CareSource®

CareSource
Ohio Provider Manual

Marketplace

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

Dear CareSource provider,

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

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

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. Our Marketplace plans help provide members with stability, peace of mind and affordable health care with heart – allowing members to select the plan which best meets their needs.

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

CareSource communicates updates to our provider network regularly at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements. You can also find the most up-to-date information on the CareSource Provider Portal (ProviderPortal.CareSource.com/OH/). For an immediate response to questions, concerns and inquiries regarding claims, policy and appeals, you can contact Provider Services at **1-833-230-2101**. Hours of availability are Monday through Friday from 8 a.m. to 6 p.m. Eastern Time (ET).

To support our providers, we have dedicated Provider Services teams specialized with each plan to help assist with questions and concerns. Additionally, an external team of Provider Managers is available to provide onsite training and work with our providers in their communities.

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

Sincerely,

CareSource®

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ABOUT CARESOURCE

Welcome

Welcome, and thank you for participating with CareSource.

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

We are a nonprofit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. In Ohio, CareSource currently serves members and consumers of our Medicaid, Dual-Eligible Special Needs (D-SNP), MyCare Ohio and Marketplace plans.

Our goal is to create an integrated medical home for our members. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy. As a managed care organization (MCO), we improve the health of our members by utilizing a contracted network of high-quality participating providers. Primary care providers within the network provide a range of services to our members, and also coordinate patient care by referring them to specialists when needed, ensuring members have timely access to health care services and receive all appropriate preventive services.

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

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

About Us

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

Vision and Mission

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

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

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

Our Services

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

In addition to the functions above, our care management programs include the following:

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

- Maternal and child health
  - Comprehensive prenatal, postpartum and family planning services
  - Outreach programs in partnership with community agencies to target members at greatest risk for preterm birth or complications
- Behavioral health (BH) and substance use disorder (SUD) management
- Collaboration with pharmacy and medication therapy management (MTM)

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

The CareSource Foundation

CareSource gets actively involved in the communities that we serve, from employees serving on hundreds of nonprofit boards to investing dollars back. We listen, we learn and we are driven to action. As a result, we launched the CareSource Foundation in 2006 to add another component to our professional services: community response. Focus areas of the CareSource Foundation are closely aligned with the greatest needs of our member demographics. Areas of emphasis include children's health, special populations such as seniors and individuals with disabilities, the uninsured and life issues such as hunger, domestic violence, SUD and homelessness.

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

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

Compliance and Ethics

At CareSource, we serve a variety of audiences – members, providers, government regulators, community partners and each other. We serve them best by working together with honesty, respect and integrity. Our Corporate Compliance Plan, along with state and federal regulations, outlines 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 and/or CareSource policy

This allows us to resolve problems promptly and minimize any negative impact on our members or

business, such as financial losses, civil damages, penalties and criminal sanctions.

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

General Compliance and Ethics Expectations of Providers

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

For questions about provider expectations, please call Provider Services at **1-833-230-2101**. The hours of operation are Monday through Friday from 8 a.m. to 6 p.m. Eastern Time (ET).

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

- Ethics and Compliance Hotline: **844-784-9583** or CareSource.ethicspoint.com
- Compliance Officer: **937-487-5110** or CorporateComplianceOfficer@CareSource.com

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

The CareSource Corporate Compliance Plan is posted for your reference on **CareSource.com** > About Us > Legal > Corporate Compliance. Please let us know if you have questions regarding the CareSource Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

Personally Identifiable Information

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

Here are a few important places to start:

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

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.

Member Consent

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

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

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

Accreditation

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

COMMUNICATING WITH CARESOURCE

CareSource communicates with our provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSource.com** and network notifications. Please reach out to our Provider Services department with any questions

Provider Services	
Monday to Friday	8 a.m. to 6 p.m. ET

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

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

Phone

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

Marketplace	
Provider Services	1-833-230-2101
Prior Authorizations	1-833-230-2101
Claim Inquiries	1-833-230-2101
Credentialing	1-833-230-2101
Member Services	1-833-230-2099
CareSource24 – Nurse Advice Line	1-866-206-4240
Fraud, Waste and Abuse Hotline	1-844-415-1272
TTY for the Hearing Impaired	1-800-750-0750 or 711

Fax

Marketplace	
Credentialing	866-573-0018
Care Management Referral	977-946-2273
Contract Implementation	937-396-3632
Fraud, Waste and Abuse	800-418-0248
Medical Prior Authorization Form	1-844-676-0372
Pharmacy Prior Authorization	866-930-0019
Provider Administered Drug Prior Authorization (Outpatient Drugs Only)	888-399-0271
Provider Maintenance	937-396-3076

Website

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

Provider Portal

URL: ProviderPortal.CareSource.com/OH/

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

Provider Portal Benefits

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

Provider Portal Tools

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

- **Payment history** – Search for payments by check number or claim number.
- **Claims features**
  - Submit claims – Using online forms, claim submission through the portal is available to traditional providers, community partners, delegates and health homes. For more information about submitting claims online, please visit the “Claim Submissions” section on page 20.
  - Claims status – Search for status of claims and claim appeals.
  - Claims attachments – Submit documentation needed for claims processing.

  - Rejected claims – Find claims that may have been rejected so that you can resubmit them.
  - Claim dispute and appeals – Search for the status of claims and claim appeals.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior authorization (PA)** – Submit medical inpatient/outpatient, home health care and Synagis®.
- **Eligibility termination dates** – View the member's termination date (if applicable) under the eligibility tab.
- **Care management referrals** – Submit automated care management forms on our portal for efficiency in enrolling members.
- **Benefit limits** – Track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy and speech therapy.
- **Care treatment plans** – Providers can view care treatment plans.
- **Clinical Practice Registry (CPR)** – Filter patient data to identify opportunities for preventive health screenings.
- **Recovery letters** – View and download letters.
- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **Member financial status and information** – View member payment responsibilities (such as deductible, copay and coinsurance) and monthly premium payment status. Also view member's payment history.
- **File grievance**
- **Service plan** – Waiver providers can review, print, respond to and acknowledge approved services.

Provider Portal Registration

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

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

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

Dental Providers

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

Mail

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

Marketplace	
Provider Appeals	CareSource P.O. Box 1947 Dayton, OH 45401-1947
Member Appeals & Grievances	CareSource P.O. Box 1947 Dayton, OH 45401-1947
Claims	CareSource P.O. Box 8730 Dayton, OH 45401-8730
Fraud, Waste and Abuse	CareSource Attn: Program Integrity and Investigations P.O. Box 1940 Dayton, OH 45401-1940

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

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

Provider Communications

Newsletters

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

Network Notifications

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

Provider Demographic Changes and Updates

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

Online

CareSource.com > Login > Provider

Email

ProviderMaintenance@CareSource.com

Fax

937-396-3076

Mail

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

CREDENTIALING AND RECREDENTIALING

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

Credentialing Process

Council for Affordable Quality Healthcare Application

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

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

Please also include copies of the following documents:

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

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

Debarment and Criminal Conviction Attestation

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

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

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

Providers Credentialed

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

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

Providers Who Do Not Need Credentialed by CareSource

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

Provider Selection Criteria

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

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

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

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

Criteria

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

  - Other quality-of-care measurements/activities
  - Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
  - Lack of issues on HHS-OIG, SAM/EPLS, or state site for sanctions or terminations (fraud and abuse)
- Signed, accurate credentialing application and contractual documents
- Participation with care management, quality improvement and credentialing programs
- Compliance with standards of care and evidence of active initiatives to engage members in preventive care
- Agreement to comply with plan formulary requirements or acceptance of Plan Drug Formulary as administered through the Pharmacy Benefit Manager (PBM)
- Agreement to access and availability standards established by the health plan
- Compliance with service requirements outlined in the provider agreement and CareSource Provider Manual

Organizational Credentialing and Recredentialing

The following organizational providers are credentialed and recredentialed:

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

Additional organizational providers are also credentialed:

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

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

The following elements are assessed for organizational providers:

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

- CLIA certificates are current
- Completion of a signed and dated application

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

Provider Credentialing Rights

- Providers have the right to review information submitted from outside sources to support their credentialing application upon request to the CareSource credentialing department. CareSource keeps all submitted information locked and confidential.
- Providers have the right to correct incomplete, inaccurate, or conflicting information by supplying corrections in writing to the credentialing department prior to presenting them to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the provider will be notified and given the opportunity to correct this information prior to presenting to the credentialing committee.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the credentialing department. An automated email is sent to providers once their application is submitted via the CareSource Provider Portal. This email directs them to contact Provider Services at **1-833-230-2101** to obtain application status updates. Provider service representatives can inform providers if their application is complete and they are showing as participating in the CareSource network, or if their application is still in process while referencing the state-specific time frames.

Provider Responsibilities

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

Recredentialing

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

Board Certification Requirements

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

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

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

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

To be credentialed as a subspecialist physicians must:

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

Delegation of Credentialing/Recredentialing

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

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

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

Delegates must be in good standing with Medicaid and Centers for Medicare & Medicaid Services (CMS). Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

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

Reconsideration and Appeals of Credentialing/ Recredentialing Decisions

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

Step 1

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

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

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

Step 2

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

Appeals Should Be Sent To:

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

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

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

Provider Disputes

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

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

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

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

Summary Suspensions

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

CLAIM SUBMISSIONS

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

MARKETPLACE PROVIDERS

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

Billing Methods

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

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

Submit Claims Online Through Provider Portal

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

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

Who Can Submit Claims Via the Portal?

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

What Types of Claims Can Be Submitted?

The following claims may be submitted through the Provider Portal:

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

Routine hearing and vision claims must be submitted to TruHearing and EyeMed respectively, through your relationship with the benefits manager. Vision claims for Ohio Marketplace must be submitted to the SuperiorVision vendor.

Electronic Funds Transfer

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

Benefits of EFT:

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

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

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

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

Electronic Claim Submission

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

Availity Clearinghouse

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

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

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

File Format

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

5010 Transactions

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

Transactions Covered Under the 5010 Requirements

- 837 Health Care Claim/Encounter
- 276/277 Health Care Claim Status Request and Response
- 835 Health Care Claim Payment/Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 278 Health Care Services Review (Prior Authorization Requests)
- 834 Benefit Enrollment and Maintenance

- 820 Group Premium Payment for Insurance Products
- NCPDP Version D.0

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

National Provider Identifier and Tax ID Numbers

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

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

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

Location of Provider Information on Professional Claims

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

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

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

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

Institutional Claims

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

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

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

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

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

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

Claims Payment Processing

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

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

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

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

Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. For more information on electronic claims, please reference the "Electronic Claims Submission" section of this chapter, on page 22.

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

- CMS 1500, formerly HCFA 1500 form – AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental claim form
- CMS 1450 (UB-04), formerly UB92 form for facilities

Please note: ORP is an ODM requirement for certain provider types for both electronic and paper claim submissions. Providers should submit this information under Box 17 of CMS 15000A.

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

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

- CMS 1500 Form Instructions: www.nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42
- UB-04 Form Instructions: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf

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

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

All claims (EDI and paper) must include:

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

What to Include on Claims That Require National Drug Code

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

Instructions for National Drug Code on Paper Claims

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

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

Do not enter hyphens or spaces with the NDC. Use three spaces between the NDC number and the units on paper forms.

Tips for Submitting Paper Claims

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

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

To ensure optimal claims processing timelines:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current form version as designated by CMS, NUCC and the ADA.
- No handwritten (including printed claims with any handwritten information) claims or Super Bills will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Fonts should be 10 to 14 point (capital letters preferred) with printing in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- It is recommended that you submit your 12-digit CareSource Provider ID, located in your welcome letter, in conjunction with your required NPI number. Please refer to sections for Professional and Institutional claim information.
- Federal Tax ID number or physician SSN is required for all claim submissions.

Please send all paper claim forms to CareSource:

CareSource
Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401

No Surprises Act

Effective Jan. 1, 2022, CareSource will comply with new state and federal requirements, in alignment with the No Surprises Act, including how we process claims from certain out-of-network providers. This applies to claims with the date of service starting Jan. 1, 2022.

The No Surprises Act, part of the Consolidated Appropriations Act of 2021, establishes patient protections for members enrolled in Marketplace plans, including protection from out-of-network providers' surprise bills (balance billing) for emergency care and other specified items or services.

CareSource presumes emergency services (including post-stabilization) and services from out-of -network providers at in-network facilities are covered under the No Surprises Act. Post-stabilization services are defined as emergency services needed to evaluate or stabilize an emergency medical condition per citation 42 CFR 438.114. Claims will be processed according to the Consolidated Appropriations Act of 2021 based on criteria below as billed on the claim. Providers are prohibited from balance billing members, aside from patient responsibility for copay, deductible, and coinsurance.

Out-of-network providers are encouraged to submit a new contract request, which can be done online at Becoming a Participating Provider or by working with a contract manager.

How to Bill Claims for Services Covered Under the No Surprises Act

Emergency Services

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

Non-Emergency Services

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

Claims paid in accordance with this Act will be notated in the claim detail section of your Electronic Remittance Advice or Explanation of Payment notice with Remark Code N830. Providers do not need to

submit documentation of notice and consent requirements with their claims. Prior authorizations will still be required for services that require medical necessity review.

Claim Submission Timely Filing

Claims must be submitted within three hundred and sixty-five (365) calendar days of the date of service or discharge. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim.

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

- If the claim is denied, then providers have ninety (90) days after the receipt of the written determination of the claim to submit a dispute or three hundred and sixty-five (365) days from the date of service or discharge to file a claim appeal.
- If the provider was denied authorization or reimbursement due to not obtaining a required prior authorization, then providers have one hundred and eighty (180) days from the date of service or discharge to submit an appeal.

Claim Processing Guidelines

- Providers have three hundred and sixty-five (365) calendar days from the date of service or discharge to submit a claim. If the claim is submitted after three hundred and sixty-five (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 sixty (60) days after receipt of the written determination of the claim to submit a dispute or three hundred and sixty-five (365) calendar days from the date of service or discharge to file a claim appeal.
- If the provider was denied authorization or reimbursement due to not obtaining a required prior authorization, then providers have one hundred and eighty (180) calendar days from the date of service or discharge to file a claim appeal.
- If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment within three hundred and sixty-five (365) calendar days of the original date of service.
- If a claim is denied for coordination of benefits (COB) information needed, the provider must submit the primary payer's explanation of benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within ninety (90) calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.

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

Searching for Claim Information Online

Claim statuses are updated daily on our Provider Portal, and you can check claims that were submitted for the previous twenty-four (24) months. You can search by member ID number, member name and date of birth or claim or patient number.

Additional Claim Enhancements on the Provider Portal

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

Procedure and Diagnosis Codes

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

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM). Available from the U.S. Government Printing Office at (202) 512-1800, (202) 512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at www.ama-assn.org/amaone/cpt-current-procedural-terminology.
- HCFA Common Procedure Coding System (HCPCS). Available at https://www.cms.gov/medicare/coding/medhcpcsgeninfo?redirect=/%20medhcpcsgeninfo/ www.cms.gov/
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org.
- NDC available at http://www.fda.gov/.

Procedures That Do Not Have a Corresponding Code

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

Code Editing

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

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

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

CareSource Provider Coding and Reimbursement Guidelines

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

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

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

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

Explanation of Payment

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

Information Included on Explanation of Payment

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

Checking Claims Status

Pended claims are claims that have been entered into our system, but have not yet been processed completely. Please remember that you can track the progress of your submitted claims at any time through our Provider Portal.

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

Other Coverage

Coordination of Benefits

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

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

Search coordination of benefits on the Provider Portal by:

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

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

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

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

Coordination of Benefits Overpayment

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

Workers' Compensation

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

Third-Party Liability/Subrogation

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

MARKETPLACE PROVIDERS

Member Financial Liability and Grace Period

Some benefits under a plan may have first dollar coverage while others will require a member to first pay an annual deductible before CareSource contributes payment for the services. In addition to the deductible, copayments or coinsurance are also applicable for many covered services. It is up to the provider to collect these amounts at the time of service. If a member overpays his or her coinsurance, the provider must refund the overpayment to the member. Please refer to the "Involuntary Member Disenrollment" section on page 40 for information on how claims processing and eligibility is affected if premiums aren't paid on time, otherwise known as the grace period.

Explanation of Benefits

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

UTILIZATION MANAGEMENT

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The UM department performs activities such as:

- Prior authorization (PA)
- Preservice review
- Urgent concurrent review
- Post-service review
- Filing an appeal
- Discharge planning
- 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. Please refer to the Pharmacy section for information about prior authorizations for outpatient and pharmacy benefit drugs.

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

	Phone	Fax
Marketplace	**1-833-230-2101**	844-676-0372

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

Criteria

CareSource utilizes nationally recognized criteria, MCG, to determine medical necessity and appropriateness of services. These criteria are designed to assist providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients. CareSource defaults to all applicable state and

federal guidelines regarding criteria for authorization of covered services.

CareSource also has a medical policy developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the applicable criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available within five business days of decision to discuss individual cases with attending physicians upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward providers or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

Our members' health is always our number one priority. Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations. You may request the information by calling or faxing the CareSource UM department. If you would like to discuss an adverse decision with CareSource's physician reviewer, please call the UM department within five business days of the determination **1-833-230-2168**.

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 **1-833-230-2099** 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 forty-eight (48) hours from the receipt of request.
Prospective Care Claims**	Within two (2) business days of receiving all information, but no more than ten (10) calendar days from the receipt of the request.
Inpatient Initial Claims when request is received at least twenty-four (24) hours before the expiration of the previous authorization or no previous authorization exists	Within forty-eight (48) hours or seventy-two (72) hours if additional information is needed and requested within twenty-four (24) hours of receipt.
Inpatient Continued Stay Claims	Within one (1) Business Day after receiving all necessary information.
Retrospective***	All retro-authorization requests must be submitted within 30 calendar days of the date of service or date of discharge. No appeal rights are provided if retro request is denied.

*** 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 pay, then the Plan will notify you. The notice will specifically describe the required 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.

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 provider to perfect the claim for Benefits; and a description of our review procedures and the time limits applicable to such procedures.

Members have one hundred and eighty (180) calendar days after they receive the Notice of an Adverse Benefit Determination to file an Appeal with us.

Post-Stabilization Services

Post-stabilization care services are covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition. PA is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a participating provider. PA is required for post-stabilization services in an inpatient setting.

To request PA for observation services as a non-participating provider or to request authorization for an inpatient admission, please visit the Provider Portal at **CareSource.com** > Login > Provider Portal.

You can also request a PA by calling our Provider Services and selecting the option to request a PA. During regular business hours, your call will be answered by our UM department. If calling after regular business hours, the call will be answered by CareSource24, our nurse advice line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

If you have questions related to post-stabilization service, please call the Provider Services lines listed above.

Access to Staff

Providers may call Provider Services to contact UM staff with any questions: **1-833-230-2101.**

Staff Availability

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

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

MEMBER ENROLLMENT AND ELIGIBILITY

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

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

Member ID Cards

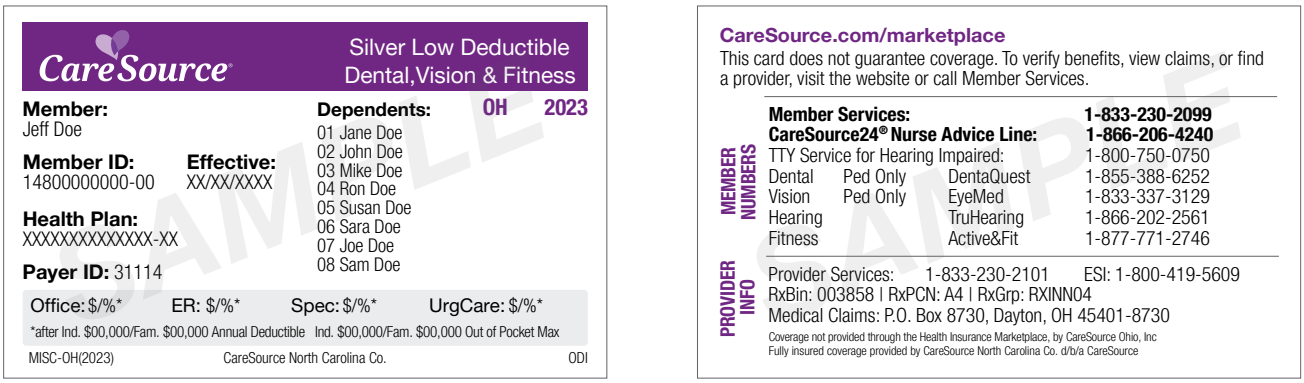
The member ID card is used to identify a CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their previous ID card. Therefore, it is important to verify member eligibility prior to each service rendered.

You can use our secure Provider Portal or call Provider Services at **1-833-230-2101** and follow the prompt to check member eligibility. Click on "Member Eligibility" on the left, which is the first tab. Make sure to enter the full 11-digit member ID for the person, and if a dependent, include the dependent suffix.

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.

Front & Back of Ohio Marketplace Member ID Card – Low Deductible Silver Plan

Front & Back of Ohio Marketplace Member ID Card – Low Premium Silver 2 Plan



ID Card Elements

The CareSource member ID card contains the following:

- Member plan – Member's selected plan will show in the upper left corner. Plans with Vision and Fitness in the plan name are the only ones which include Adult benefits for those services.
- Member – This is the name of the plan holder.
- Member ID – This is the ID number + suffix for the plan holder.
- Health plan number.
- Payer ID number.
- Copay amounts for office, emergency room, specialist and urgent care visits.
- Deductible and Maximum Out of Pocket Limits for Member's Plan – for family plans it will show the family amounts, however, members will have an individual deductible or MOOP that is half the family amount.
- Dependents – When checking eligibility and/or submitting claims for dependents, please ensure you replace the subscriber suffix (last 2 digits, usually 00) of the Member ID number with the dependent suffix from the ID card.
- Member Services phone number.
- CareSource24 Nurse Advice Line.
- Provider Services phone numbers.
- Benefit Manager Information – CareSource partners with several benefit managers to provide our members with the best service possible in specific benefit categories. This section identifies the benefit category, company name and contact number.
- Address to submit medical claims, though it is recommended to submit electronically.
- Pharmacy numbers.

New Member Welcome Kits

Once a member has paid to effectuate their coverage, each household receives a new member kit and two or more ID cards that include each family member who has joined CareSource.

New Member Kit Elements

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

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

Member Disenrollment

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

Member Grace Period

Members have a federally mandated ninety (90)-day grace period if they are receiving advance premium tax credit (APTC), or a thirty-one (31)-day grace period if they are not receiving APTC in which to make their payment.

- This is not applicable for their initial payment
- For APTC-receiving members, thirty (30) days after their due date CareSource will:
  - Flag the member in the eligibility file on the Provider Portal, suspend pharmacy benefits and pend claims rendered
- For non-APTC members, the day after their due date, CareSource will:
  - Flag the member in the eligibility file and on the Provider Portal, suspend pharmacy benefits and pend any claims rendered

If members bring their account into good standing before the expiration of the grace period, pharmacy benefits will start again and pended claims will be processed.

Member Termination

After the grace period has expired, the member is terminated for non-payment of premium.

- CareSource will retroactively terminate the member to either the last day of the first month of the grace period (APTC) or the last paid date (non-APTC).
- CareSource will then deny any claims that are pended during the grace period and reserves the right to recover any amounts paid in this period.

COVERED SERVICES AND EXCLUSIONS

CareSource's Marketplace product is compliant with the Affordable Care Act (ACA) in terms of benefit offerings and cost share applications. Please refer to **CareSource.com** > Plans > Marketplace > Benefits and Services and the "Referrals and Prior Authorizations" section of this manual on page 58 for more information about referral and PA procedures.

Benefit Limits

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

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

Medical Necessity Determinations

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

If a service cannot be covered, providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Provider Appeals Procedures" section on page 68 of this manual for information on how to file an appeal.

Pediatric Vision

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

Routine Hearing Exams and Hearing Aids

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

Optional Adult Vision and Fitness

CareSource's Vision & Fitness plans provide adult members (19 years and older, except as stated below) the ability to access the following benefits:

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

Fitness – Available for members age 18 and above, CareSource is proud to offer our adult members access to the EngageFitness program with no member cost share. The Active&Fit program provides your patient with a no cost access to their network of participating fitness centers and select YMCAs along with access to up to two home fitness kits per benefit year, online tools such as fitness center search, a quarterly online newsletter, online classes and more. *The Active&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit is a trademark of ASH and used with permission herein.*

MEMBER SUPPORT SERVICES AND BENEFITS

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

CareSource Member Services

CareSource Marketplace members can access the Member Services department by calling our toll-free number and following the menu prompts at **1-833-230-2099**.

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

- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Eve
- Christmas Day

Member Services is available 7 a.m. to 7 p.m. ET, Monday through Friday. Please visit **CareSource.com** > About Us > Contact Us for more information on the holiday hours.

Benefit Manager Member Services

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

- EngageFitness (American Specialty Health): 1-877-771-2746
- Routine Vision Services and Glasses/Contacts (EyeMed): 1-833-337-3129
- Routine Hearing Services and Hearing Aids (TruHearing): 1-866-202-2561

CareSource24, Nurse Advice Line

Members can call our nurse advice line 24 hours a day, 7 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 PCP by explaining the importance of their role in coordinating the member's care. For improved care coordination with PCPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse provided.

Key features of this service include nurses who:

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

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

Care Management/Outreach

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

offer individualized education and support for many chronic diseases. You can refer a member to Care Management by calling **1-833-230-2037**.

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.

Perinatal Care Management

CareSource's perinatal and neonatal care management program utilizes a multi-disciplinary team with extensive OB and NICU clinical experience. Specialized nurses are available to help manage high-risk pregnancies and medically complex newborns by working in conjunction with providers and members. The expertise offered by the staff includes a focus on patient education and care coordination, and involves direct telephone contact with members and providers.

We encourage our prenatal care providers to notify our Care Management department at **1-833-230-2034** when a member with a high-risk pregnancy has been identified. Care Management is notified of medically complex infants at the time of admittance to the neonatal intensive care unit.

Disease Management Program

Our free Disease Management Program helps our members find a path to better health through information, resources and support.

We help our members through:

- The MyHealth online program for members 18+ to participate in a journey to improve their health
- Newsletters with helpful tips and information to manage their disease.
- Coordination with outreach teams such as wellness advocates and health coaches
- One-to-one care management

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

Benefits to Members and Providers

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

Disease Management Referrals

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

Emergency Department Diversion

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

We instruct members to call their PCP or the CareSource24 nurse advice line if they are unsure if they need to go to an ED. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. We offer enhanced reimbursement to PCP offices for holding evening or weekend hours to help ensure that our members have alternatives other than the ED available to them when they need medical care outside of normal business hours. Please see the “Primary Care Providers” chapter on page 83 of this manual for more information.

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

Interpreter Services

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

CareSource requires providers, at their own expense, to offer sign and other language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking proficiency. 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.

For any questions, please contact our Provider Services department at **1-833-230-2101** (TTY for the hearing impaired: 1-800-750-0750 or 711). We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during Healthchek exams as needed. CareSource endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices. The recommended schedule is included in this section of the manual. This schedule is updated annually. The most current updates are located on www.aap.org.

Immunization Codes

Since Oct. 1, 2015, CareSource has required providers to use ICD-10-CM Codes and CPT Codes on claims. Please refer to the Code Tables located on the CMS website at https://www.cms.gov/medicare/coding-billing/icd-10-codes/2023-icd-10-cm.

CMS Coding Guidelines are also available at 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.

MEMBER GRIEVANCE AND APPEALS PROCEDURE

Marketplace members may contact Member Services at **1-833-230-2099** with any questions they have about benefits, including any questions about coverage and benefit levels, annual deductibles, coinsurance copayment, and annual out-of-pocket maximum amounts; specific claims or services they have received; our network; and our authorization requirements.

We have implemented the Complaint Process 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 providers.

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

Marketplace members may also submit a complaint by calling us at **1-833-230-2099**. 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.

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.

Providers 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 initial Adverse Benefit Determination. We will reconsider the initial Adverse Benefit Determination within five (5) business days after the request for reconsideration. The reconsideration must be conducted between the provider 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 initial Adverse Benefit Determination. They do not need to submit expedited appeals in writing. This communication should include:

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

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

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

For expedited requests for Benefits that have been denied, members or their Authorized Representative can call the Plan at **1-833-230-2099** to request an expedited appeal. A treating physician requesting an expedited review of an adverse benefit determination for medical necessity does not need a written authorization to appeal on behalf of the member.

The Plan offers one (1) level of appeal. The Plan must notify the members of the Expedited appeal determination involving a Pre-Service denial within forty-eight (48) hours and within ten (10) calendar days after receiving the completed appeal for a pre-service denial and thirty (30) completed 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 (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 their behalf, or their provider 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 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 additional information is needed. 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 appeal will be reviewed by an individual not involved in the initial decision. For clinical related appeals, the appeal will be reviewed by a provider 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 provider consulted. A denial will also include notice of the member's right to have an External Review of the denial and the procedures to obtain that 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.
- **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 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 48 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 one hundred and eighty (180) calendar days after receiving the Adverse Benefit Determination. We must notify the member or his/her Authorized Representative of our benefit determination within 10 calendar days after receiving the request for the appeal. We may require a one-time extension of no more than 10 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 30 calendar days after receiving the request for the appeal.

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 provider 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. We will complete expedited review of an appeal as soon as possible given the medical needs but no later than 48 hours after our receipt of the request and will communicate our decision by telephone to the member's attending Physician or the ordering provider. We will also provide written notice of our determination to the member, attending Physician or ordering provider, and the Facility rendering the service.

Members may request an expedited review for:

- Claims (excluding appeal claims) 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 emergent 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.

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 Independent Review Entity (IRE) 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 IRE 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.

Standard reviews are normally completed within 30 calendar days. An expedited review for urgent medical situations is normally completed within 48 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 may be requested concurrently with a request for an expedited external review request for an Adverse Benefit Determination 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.

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.

Please Note:

- 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 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 IRE.

Request for External Review

Regardless of whether the External Review case is to be reviewed by an IRE or the Department of Insurance, the member or his/her Authorized Representative must request an External Review through us within 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 IRE 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 10 Business Days after receipt of the notice, the member may submit additional information in writing to the IRE 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 IRE 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.

Independent Review Organization Assignment

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

Independent Review Organization 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 30 calendar days of receipt by us of a request for a standard review or within 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 IRE 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 IRE'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 IRE 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 IRE'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 IRE 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 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.

Member Questions

Members may contact us by mail, fax, or phone. Please call Member Services at **1-833-230-2099**.

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://insurance.ohio.gov/about-us/divisions/consumer-services

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.

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

REFERRALS AND PRIOR AUTHORIZATIONS

CareSource uses a select network of hospitals, physicians and ancillary providers. Typically, CareSource does not pay for non-network, non-emergent services; however, these may be provided with PA from CareSource's Utilization Management (UM) team. There are specific criteria for obtaining PA. Please visit the Provider Portal at **CareSource.com** for the most current information on PA and referral requirements.

Please note: PA does not guarantee payment.

Referral Information

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

Referral Procedures

Any treating doctor can refer CareSource members to specialists. Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists require PA for any services rendered to CareSource members.

You can also submit a request on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal. You can request a PA by calling Provider Services and telling our interactive voice response system (IVR) that you want to request a PA.

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

CareSource Managed Care

In processing claims, CareSource reviews requests for PA, 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 **1-833-230-2099**.

Categories of Prior Authorization, Predetermination and Medical Requests:

- **Urgent Review Request** – A request for PA or Predetermination that in the opinion of the treating provider 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.

Definitions

- ***Prior Authorization (PA)*** – 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 the 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 providers know which services require Prior Authorization and will obtain any required PA or request a Predetermination if they feel it is necessary. The ordering network providers will contact us to request PA or a Predetermination review. We will work directly with network providers regarding such PA requests. 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.

Utilization Management Referrals and Prior Authorizations

Prior Authorization Procedures

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

Online

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

Providers can use the Procedure Code Look-Up Tool at **CareSource.com** > Prior Authorizations > Procedure Code Look-Up Tool to research services requiring prior authorizations.

Phone

1-833-230-2101

Fax

1-844-676-0372

Mail

CareSource
P.O. Box 1307
Dayton, OH 45401

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

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource Member ID number
- Provider name and NPI/TIN
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity for the service

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

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

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

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

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

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

For all PA decisions (standard or urgent), CareSource provides notice to the provider and member as expeditiously as the member's health condition requires. Please specify if you believe the request is urgent.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Please note: Any participating facility/provider requesting PA for an elective admission must obtain PA for the use of any out of network radiologist, pathology, hospitalist and laboratory (RAPHL) provider.

Categories of Prior Authorization, Predetermination and Medical Requests:

- **Urgent Review Request** – A request for PA or Predetermination that, in the opinion of the treating provider 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 PA or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent Review Request** – A request for PA 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 PA 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.

Determination Timeframes

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

Review Type	Time for plan to respond when all information is present	Time for plan to request additional information	Provider response time to submit additional information	Plan response time after receiving additional information
Inpatient Notification (DEMO)	N/A	N/A	48 hours	24 hours
Inpatient Initial	3 calendar days	24 hours	48 hours	24 hours
Inpatient Continued Stay Review	24 hours	1 business day	48 hours	24 hours
Outpatient/Elective Non-Urgent	10 calendar days	30 calendar days	N/A	2 business days
Outpatient/Elective/ URGENT	48 hours	48 hours	N/A	2 business days
Retrospective	Within 30 days	30 calendar days	N/A	30 days from receipt of request

PHARMACY

Prescription Drug Coverage

CareSource partners with Express Scripts, Inc. to process medication claims at retail pharmacy, mail-order pharmacy, or specialty pharmacy. Express Scripts, Inc. processes medication claims for all CareSource Ohio Marketplace plans to provide continuity for provider offices and CareSource members.

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. This also includes those drugs that are administered in the patient's home and/or administered through a home health agency are billed on the medical benefit through CareSource.

Copayment/Coinsurance Requirements

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

For some covered prescription drugs a coinsurance is applied. Coinsurance is a percentage 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 thirty (30) percent. In this case, a $250 drug will be more costly than a $25 drug.
- The drug may not be on a preferred tier on the formulary, so the member pays at a higher tier.
- The member may be buying a more expensive brand-name drug when there is a generic equivalent available for less money, if authorized.

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

For a complete list of drugs available, visit **CareSource.com** > Providers > Tools & Resources > Drug Formulary. Members may also confirm coverage and costs of a specific drug using the CareSource Price a Medication tool at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions.

Tiered Medications

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

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

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

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

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

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

*Accredo, a full-service specialty pharmacy, will be the preferred in-network specialty pharmacy for many of your patients with CareSource health benefits.

Drug Formulary

CareSource uses a list of covered drugs, called a drug formulary. The drug formulary contains information about drugs covered, their cost share tiers and limitations of coverage (such as prior authorizations quantity limits and step therapy protocols). Drugs are listed by therapeutic class and by alphabetical index so that therapeutic interchanges for most drug classes are easier to compare. To learn more about how to use our pharmaceutical management procedures, please visit our website's Pharmacy page at **CareSource.com** > Provider Overview > Education > Patient Care > Pharmacy.

CareSource updates the drug formulary regularly and communicates any updates online on the Drug Formulary Changes pages. The most up-to-date formulary may be found online at **CareSource.com** > Providers > Tools & Resources > Drug Formulary. Drugs not listed on the Drug Formulary are not covered without prior approval.

Quantity, Supply, Duration and Benefit Limits

Quantity limits and dosing limits are based on several factors such as the manufacturer's recommended dosing frequencies, long-term considerations, diagnosis and best practices, and/or Food & Drug Administration (FDA) recommendations. Limits on opioids or other substances of abuse are based upon maximal morphine equivalent dosing limits and/or applicable law. Additionally benefit limitations may pertain to preventive coverage or as defined by applicable rights to coverage for our members.

Step Therapy

Certain medications on the drug formulary are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a first step formulary medication used to treat the same condition be tried and failed prior to the approval of a step two formulary medication.

A reasonable clinical trial of the step one drug is defined to include appropriate use for labeled or compendia-supported indications, titration of the step one drug (where appropriate), and supporting evidence (such as provider notes or lab results) to show the step one drug has failed. Step two drugs are formulary medications which may require the member to pay higher cost share and also may be more costly to the plan. Step therapy is designed to preserve best practice and protect our member's financial medication burden.

Generic or Biosimilar Substitution & Therapeutic Exchange

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

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

Prescription generic drugs are:

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

If a non-formulary brand drug is requested instead of the generic equivalent, a non-formulary exception request would be required. Our administrative policies require submission of clinical documentation including clinical notes, proper MedWatch form submissions, etc., as explained in the policies. A determination of clinical appropriateness will be made. If approved, members will pay higher cost-share for the non-formulary drug.

A list of covered drugs is available on **CareSource.com** > Providers > Tools & Resources > Drug Formulary. This site also includes other information about the CareSource pharmacy program.

Prior Authorization

Medications administered under the pharmacy benefit may require prior authorization before they will be covered. Refer to the Formulary to determine which drugs need prior authorization. Exception requests for medications not listed on the Formulary will also be considered (see below).

PA requests for medications covered under the pharmacy benefit may be submitted electronically via the CoverMyMeds or SureScripts prior authorization portals or by fax at 1-866-930-0019. In emergent situations, requests may also be accepted via phone at **1-833-230-2101**.

Medications to be administered in an outpatient setting by a physician and billed under a member's medical benefit may also require prior authorization.

PA requests for medications covered under the medical benefit may be submitted electronically through the CareSource Provider Portal or by fax at 1-888-399-0271.

Please note that PA and exception review requests not accompanied by the necessary clinical information might take longer to process and might result in denials.

For all PA decisions (standard or expedited), CareSource provides notice to the provider and member as expeditiously as the member's health condition requires. Please specify if you believe the request is urgent.

Review Type	Decision Turnaround Time
Pharmacy Benefit Urgent	24 clock hours
Pharmacy Benefit Standard	72 clock hours
Medical Benefit Urgent	24 clock hours
Medical Benefit Standard	10 calendar days
Medical Benefit Retrospective	30 calendar days

Medical Reasons for Exceptions

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

Clinically appropriate reasons for approving an exception could include lack of available alternatives on our formulary to treat the member's condition, a severe intolerance or allergy to all of our formulary drugs causing hospitalization or submission of a MedWatch notice to the Federal Drug Administration (FDA), or the member has failed all available formulary options.

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

CareSource has an exception process that allows the member, the member's representative or the prescribing physician to make a request for a formulary coverage exception, or an exception to UM. The member, member's representative or prescribing physician may initiate the request by calling Member Services or by completing an online Member Exception request form located on **CareSource.com** > Member Overview > Tools & Resources > Forms. CareSource then reaches out to the provider to obtain the appropriate documentation.

CareSource will provide a decision no later than seventy-two (72) hours after the request is received, or within twenty-four (24) hours if the request is expedited.

If the initial exception request is denied, providers have the right to request an external review by an Independent Review Organization (IRE). The external review process is outlined in the "Member Grievances and Appeals" section on page 48 of this manual for the Marketplace plan.

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. Our MTM vendor is CSS Health. You may be contacted by a pharmacist to discuss your patients' medications. We also encourage members to talk with their pharmacist about their medications, as we want to make sure they are getting the best results from the medications they are taking.

Network Pharmacies

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

PROVIDER APPEALS PROCEDURES

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

Please note: If time frames in this manual differ from the provider agreement, the agreement will be the presiding authority.

Claim Dispute Process

A dispute is the first formal review of the processing of a claim by CareSource (excluding denials based on medical necessity). Providers can submit a claim payment dispute when the provider disagrees with payment of any other post-service claim denial. If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file a dispute or appeal.

Claim Dispute Process for Participating and Non-Participating Providers

- Claim disputes must be submitted in writing or by using the CareSource Provider Portal.
- The dispute must be submitted within 90 calendar days after the provider's receipt of the written determination of the claim.
- If CareSource fails to render a determination for the dispute within 30 days after receipt, an appeal may be submitted.

Appeals of Claims Denials or Adverse Decisions

If you do not agree with the decision of a processed claim or dispute, you will have 365 days from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required timeframe, the claim will not be considered and the appeal will be denied. If the appeal is denied, providers will be notified in writing. If the appeal is approved, payment will show on the provider's Explanation of Payment (EOP).

How to Submit Claim Appeals

Providers can submit claims online.

Online

CareSource.com > Login > Provider Portal

From the **Providers** menu, select Claims Appeals.

All provider appeals requested must be submitted electronically. Mail submissions will no longer be accepted and will not be processed. The only exception is an appeal that has a medical record submission that is over 100 MB. These submissions must be submitted on disc to the CareSource Appeals department at the following address:

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

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

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

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

No Surprises Act/Balance Billing

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

If you wish to initiate the open negotiation period for purposes of determining the amount of total payment, please do so within 30 business days from the date of initial payment or notice of denial of payment, by emailing an Open Negotiation Notice to CareSource's Grievance and Appeals department at MarketplaceIDR@CareSource.com.

If the 30-day open negotiation period does not result in an agreement on the total payment for the qualified IDR item(s) or service(s), you may initiate the Federal IDR process within four days after the end of the open negotiation period. Please visit our website https://www.caresource.com/providers/provider-portal/appeals for more information. For additional questions or concerns you can contact Provider Services at **1-833-230-2101**.

Provider Appeals/Clinical Appeals

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

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

Timeline for Pre-Service Clinical Appeals

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

- Provider – within 180 days from the date of denial issued by a Utilization Management or Pharmacy, with member's written consent, from the date of service or date of discharge

Additional Details about Pre-Service Clinical Appeals

Timing for Medical Necessity Appeals

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

Appeals Filed on Behalf of the Member

Medical necessity appeals filed by members or providers on behalf of a member must be submitted to CareSource within 180 days and will be resolved within 10 calendar days of receipt or as expeditiously as the member's condition warrants. Appeals on behalf of the member must include written authorization to appeal on their behalf for the specific service that is being appealed. All other medical necessity appeals will be resolved within thirty (30) calendar days of receipt. MyCare has 15 days to resolve pre-service and 30 days to post.

Expedited Appeals

An expedited appeal should be considered if the provider feels that the patient's life or health is at risk if a decision about care is not made in a timely manner and the service has not already occurred. Following NCQA guidelines, if a treating physician requests the expedited appeal for review of medical necessity, then a written authorization to appeal on behalf of the member is not necessary.

Requests may be a verbal request and should be submitted to the Grievance and Appeals department by calling **1-833-230-2101.**

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

The member and provider will be notified in writing of the determination to process as a standard appeal within two calendar days of receipt of the appeal, including information that the member can appeal the decision. In the event that CareSource denies the request for an expedited appeal, the appeal will

be resolved within 10 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

Expedited appeals will be resolved and verbal notification will be made within 48 hours of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution timeframe is extended.

Notification of Resolution

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

Extending an Appeal

A member can verbally request that CareSource extend the timeframe to resolve a standard or expedited appeal up to 14 calendar days. CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days. CareSource must submit documentation that the extension is in the member's best interest to the Ohio Department of Medicaid (ODM) for prior approval. If ODM approves the extension, CareSource must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

CARESOURCE MEMBER RIGHTS AND RESPONSIBILITIES

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

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

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

Members of CareSource are also informed of the following responsibilities:

- Supply information needed, to the extent possible, that the organization and its doctors need in order to provide care.
- Follow the plans and instructions for care that you have agreed to with doctors.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

- Be enrolled and pay any required premiums.
- Pay an annual deductible, copayments and coinsurance.
- Pay the cost of limited and excluded services.
- Choose network providers and network pharmacies.
- Show your ID card to make sure you receive full benefits under the plan.

HIPAA Notice of Privacy Practices

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

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

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

Thank you for your assistance in providing requested information to CareSource in a timely manner.

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

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

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

AMERICANS WITH DISABILITIES ACT

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

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

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

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

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

CARESOURCE HEALTH EQUITY COMMITMENT

CareSource has a long-standing commitment to addressing the need for culturally competent care in our member populations, or social determinants, that impact member health outcomes. We have maintained a Cultural Competency Commitment for several years, as part of our desire to serve the community and to meet regulatory requirements. We have enhanced and expanded Commitment to Cultural Competency, via our CareSource Commitment to Health Equity or CHEC program. The CHEC seeks to focus on the social determinants of health and to influence and identify health disparities and inequities that impact our members.

Health equity enables everyone to achieve their full health potential. This requires addressing historical and contemporary injustices and removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care (The Health Policy Institute of Ohio (HPIO), 2018). Health inequities are directly related to the existence of historical and current discrimination and social injustice. CareSource recognizes that many of our members experience health disparities and come from cultural and ethnic backgrounds that may impede their ability to achieve positive health outcomes. We have, and continue to, develop and enhance programs to address disparities and promote understanding of how cultural beliefs impact member health decisions.

CareSource considers providing equitable and culturally competent care and services a core value of our organization. We recognize language and cultural differences have a significant impact on member health care experience and outcomes. According to the US Department of Health and Human Services, Office of Minority Health, the lack of culturally and linguistically appropriate services is one of the most modifiable factors in improving health care.

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

CareSource prohibits its providers or partners from refusing to treat, serve or otherwise discriminate against an individual because of race, color, national origin, disability, age, religion, or sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes).

CLAS Standards: National Culturally & Linguistically Appropriate Standards

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

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

Network providers must ensure that:

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

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

Member Health, Safety and Welfare

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

QUALITY IMPROVEMENT PROGRAM

CareSource is committed to providing evidence-based care in a safe, member-centered, timely, efficient and equitable manner. The scope of our CareSource Quality Improvement (QI) Program is comprehensive and inclusive of both clinical and non-clinical services as well as health, safety and/or welfare concerns. CareSource monitors and evaluates the quality and safety of the care and service delivered to our members emphasizing:

- Accessibility to care
- Availability of services and practitioners
- Quality of care and member safety
- Medical and behavioral health services
- Internal monitoring, review and evaluation of program areas, including Utilization Management, care coordination and Pharmacy

Member and provider satisfaction and health outcomes are monitored through:

- Quality improvement activities
- Routine health plan reporting
- Annual Health Effectiveness Data and Information Set (HEDIS®) measures the quality of our health plan
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures patient experience with the health care system
- Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Quality Rating System (QRS) and QHP Enrollee Survey
- Member Surveys
- Review of accessibility and availability standards
- Utilization trends

CareSource assesses our performance against goals and objectives that are in keeping with industry standards. We complete an annual evaluation of our QI Program.

Program Scope

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

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

Quality Strategy

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

Institute for Healthcare Improvement Triple Aim for Populations

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

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

- Promote staff care and satisfaction
- Promote health equity

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

Quality Measures

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

CareSource uses HEDIS to measure the quality of care delivered to members. HEDIS is developed and maintained by NCQA. The HEDIS tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence-based care and address the most significant areas of care. Potential quality measures include the following:

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer and chlamydia)
  - Well-child care
- Chronic disease management
  - Diabetes care: A1c control, diabetic eye exam, and kidney health
  - Controlling high blood pressure
- Prenatal/Postpartum Care
  - Maternal health outcomes
  - Infant health outcomes
- Behavioral health
  - Follow-up after hospitalization for mental illness
  - Depression screening and follow-up
  - Follow-up for children prescribed attention deficit/hyperactivity disorder (ADHD) medication
- Safety
  - Use of imaging studies for low back pain

CareSource uses CAHPS surveys to capture member perspectives on health care quality for Medicaid and Medicare plans. CAHPS is a program overseen by the United States Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ). Potential CAHPS measures include:

- Customer service
- Getting care quickly

- Getting needed care
- How well doctors communicate
- Ratings of all health care, health plan, personal doctor or specialists

Preventive Guidelines and Clinical Practice Guidelines

CareSource approves and adopts evidence-based nationally recognized standards and guidelines and promotes them to providers to help inform and guide clinical care provided to members. Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management tools. Guidelines are reviewed at least every two years or more often as appropriate, and updated as necessary. They may be found at **CareSource.com** > Providers > Education > Patient Care > Health Care Links.

The use of these guidelines allows CareSource to measure their impact on member health outcomes. Review and approval of the guidelines are completed by the Market CareSource Provider Advisory Committee (PAC). The CareSource Enterprise PAC approved the guidelines and Quality Enterprise Committee (QEC) is notified of guideline approval. Topics for guidelines are identified through analysis of member population demographics and national or state priorities. Guidelines may include, but are not be limited to:

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

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

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

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

Quality of Care Reviews

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

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

In order to properly assess quality of care concerns CareSource Enterprise Quality Improvement initiates contact with providers to request medical records using established processes and timelines. As per our

policies and provider contracts, we are authorized to ask for protected health information for health care operations, which includes quality issue reviews. Medical record requests are forwarded to providers via mail, e-mail or fax and may be returned to CareSource via these same mechanisms as detailed in the medical record request document.

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

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

Access Standards

CareSource has a comprehensive quality program to help ensure our members receive the best possible health care services. It includes evaluation of the availability, accessibility and acceptability of services rendered to patients by participating providers.

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

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

Primary Care Providers

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

Specialists

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

Behavioral Health

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Non-life threatening emergency	Not to exceed 6 hours
Urgent care*	Not to exceed 48 hours
Initial visit for routine care	Not to exceed 10 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 provider is unable to see the member within the appropriate timeframe, CareSource will facilitate an appointment with a participating provider or a non-participating provider, if necessary.

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

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

How to Submit Changes to CareSource

Online

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

Email

ProviderMaintenance@CareSource.com

Fax

937-396-3076

Mail

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

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

Consumer Surveys

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

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 provider are subject, and in accordance with accepted practices.

Provider Performance and Profiling

CareSource monitors over and underutilization of medical services. Provider profiling is done periodically to measure utilization of common inpatient and outpatient services such 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 providers upon request, and routine periodic reporting is under development.

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

PRIMARY CARE PROVIDERS

Primary Care Provider Concept

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

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

Primary Care Provider Roles and Responsibilities

PCP care coordination responsibilities include at a minimum, the following:

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

Primary Care Providers are responsible for:

- Treating CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plans outlined in this manual.
- Providing 30 days of emergency coverage to any CareSource patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by CareSource patients for emergency or urgent care if notified of the visit.
- Ensuring demographic and practice information is up-to-date for directory and member use.

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

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

Immunization Schedule

Immunizations are an important part of preventive care 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.

Clinical Practice Registry and Member Profile

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

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

Key Benefits of the Registry

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

Information Included on the Registry

- Well-baby visits (zero to15 months)
- Well-care (two to 21 months)
- Asthma
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening
- Lead screening
- Diabetes (e.g. cholesterol, eye exam, hematology, kidney)
- Emergency room visits

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

Member Profile

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

Key Benefits of the Member Profile

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

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

After-Hours Care

Telephone Arrangements

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

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

Enhanced Reimbursement

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

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

KEY CONTRACT PROVISIONS

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

Provider Responsibilities

- Providing CareSource with advance written notice of any intent to terminate an agreement with us. This must be done ninety (90) days prior to the date of the intended termination and submitted on your organization's letterhead.
  - **Minimum 60-day notice is required:** If you plan to close your practice to new patients. If we are not notified within this time period, you will be required to continue accepting CareSource members for a 60 calendar day period following notification.
- **For Primary Care Providers (PCPs) only:** 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 primary care provider (PCP) or a back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider and only recommends emergency room use for after hours.
- Submission of claims or corrected claims should be submitted within 365 days of the date of service or discharge.
- Appeals must be filed within 365 days of the date of service or discharge.
- Providers should keep all demographic and practice information up to date. Information updates can be submitted on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal

CareSource Responsibilities

- Paying 93 percent of clean claims within 30 days of receipt.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the "Provider Appeals Procedures" sections for each plan in this manual.
- Offering a 24-hour Nurse Advice Line for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance which involves subtracting the primary payment from the lessor of the primary carrier allowable or the Medicaid allowable. (If the member's primary insurer pays a provider equal to or more than CareSource's fee schedule for a covered service, CareSource will not pay the additional amount.)

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

Examples:

- Participating providers, or their designee, are expected to make daily visits to their patients who have been admitted as inpatient to an acute care facility or arrange for a colleague to visit.
- Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.

Participating providers are expected to treat members with respect. CareSource members should not be treated any differently than patients with any other health care insurance. Please reference member rights in the "CareSource Member Rights and Responsibilities" chapter on page 71 of this manual.

Submitting Provider Changes

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

Why is it important to give changes to CareSource?

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

How to Submit Changes to CareSource:

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

Other ways to submit changes include:

Email

ProviderMaintenance@CareSource.com

Fax

937-396-3076

Mail

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

Americans with Disabilities Act Standards

Additionally, providers will remain compliant with Americans with Disabilities Act (ADA) standards, including but not limited to:

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

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

FRAUD, WASTE AND ABUSE

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

Definition of Terms

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

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

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

Improper Payments are any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts. Anyone who identifies an improper payment should report it to CareSource using one of the reporting methods below.

Examples of Member Fraud, Waste and/or Abuse:

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

Examples of Provider Fraud, Waste and/or Abuse:

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

Examples of Pharmacy Fraud, Waste and/or Abuse:

- Prescription drugs not dispensed as written
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed
- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two (2) orders to seek higher reimbursement
- Dispensing expired, fake, diluted or illegal drugs
- Billing prescriptions not filled or picked up

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

Examples of Employee Fraud, Waste and/or Abuse:

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

Examples of Vendor Fraud, Waste and/or Abuse:

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

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

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Contract termination
- Employee disciplinary actions
- Reporting to one (1) or more applicable state and federal agencies
- Legal actions

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

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

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

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

The False Claims Act addresses those who:

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

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

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

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

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

- Within six years from the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about the illegal conduct, but in no event later than 10 years after the illegal activity

Protection for Reporters of Fraud, Waste or Abuse

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

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

Other Fraud, Waste and Abuse Laws

- Under the federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program. 42 U.S.C. §1320a-7b.

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

Prohibited Affiliations

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

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

Disclosure of Ownership, Debarment and Criminal Convictions

Before CareSource enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment, proposed for debarment, suspension or declared ineligible status related to federal programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity. You must also notify CareSource of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration.

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

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

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

How to Report Fraud, Waste or Abuse

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

Options for Reporting Anonymously:

Call the Fraud Hotline at 1-844-415-1272. Our fraud, waste and abuse hotline is available 24 hours a day.

Write:

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

Options for Reporting That Are Not Anonymous:

- **Fax:** 800-418-0248
- **Email:** fraud@CareSource.com

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

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

Physician Education Materials

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

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

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