External Review – except in the following instances:

- We agree to waive the exhaustion requirement;
- The member did not receive a written decision of our Internal Appeal within the required time frame;
- We failed to meet all requirements of the Internal Appeal process unless the failure was minor and did not cause – and is not likely to cause – prejudice or harm to the member so long as the Plan demonstrates that the violation was for good cause or due to matters beyond our control and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the member. This

exception will not be available if the violation is part of a pattern or practice of violations by the Plan; or
- An expedited External Review is sought simultaneously with an expedited Internal Appeal.

If the member believes that they have exhausted the Internal Appeals process and are entitled to an External Review, as outlined below, because of the Plan's failure to adhere to all of the requirements of Internal Appeal process, then within ten (10) days after receiving the member's written request, we will provide to the member a written explanation of the basis, if any, for asserting that the alleged violation of the Internal Appeals process does not entitle the member to claim exhaustion.

If the member submits a request for External Review and the Independent Review Organization rejects the member's request for immediate review on the basis that the Plan met the requirements of one of the exceptions, as outlined above, then within ten (10) days after the Independent Review Organization rejects the member's request for immediate review, we will provide the member notice of their opportunity to resubmit and, as appropriate, pursue a review an Internal Appeal of an Adverse Determination.

# External Review Process

**External Review of the Final Adverse Benefit Determination Notice**

The Plan provides a process that allows the member the right to request an independent External Review of an Adverse Determination or a Final Adverse Determination notice. However, the member must generally exhaust the Plan's Internal Appeal process before seeking an External Review. The member will not pay for the External Review.

The member will not be subject to retaliation for exercising their right to request an independent External Review.

External Reviews are conducted by Independent Review Organizations.

**Request for External Review**

The member or their Authorized Representative may request an External Review of an Adverse Determination or a Final Adverse Determination notice through the Offices of the Insurance Commissioner of the State of West Virginia ("Commissioner") within one hundred twenty (120) days of the date of the notice of the Adverse Determination or Final Adverse Determination issued by us. All External Review requests must be in writing, except for a request for an Expedited External Review, which may be requested orally. In addition to filing the request for External Review, the member will also be required to authorize the release of their medical records as necessary to conduct the External Review.

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

West Virginia Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305

If the member or their Authorized Representative would like to file an expedited External Review, then the member may submit the request for expedited External Review orally by calling West Virginia Offices of the Insurance Commissioner at **1-888-879-9842**.

## External Review Conducted by Independent Review Organization

There are three (3) types of External Reviews conducted by Independent Review Organizations: (1) Standard, (2) Expedited and (3) Experimental or Investigational.

**Standard External Review**

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

1. The member is or was a Covered Person at the time the Health Care Service was requested or, in the case of a retrospective review, was a Covered Person under the Plan at the time the Health Care Service were provided;
2. The Health Care Service that is subject of the Adverse Determination or Final Adverse Determination is a covered service under the Plan, but for a determination by the Plan that the Health Care Service is not covered by it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
3. The member is deemed to have exhausted the Plan's Internal Appeal process; and
4. The member has provided all the information and forms required to process the External Review.

Once the member has requested a standard External Review through the Commissioner, within two (2) Business Days of receipt of such request, the Commissioner should forward a copy of the member's request for a standard External Review to the Plan. Then, within five (5) Business Days following receipt of the member's request for a standard External Review, the Plan will send the member and the Commissioner the Plan's determination as to whether the member's request is complete and if it is eligible for a standard External Review, which will be based on the above mentioned criteria.

If the member's request for a standard External Review is not complete, then the Plan will notify the member and the Commissioner, in writing, of what information or materials are needed to make the request complete.

If the member's request for a standard External Review is not eligible for review, then the Plan will notify the member and the Commissioner, in writing, of the reasons for ineligibility. Notwithstanding the Plan's decision to deny the member's request for a standard External Review, the member may appeal the Plan's decision to the Commissioner, who may then determine that the member's request for a standard External Review is eligible for review and require that it be referred for a standard External Review.

**Expedited External Review**

Except for a retrospective Adverse Determination or Final Adverse Determination, the member is entitled to an Expedited External Review by an Independent Review Organization in the following instances:

1. If the Plan's Adverse Determination involves a medical condition where the time-frame for expedited review under the Plan's Internal Appeal process would seriously jeopardize the member's life, health

or ability to regain maximum function, then the member may request an expedited review under the Plan's Internal Appeal process, while simultaneously a requesting for expedited External Review;

2. If the Plan's Adverse Determination is based on our determination that the treatment or service is experimental or investigational and where the member's treating physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated;
3. If the Plan's Final Adverse Determination involves a medical condition where the time-frame for completion of a standard External Review would seriously jeopardize the member's life or health or ability to regain maximum function, or
4. If the Plan's Final Adverse Determination concerns an admission, availability of care, continued stay, or Health Care Service for which the member received Emergency Health Services, but have not been discharged from a facility.

Once the member has requested an expedited External Review through the Commissioner, the Commissioner should immediately forward a copy of the member's request for an expedited External Review to the Plan. Immediately following receipt of the member's request for an expedited External Review, the Plan will immediately notify the member and the Commissioner of the Plan's determination as to whether the member's request is eligible for an expedited External Review.

Notwithstanding the Plan's decision to deny the member's request for an expedited External Review, the member may appeal the Plan's decision to the Commissioner, who may then determine that the member's request for an expedited External Review is eligible for review and require that it be referred for an expedited External Review.

**Experimental or Investigational External Review**

The member may request an experimental or investigational External Review when the member's Adverse Determination or Final Adverse Determination notice involves a denial of coverage based on the determination that the Health Care Service or treatment recommended or requested is experimental or investigational.

Once the member has requested an experimental or investigational External Review through the Commissioner, within one (1) Business Days of receipt of such request, the Commissioner should forward a copy of the member's request for an experimental or investigational External Review to the Plan. Then within six (6) Business Days following receipt of the member's request for an experimental or investigational External Review, the Plan will send the member and the Commissioner the Plan's determination as to whether the member's request is complete and if it is eligible for an experimental or investigational External Review.

If the member's request for an experimental or investigational External Review is not complete, then the Plan will notify the member and the Commissioner, in writing, of what information or materials are needed to make the request complete.

If the member's request for an experimental or investigational External Review is not eligible for review, then the Plan will notify: the member and the Commissioner, in writing, of the reasons for eligibility. Notwithstanding the Plan's decision to deny the member's request for an experimental or investigational External Review, the member may appeal the Plan's decision to the Commissioner, who may then determine that the member's request for an experimental or investigational External Review is eligible for review and require that it be referred for an experimental or investigational External Review.

**Note**: If the member's Physician certifies, in writing, that the recommended or requested Health Care Service or treatment (that is subject of the request) would be significantly less effective if not promptly initiated, then the member may request an expedited External Review as noted above.

**Independent Review Organization Assignment**

Once the Plan notifies the Commissioner that the member's request for External Review is eligible for review, the Commissioner should assign an Independent Review Organization ("IRO") to the member's External Review and should notify the member of such assignment.

The assignment should be done on a random basis among the IROs qualified to conduct the particular External Review, based on the nature of the Health Care Service that is the subject of the Adverse Determination or Final Adverse Determination and on other circumstances, including conflict of interest concerns.

**Independent Review Organization Review and Decision**

The Independent Review Organization should consider all documents and information considered by us in making the Adverse Determination or Final Adverse Determination, any information submitted by the member and other information such as the member's medical records, the member's attending health partner's recommendation, consulting reports from appropriate health partners, the terms of coverage under the Plan, the most appropriate practice guidelines, clinical review criteria used by the Plan or our utilization review organization and the opinions of the Independent Review Organization's clinical reviewers.

The Independent Review Organization should make its decision as follows:

1. Within forty-five (45) days after a standard External Review request is assigned by the Commissioner to the IRO.
2. Within seventy-two (72) hours after an expedited External Review request is assigned by the Commissioner to the IRO, except for an expedited External Review involving experimental or investigational Health Care Services or treatment, which should be decided within eight (8) days after an experimental or investigational expedited External Review request is assigned by the Commissioner to the IRO.
3. Within forty-one (41) days after an experimental or investigational External Review request is assigned by the Commissioner to the IRO.

The IRO should notify the member or their Authorized Representative, the Plan and the Commissioner of its decision.

**Binding Nature of External Review Decision**

Absent judicial review or other lawful means of redress, the external review decision will be deemed binding. However, if either the Plan or the member is adversely affected by the IRO's decision, then the Plan and the member are both entitled to judicial review of the IRO's decision. This shall not be deemed to prevent other means of redress or relief provided by law.

**If the Member Has Questions About Their Rights or Needs Assistance**

The member may contact us by mail or phone. Please call Member Services at **1-888-815-6446**.

The member may also send correspondence to:

CareSource
Attention: West Virginia Member Appeals
P.O. Box 1947
Dayton, OH 45401

**Note**: If the member requests language services, then the Plan will provide service in the requested language through bi-lingual staff or an interpreter. If requested, then the Plan will provide language services to help (1) assist the member in registering a complaint or appeal and (2) notify the member about their complaint or appeal

If the member, (a) needs the assistance of the governmental agency that regulates insurance; or (b) has a complaint they have been unable to resolve with the insurer, then the member may contact the Commissioner:

Office of the Insurance Commissioner of the State of West Virginia
Consumer Service Division
P.O. Box 50540
Charleston, West Virginia 25305
Consumer Hotline: 1-888-879-9842
Facsimile: 1-304-558-4965

## Definitions:

For purposes of this section, the following definitions apply—

**Adverse Determination** means a determination by an issuer or its designee utilization review organization that an admission, availability of care, continued stay or other healthcare service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the issuer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated.

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

**Final Adverse Determination** means an Adverse Determination that has been upheld by the Plan at the completion of the Internal Appeals process described in this Section.

**Independent Review Organization** means an entity that conducts independent External Reviews of Adverse Determinations and Final Adverse Determinations.

**Internal Appeal** means the review by the Plan of an Adverse Determination.

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