CareSource

Network Notification

Notice Date: **March 11, 2020**
To: **Providers**
From: **CareSource**
Subject: **Provider Portal Quick Start Guide**

There are multiple ways that you can upload documentation or attachments on the CareSource Provider Portal. This document provides instructions for submitting information for the following scenarios.

You can click the link to navigate directly to the relevant section of the document.

- Submit a retro-authorization

- Submit hospital medical records or consent forms for denied claims

- Submit hospital medical records or consent forms proactively for claims

- File a claim dispute with supporting documentation

- File a claim appeal with supporting documentation

In addition to this guide, please refer the following, as needed:

- Payment Review Tool, to understand CareSource's policy for claim reviews such as readmissions, inpatient hospital claims with diagnosis-related group (DRG), high dollar claims, place of service validation and DRG.

- The Provider Manual that is available on CareSource.com for each plan, which outlines claim submission timely filing information. The Provider Manual may be found at **CareSource.com** > Providers > Tools & Resources > Provider Manual.

- Appeal information, such as when and how to file a dispute or an appeal, is also located on **CareSource.com** > Providers > Provider Portal > Provider Appeals.

SUBMIT A RETRO AUTHORIZATION

Retro authorizations will only be approved when the service meets **all** of the following requirements:

- The service is directly related to another service for which prior approval has already been obtained and that has already been performed;
- The new service was not known to be needed at the time the original prior authorized service was performed; *and*
- The need for the new service was revealed at the time the original authorized service was performed.

Unless the member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria must be met to qualify for a retro authorization review.

Guideline for submitting a retro authorization: If a member had an active coordination of benefits (COB) on the DOS, no prior authorization is required, as the rules of the primary insurance are followed.

To enter a retro authorization, complete the following steps:

1. From the **Providers** menu, select **Prior Authorization and Notifications**.
2. Click the **Medical (Inpatient & Outpatient)** tab.
3. Click the appropriate tab to enter the member's CareSource ID, Medicaid ID, or Member Info (name and date of birth).
4. Enter the **Start Date of Service** and click **Search**.
5. Click the **COB Information** tab and verify if the member has other insurance.
   NOTES:
   - The Portal may block retro authorizations from being submitted if the COB was not active on the DOS but is now active.
   - If the member has other insurance, select **Add COB Information**, then complete and submit the form.
6. If neither of the two scenarios above apply, click **Verified** to continue the retro authorization.
7. Select the **Inpatient** or **Outpatient** authorization type.
8. Complete the required form fields, then click continue.
9. If prompted, complete clinical indications, upload supporting documentation and submit authorization.

SUBMIT HOSPITAL MEDICAL RECORDS OR CONSENT FORMS FOR DENIED CLAIMS

A new **Document Upload** tab is available on the **Claims Detail** view when a claim is denied due to certain missing attachments. Use this option to upload documentation instead of submitting an appeal or corrected claim.

To upload documentation for a denied claim, do the following:

1. From the left hand **Member Search** menu, click **Claim Information**. Locate the claim on the **Claim Information** page.

2. Click the **View Detail** link for the denied claim.

3. On the **Document Upload** tab, review the reason the claim was denied and then upload the appropriate documentation.

4. Complete the required fields (marked with a red asterisk).

5. Add **Notes** if needed.

6. Click **Submit Documents**.

NOTES:

- This feature is available for claims that have been denied for missing consent forms or for missing medical records needed for hospital readmission, re-admit original discharge or unlisted code claims.

- Additional types of attachments will be included in this feature in the future.

SUBMIT HOSPITAL MEDICAL RECORDS OR CONSENT FORMS PROACTIVELY FOR CLAIMS

To ensure that a claim for abortion, hysterectomy or sterilization is processed correctly, providers can upload a member consent form on the CareSource Provider Portal for the procedure. The consent form will be matched with member's corresponding claim so that the claim can be processed successfully.

To upload a consent form, do the following:

1. From the left hand **Member Search** menu, click **Member Eligibility** to perform an eligibility check for the member for a particular date of service.
2. Upon validation that the member is eligible for the selected date of service, select the **Upload Consent Form** option listed in the **Member Information** section.

3. In the **Upload Consent Form** area, browse for, select, and upload the consent form for the member. The file size is limited to 12 MB.
4. After uploading the consent form for the member, select the appropriate **Procedure Type**.
5. Enter the associated **Claim Number**, if available. The **Claim Number** is required for denied claims.

After submitting the consent form, CareSource staff will be able to process the appropriate claim by matching it up with the consent form for the date of service provided.

A hospital/facility can now upload large files (up to 100 MB) on the Provider Portal in conjunction with their **readmission**, **re-admit original discharge**, or **unlisted code** claim submissions.

To upload a hospital medical records, do the following:

1. From the left hand **Providers** menu, select **Claim Attachment**.
2. Search for a member using the correct **Date of Service** to ensure proper eligibility.
3. After verifying the member eligibility, select the appropriate **Submission Reason**, enter the required information (indicated with a red asterisk), upload the appropriate documents and click **Submit**.

   Please submit records that directly correspond and support the billed services that were denied. Submitting an entire medical record versus documents related to a specific stay or visit could delay the processing turnaround time.

NOTE: If you submit documentation for a claim and do not indicate the specific claim number for which the documentation applies, the documentation will apply only to claims received **after** the receipt date of the consent form or hospital medical records. For example, documentation uploaded on 1/6/2020 will systematically apply to claims received by CareSource on or after 1/6/2020. It will not apply to claims received prior to 1/6/2020. **To upload documentation applicable to a previously submitted claim, you must enter the corresponding claim number when submitting the attachment to ensure systematic alignment.**

FILE A CLAIM DISPUTE WITH SUPPORTING DOCUMENTATION

File a claim payment dispute for a claim underpayment, a partially or fully denied claim (please see below for a few exceptions), or for an adverse claim payment decision.

A claim number is required to submit your claim dispute through the Provider Portal. Any supporting documentation should also be attached.
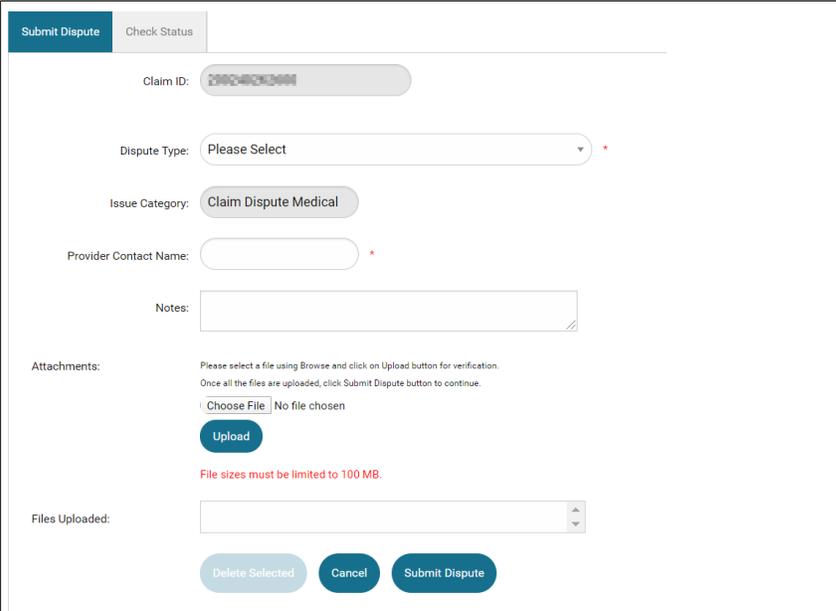
NOTE: CareSource is currently unable to receive dental appeals or disputes through the Provider Portal. If you need to submit an appeal or dispute involving a dental claim, please mail or fax your submission.

The following should not be submitted as a dispute:

- If you are responding to a denied authorization that required medical necessity review, please submit an appeal.
- If you are submitting a request due to overpayment, please submit a claim recovery request.
- If your claim was denied due to a missing consent form, please upload the consent form.
- If your hospital claim was denied due to missing medical records, upload the medical records.

To submit a dispute, do the following:

1. From the left hand **Providers** menu, click **Claim Disputes**.
2. Locate the claim for which you want to submit a dispute.
3. Complete the appropriate information and upload an attachment (up to 100 MB) if needed. Required fields are marked with a red asterisk. At a minimum, the dispute must include:
   - Sufficient information to identify the claims in dispute
   - A statement of why you believe a claim adjustment is needed (enter in the **Notes** field)
   - Pertinent documentation to support the adjustment

4. Click **Submit Dispute**.

NOTES:

- You can return to the **Claim Disputes** page to check status of your appeal using the **Claim ID** or **Dispute ID** that was generated when you submitted the dispute.

- Dispute acknowledgement and decision letters for Ohio Medicaid, Ohio Marketplace, Ohio MyCare, and Ohio Medicare Advantage claims, can be located on the **Provider Documents** page.

FILE A CLAIM APPEAL WITH SUPPORTING DOCUMENTATION

Review the reasons and timeframes for submitting an appeal below based upon the specific plan.

Submit an appeal for the following reasons	
Medicaid/MyCare/Marketplace	• **Denied authorization** – You will need member consent to appeal on their behalf. • Disagreement on underpaid or denied claim if after dispute timely filing or you do not agree with dispute decision.
Medicare Advantage/Dual Special Needs (DSNP)	• **Denied authorization** – provider will need member consent to appeal on their behalf. • Non-participating providers can appeal underpaid or denied claims. Per Centers for Medicare & Medicaid Services (CMS) guidelines, participating providers do not have claim appeal rights.
Timeframe to submit an appeal	
OH Medicaid and Marketplace	• **Claim appeal** – 365 calendar days from the date of service (DOS) or date of discharge. • **Clinical appeal** – 180 calendar days from the DOS, denial, or discharge. • **Takeback response** – 90 days from the date of recoupment to submit an appeal in response to a plan initiated takeback, or 365 days from the DOS (whichever is greater).
OH Medicare Advantage/MyCare/DSNP	• **Claim appeal** – 120 days from the DOS or date of discharge. *For a Medicare service, non-contracted providers (MyCare only): 180 calendar days from the remittance notification date.* • **Clinical appeal** – 60 days from the date of denial on authorization. • **Takeback response** – 90 days from the date of recoupment to submit a dispute in response to a plan initiated takeback, or 120 days from the DOS (whichever is greater).

NOTE: CareSource is currently unable to receive dental appeals or disputes through the Provider Portal. If you need to submit an appeal or dispute involving a dental claim, please mail or fax your submission.

In addition to this guide, please refer the following, as needed:

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To submit an appeal, do the following:

1. From the left hand **Providers** menu, click **Claim Appeals**.

2. Locate the claim for which you want to submit an appeal.

3. Select the appropriate **Appeal Type**.

4. Complete the remaining required information (marked with a red asterisk).

5. Enter the reason for the appeal and any other applicable information in the **Notes** box.

6. You can upload an attachment, up to 100 MB, that is necessary for your appeal.

7. Click **Submit Appeal**.

NOTES:

- You can return to the **Claim Appeals** page to check status of your appeal using the **Claim ID** or **Appeal ID** that was generated when you submitted the appeal.

- Appeal acknowledgement and decision letters for Ohio MyCare and Ohio Medicare Advantage claims can be located on the **Provider Documents** page.