Provider Disputes or Appeals

Quick Reference Guide (Ohio Medicaid)

Providers may request review of claim or authorization denials via the methods below.

Claim Disputes

When to Use:

Any provider complaints, appeals, or requests for reconsideration about a claim determination (refer to the Provider Manual for criteria specifics including time frames).

Include

- Member name and ID
- Claim identifiers
- Reason an adjustment is needed
- Supporting documentation

After exhausting CareSource's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please refer to the Utilization Management section of the Provider Manual.

Important

If the claim was submitted incorrectly, submit a corrected claim first. No dispute is needed. Also, if additional documentation is needed for your claim, you may submit the documents on the Provider Portal. A dispute is not needed.

Clinical Appeals

When to Use:

Pre-Service Appeal - Any provider disagreement with the decision to deny, limit, reduce, suspend, or terminate a covered service for the lack of medical necessity prior to being completed.

Key Points

- The member's name, CareSource member ID number, and date of birth
- The provider's name, CareSource provider billing number, and rendering National Provider Identifier (NPI), if available
- Code/service being appealed
- All clinical documentation pertinent to a medical necessity review of a denied authorization
- The prior authorization request number, if you have it

Note

Time frames may vary. Refer to the Provider Manual for time frame specifics.

HOW TO SUBMIT

Provider Portal (preferred) - Refer to the Provider Manual for mail and fax options.

Reminder: Time frames for disputes and appeals vary by state and plan. Refer to the Provider Manual for additional information.