Provider Manual

Wisconsin

Marketplace

CareSource®





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

Dear CareSource (formerly Common Ground Healthcare) Provider,

Thank you for participating with CareSource. We value our relationships with our provider partners and actively work to make it easier for you to deliver quality care to our members.

****Attention Providers****

As we are transitioning website content, we want to make sure you have direct access to the information you need. Click here to view the following:

- Provider Policies
- Updates & Announcements

CareSource members enrolled in our individual and family health plans on the Health Insurance Marketplace® and Off-Exchange pay any premiums and cost-sharing amounts (deductibles, coinsurance, copayments, etc.) that apply to their coverage based on their plan selection and subsidy level.

This manual is a resource for working with our plans. It communicates our policies, programs, and outlines key information that makes it more efficient for you to do business with us. This includes claims submission and reimbursement processes, prior authorizations, member benefits and more.

In the event there is a conflict between this manual and your provider agreement with CareSource, your agreement will supersede this manual. Providers who are contracted to participate in CareSource products must comply with the policies and procedures contained in this manual, which are available on our website **CareSource.com**. You may request a printed copy of this manual by calling Provider Services at **1-833-230-2101**. Our hours of operation are Monday through Friday from 8 a.m. to 6 p.m. Eastern Time (ET).

CareSource communicates updates to our provider network regularly on our website. You can also find the most up-to-date information on our CareSource Provider Portal at **CareSource.com**.

To better support our providers and offer an immediate response to questions, concerns and inquiries, we offer claims, policy and appeals assistance through our Provider Services call center. We have a dedicated team to assist with your questions and concerns. Additionally, a team of specialists is available to provide onsite training and work with providers in their communities. We know great health care begins with you. Together, we can help attain better outcomes for CareSource members.

Sincerely,
CareSource

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ABOUT US

Welcome

Thank you for participating with CareSource.

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

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. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy.

CareSource offers an Exclusive Provider Organization (EPO) product, which utilizes a contracted network of high-quality participating providers to improve the health of our members. Primary care providers (PCPs), behavioral health and specialty providers within the CareSource network provide a range of services to our members to ensure timely access to health care services and members receive all appropriate preventive services.

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

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

Vision and Mission

Our vision: Transforming lives through innovative and health services.

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

About CareSource in Wisconsin

CareSource offers a nonprofit health insurance option to individuals and families in Eastern Wisconsin. CareSource offers an integrated care network to ensure that our members receive the highest quality, most cost-effective care. We work primarily with Aurora Health Care, Bellin Health, Door County Medical Center, Watertown Regional Medical Center, and Children's Hospital and Health System providers. Our mission is *Putting Members First. Pursuing Better Healthcare.* We exist to give members a voice in their health insurance and are committed to changing the health insurance experience through advocacy, open dialogue, and great service to our members.

About CareSource

CareSource® is a nonprofit, nationally recognized managed care organization with over two million members. Headquartered in Dayton, Ohio, since its founding in 1989, CareSource administers one of the largest Medicaid managed care plans in the United States. The organization offers health insurance, including Medicaid, Health Insurance Marketplace and Medicare-Medicaid products. As a mission-driven organization, CareSource is transforming health care with innovative programs that address the social drivers of health, barriers to accessing health care, prevention and access to care. For more information, visit: **CareSource.com**.

Administrative Structure

CareSource will provide operational support and services including claims processing and appeals, all member and provider services, and managing the provider network. As a CareSource provider, you will interact with CareSource when verifying member eligibility, submitting requests for prior authorization, using our ***Find a Doctor*** provider directory tool and our Provider Portal, or interacting with some of our member services like our nurse advice line. CareSource is here to support you whenever needed.

Provider Policies

CareSource works to ensure you have access to all the information a provider partner needs. You can view our provider policies by visiting **CareSource.com** > Providers > Provider Policies.

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 the CareSource MyLife℠ secure portal and member call center, as well as our benefit manager(s):
  - Pharmacy: Express Scripts, Inc.

In addition to the functions above, our Care Management programs include the following:

- Low, medium and high-risk/complex case management – a "no wrong door" referral intake
- Telephonic case management
- Transition of care program
- Disease management for
  - Cancer and cancer prevention
  - Diabetes and diabetes prevention
  - Depression and depression prevention
  - HIV, AIDS and HIV prevention
  - Sepsis/chronic wounds
  - And others based on member needs
- 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)
- Maternal and child health
  - Dedicated neonatal intensive care unit (NICU) case management nurses
  - 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 and substance use disorder (SUD)
- Collaboration with pharmacy and medication therapy management (MTM)

For more information on these programs, see the **"Member Support Services and Benefits"** chapter of this manual.

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 (CCP) was developed to continue our commitment to conduct business in a legal and ethical environment. It has been established to:

- Formalize our commitment to honest communication within the company and within the community
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state and federal laws and regulations
- Implement a system for early detection and reporting of noncompliance with laws, regulations or CareSource policy

This allows us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties, and criminal sanctions.

Our CCP is a formal company policy that outlines how everyone who represents CareSource and 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. All providers are required to review and comply with CareSource's CCP.

You can find the CareSource Corporate Compliance Plan on **CareSource.com** > About Us > Legal > Corporate Compliance.

General Compliance and Ethics Expectations of Providers

- Act according to the compliance standards.
- Let us know about suspected violations or misconduct.
- Share any suspected fraud, waste and abuse.
- Let us know if you have questions

  For questions about provider expectations, please call your Provider Engagement Specialist or Provider Services at **1-833-230-2101**.

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

- **Ethics and Compliance**
- **Online:** CareSource.ethicspoint.com
- **Hotline:** 1-877-725-4583 - Any issues submitted to the Ethics and Compliance Hotline may be submitted anonymously.
- **Compliance Officer:** 937-487-5110 or CorporateComplianceOfficer@CareSource.com

  Please let us know if you have questions regarding the Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

Personally Identifiable Information (PII)

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 that guide handling of PII to ensure it is appropriately protected wherever it is stored, processed, and transferred in the course of conducting normal business. As a provider, you should take measures to secure your sensitive provider data. You are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure protected health information (PHI). You should have controls in place to protect sensitive PII and PHI.

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace and shred this content when it is 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. Like you, CareSource is a covered entity under HIPAA. Covered entities are permitted 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 HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. You can find this form at **CareSource.com** > Members & Beneficiaries > Forms.

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

Accreditation

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our 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.
Visit www.NCQA.org for more information.



COMMUNICATING WITH CARESOURCE

CareSource communicates with our provider network through a variety of channels, including phone, fax, provider newsletters, our website and network notifications. We encourage you to reach out to your assigned Provider Engagement Representative with any questions.

Hours of Operation

Provider Services 1-833-230-2101		
CareSource Individual Marketplace and Individual Commercial Plans	Monday through Friday	7 a.m. to 5 p.m. Central Time (CT)

Member Services 1-877-514-2442		
CareSource Individual Marketplace and Individual Commercial Plans	Monday through Friday	8 a.m. to 5 p.m. CT

Representatives are available by telephone Monday through Friday, except on observed holidays.

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.

Wisconsin	
Provider Services	1-833-230-2101
Prior Authorizations	1-877-514-2442
Claim Inquiries	1-833-230-2101
Credentialing	1-833-230-2101
Member Services	1-877-514-2442
24-Hour Nurse Advice Line	1-833-687-7394
Fraud, Waste and Abuse Hotline	1-844-415-1272
TTY for the Hearing Impaired	711

Fax

Wisconsin	
Credentialing	937-396-3168
Contract Implementation	937-396-3632
Fraud, Waste and Abuse	800-418-0248
Pharmacy Prior Authorization Form	866-930-0019
Outpatient Drugs Covered Under Medical Benefit Prior Authorization Form	888-399-0271
Provider Appeals	937-531-2398
Provider Maintenance	937-396-3168

Provider Representative Information

Our goal is to build collaborative and mutually supportive relationships with our network. CareSource's Provider Representatives are dedicated to helping your practice.

Prior Authorization Quick Reference Guide

New Vendor	Contact Information	Vendor it replaced	Used For	Examples (include but not limited to)
Evolent, formerly known as NIA/RAdm	Phone: **1-866-500-7704** Peer-to-Peer: 1-866-500-7704 www.radmd.com/RadMD/Common/Avuf.aspx	SHP	Medical Imaging and Radiology	MRI/MRAs CT/CTA Scans PET Scans
Nant Health- also known as Eviti	Phone: **1-888-482-8057** Fax: 888-468-1423 Peer-to-Peer: 1-866-968-7482 connect.eviti.com/idserver/Account/Login	SHP	Medical Oncology	Oncology related items whether it is through the physician or the pharmacy (self-administered)
Turning Point	Phone: **1-414-296-6120** Fax: 414-400-9404 Peer-to-Peer: 1-800-581-3920 www.myturningpoint-healthcare.com	SHP	Cardiac and Orthopedic/ Musculoskeletal Services	Spinal surgery Joint replacement Pacemaker Cardiac surgeries
CareSource UM (MHK tool used for specialty infusion)	Medical Phone: **1-877-514-2442** Fax: 844-676-0372 Peer-to-Peer: 1-833-230-2168 ProviderPortal.CareSource.com/WI	SHP	All other medical authorizations and specialty medications	
	Specialty Medications Phone: **1-877-514-2442** Fax: 888-399-0271 Peer-to-Peer: 1-833-230-2168 ProviderPortal.CareSource.com/WI	Magellan		

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 announcements, our provider manual, claims, information, frequently asked questions, clinical guidelines, preventative guidelines, and much more.

Provider Portal

Our secure online Provider Portal allows you instant access to valuable information at any time. You can access the Provider Portal at **CareSource.com** > Providers > Provider Portal.

Simply enter your username and password (if you are already a registered user) or fill out your information to become a registered user. Assisting you is one of our top priorities in delivering 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 web browser 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 – Submit claims using online forms or upload a completed claim. Claim submission through the portal is available to traditional providers, community partners, delegates, and health homes. For more information about submitting claims online through our Provider Portal, please visit the **"Claim Submissions"** chapter of this manual.
  - Claim Status – Search for status of claims.
  - 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 – Submit and search for claim appeals and disputes.
  - Submit pertinent medical records when prepayment review is required for reimbursement of claims.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior authorization** – Request authorization for medical and behavioral inpatient/outpatient services, as well as pharmacy authorizations.
- **Eligibility termination dates** – View the member's termination date (if applicable) under the eligibility tab.
- **Benefit limits** – Track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy, speech therapy and more.

- **Care treatment plans** – View care treatment plans for patients on our Provider Portal.
- **Clinical Practice Registry (CPR)** – Review member gaps in care. View and sort CareSource members into actionable groups for improved focus on preventive care (e.g., well-baby visits, diabetes, asthma and more). Look on the **"Member Eligibility"** page for alerts to notify you what tests a patient needs.
- **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 status.
- **Monthly membership lists** – View and download current monthly membership lists.
- **Case management referrals** – Submit automated case management forms on our Provider Portal for efficiency in enrolling members.
- **Information exchange** – Share relevant member information to facilitate better integration of behavioral health, dental and medical care.
- **File grievance**

Portal Registration

If you are not registered with our Provider Portal, please follow these easy steps:

1. Visit the Provider Portal. Click "Sign Up" to establish your account by creating your username and password*.
2. For added security, set up multifactor authentication.
3. To connect your account, you will need information provided in your welcome letter, including your Provider Name, Tax ID, CareSource Provider ID and your ZIP Code.
4. Review and accept the agreement.

*Please note that your first registered account will become the account Administrator and may add additional users.

Once registered, access our Provider Portal by clicking the Login button at the top of any page.

Forms

Effective January 1, 2025, Providers may access plan forms at **CareSource.com** > Providers > Tools & Resources > Forms.

Mailing Addresses

General Mailing Address	CareSource P.O. Box 8738 Dayton, OH 45401-8738
Medical Prior Authorization Submission Address	CareSource Attn: Utilization Management Department P.O. Box 1307 Dayton, OH 45401-1307
Behavioral Health Prior Authorization Submission Address	CareSource Attn: Behavioral Health Utilization Management Department P.O. Box 1307 Dayton, OH 45401-1307
Medical Claims Submission Mailing Address	CareSource Attn: Claims Department P.O. Box 1305 Dayton, OH 45401
Provider Claims Dispute Mailing Address	CareSource Attn: Claim Disputes P.O. Box 2008 Dayton, OH 45401
Provider Appeals Mailing Address	CareSource Attn: Provider Appeals P.O. Box 2008 Dayton, OH 45401 Please visit our website for more information on how to submit appeals online.
Provider Clinical Appeals Mailing Address	CareSource Attn: Provider Clinical Appeals P.O. Box 1947 Dayton, OH 45401 Please visit our website for more information on how to submit appeals online.
Member Appeals and Grievances Mailing Address	CareSource Attn: Member Appeals P.O. Box 1947 Dayton, OH 45401
Fraud, Waste and Abuse Address	Write: CareSource Attn: Program Integrity Department P.O. Box 1940 Dayton, OH 45401-1940 Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.

Provider Communications

Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway at CareSource. We will also share updates to adopted Evidence Based Guidelines through our newsletters.

****Attention Providers****

As we are transitioning website content, we want to make sure you have direct access to the information you need. Click here to view the following:

- Provider Policies
- Updates & Announcements

Network Notifications

We regularly communicate policy and procedure updates to CareSource providers via network notifications. Effective January 1, 2025, Network notifications are found on our website at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements.

Provider Policies

CareSource maintains medical, pharmacy, reimbursement, and administrative policies on our website. Approved policies may be found at **CareSource.com** > Providers > Tools & Resources > Provider Policies. Policies are regularly reviewed, updated, withdrawn or added, and therefore subject to change. CareSource provides notice to providers regarding a change in policy at least 30 calendar days prior to implementation.

Provider Training

CareSource encourages our providers to access our on-demand and scheduled virtual training on topics related to your practice. This training provides key information for you to do business with us. Providers may access CareSource's trainings and events by visiting **CareSource.com** > Providers > Education > Training & Events. Providers may also contact their assigned Provider Representative for additional live training support.





CREDENTIALING AND RECREDENTIALING

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

All practitioners who provide care to CareSource members must be appropriately credentialed under CareSource's Credentialing Program. This may require the completion of a credentialing application or may be achieved through delegation of credentialing obligations to a provider organization. CareSource will not pay for services provided by uncredentialed practitioners, and providers are prohibited from billing CareSource members for these charges.

Credentialing Process

Council for Affordable Quality Healthcare Application

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

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

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current) or Controlled Substance Registration (CSR)
- Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable
- Standard collaborative 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 its providers and the providers' employees have not been debarred or suspended by any state or federal agency. CareSource also requires that its providers and the providers' employees disclose any criminal convictions related to federal health care programs. "Provider employee" is defined as directors, officers, partners, managing employees or persons with beneficial ownership of more than five percent of the entity's equity.

Providers must offer a list that identifies all of the provider employees, as defined above, along with the employee's tax identification or social security numbers. 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, based on the NCQA standards and the appropriate federal and individual state department of insurance requirements.

Who Is 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.

The following providers listed in the Provider Directory do not need to be credentialed:

- Providers who practice exclusively within the inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting.
- Providers who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the CareSource Provider Directory.
- Pharmacists who work for a pharmacy benefit management (PBM) organization.
- Providers who do not provide care for members in a treatment setting (e.g. board-certified consultants).
- Covering providers (locum tenens).
- Medical directors of urgent care centers and ambulatory surgical centers.

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.

Selection Criteria:

- Active and unrestricted license in the state issued by the appropriate licensing board.
- Current DEA certificate (if applicable).
- Successful completion of all required education.
- Successful completion of all training programs pertinent to one's practice.
- For MDs and DOs, successful completion of residency and/or fellowship training pertinent to the requested practice type.
- For other providers where special training is required or expected for services being requested, successful completion of training.
- Board Certification is not required for primary care specialties. 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.
- An advanced practice registered nurse (APRN) may be credentialed as a primary care provider if that APRN maintains compliance with the rules set forth by the Wisconsin Board of Nursing and Wisconsin specific codes. The APRN is expected to be familiar with these rules.
- Education, training, work history and experience are current and appropriate to the scope of practice requested.
- Malpractice insurance at specified limits 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.
- Agreement to access and availability standards established by the health plan.
- Compliance with service requirements outlined in the provider agreement and CareSource Provider Manual.

Please Note: Any pending and/or suspected fraud, waste and abuse investigation(s) or case(s) against the provider may affect the provider's credentialing application.

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
- Free-standing Rural Health Center
- Free-standing Inpatient Psychiatry Health Facility
- Outpatient Infusion Center

Additional organizational providers are also credentialed:

- Hospice providers
- Urgent care facilities, free-standing and not part of a hospital campus
- Dialysis centers
- Durable Medical Equipment providers
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Free-standing facilities that provide outpatient, non-emergent advanced radiology services (including MRI/MRA, CT and PET scans)

In addition to the Ambulatory Surgical Facilities, Opioid Treatment Facilities, Rural Health Centers, Free standing Inpatient Psychiatry Health Facilities and Outpatient infusion Center being credentialed the Medical Director or senior provider responsible for medical services will be credentialed using the standard, provisional credentialing or recredentialing process. If a Medical Director or Senior Physician is denied credentialing the facility will also not be credentialed.

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 is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body
- Malpractice/Liability insurance coverage is maintained and meets contract minimums
- Clinical Laboratory Improvement Amendments (CLIA) certificates are current (if applicable).
- Completion of a signed and dated application.
- If not approved by an accrediting body must have a CMS Site survey or agree to a site visit.

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

Provider Credentialing Rights

- Practitioners have the right to review information submitted to support their credentialing application upon request to the CareSource Credentialing department. CareSource keeps all submitted information locked and confidential.
- Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing department prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, CareSource will request that the provider submit written clarification to the Credentialing department electronically, by e-mail, fax or by certified mail, return receipt requested and the provider will be given five business days to respond. Nonresponse within that time frame will result in discontinuance on the sixth day.
- 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 Provider Portal. This email directs them to contact Provider Services at **1-833-230-2101** to obtain application status updates. Provider service representatives are able to 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 state- specific time frames. Practitioners also have the ability to check the status of their application by visiting the **CareSource.com** website, signing into the Provider Portal, and entering their application and NPI numbers.

Provider Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. CareSource will initiate immediate action in the event that the participation criteria are no longer met.

Providers are required to inform CareSource of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification, or any event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

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

Board Certification Requirements

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.

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 time frame specified by their respective board. Failure to become certified may result in termination as a participating provider.

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

To be credentialed as a subspecialist physician must:

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

Delegation of Credentialing/Recredentialing

CareSource will 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, utilizes an NCQA-accredited credentials verification organization (CVO), or is a delegate who agrees to follow NCQA credentialing standards. Prior to delegation and annually thereafter, delegates must successfully pass a delegation audit demonstrating compliance with NCQA, federal and state requirements.

All delegation audits will be performed utilizing the most current NCQA, and regulatory requirements. The following will be included (at a minimum) in the audit review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing Committee meeting minutes from the previous year
- Credentialing and recredentialing provider file review
- Annual Credentialing System Control Audit Report
- Ongoing monthly monitoring reports

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

CareSource may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited Health plan, Credentialing vendor or Certified Verification Organization (CVO). Providers will be notified of this and must adhere to the requests from the chosen CVO.

Regardless of the terms of delegation, CareSource reserves the right to approve, suspend or terminate practitioners or practice sites.

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 Provider Hearing Plan. To submit a request, the following steps apply:

Step 1

Submit to the Chief Medical Officer a reconsideration request in writing, along with any other supporting documentation.

CareSource Chief Medical Officer
P.O. Box 8738
Dayton, OH 45401-8738

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

Step 2

If the committee maintains the original decision, an appeal may be made consistent with provisions of the Provider 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 May Be Sent To:

CareSource
Attn: Chief Medical Officer
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 Provider Hearing Plan, please visit **CareSource.com/documents/multi-multi-p-1553807-provider-fair-hearing-plan.pdf**.

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

If the provider disagrees with the payment determination and wishes to request a reconsideration, the provider may submit such reconsideration as described below to CareSource. All provider requests for claims reconsideration must be received by CareSource within 12 months of the date the claim was originally paid unless state or federal law or any applicable provider agreement between the parties stipulate other requirements. Please refer to the Claim Reconsideration Form. Providers may also call CareSource at **1-833-230-2101** or submit written or electronic documentation to:

CareSource Provider Reconsiderations
ATTN: Claims Department
P.O. Box 8738
Dayton, OH 45401-8738

Providers who send a written request for reconsideration should include the following information: Provider name, TIN, member name and ID number, date of service, claim number, charge amount, initial payment and a brief description of the basis for the reconsideration (i.e.: coding related issues, incorrect payment, changes in prior reported units or codes, etc.). In addition, be sure to include any relevant supporting documentation (medical records, copy of invoice, etc.).

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 Chief Medical Officer, 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 Provider Hearing Plan unless an exception applies. Exceptions are set forth in the Provider Hearing Plan.





CLAIM SUBMISSIONS

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

In general, CareSource follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. You can review our provider policies, by visiting **CareSource.com** > Providers > Provider Policies. For expedited claims processing and payment delivery, please ensure addresses and phone numbers on file with CareSource are up to date. For more information on how to update this information, go to the **Submitting Provider Changes** section of this manual.

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 through our Provider Portal. You can access the CareSource Provider Portal at **CareSource.com** > Providers > 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 100 MB 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?

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

What Types of Claims Can Be Submitted?

- Professional medical office claims (CMS 1500 and 837P)
- Medical/surgical claims
- Institutional claims (UB-04 and 8371)
- Behavioral health claims

Claim status is updated daily on our Provider Portal. You can also check claims that were submitted for the previous 24 months.

Electronic Funds Transfer

CareSource offers electronic funds transfer (EFT) as a payment option. You can enroll with ECHO for payment and choose EFT as your payment preference for CareSource or you complete the ECHO enrollment form located on **CareSource.com** > Providers > Claims and fax, email or mail it back to ECHO. For questions, call ECHO Customer Support at 1-888-834-3511. Providers who elect to receive EFT payment may also elect to receive an EDI 835 (Electronic Remittance Advice). Providers can download their Explanation of Payment (EOP) from the Provider Portal or request 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 hours a day, seven days a week; free training is also offered for providers.
- **Reliable** – Claim payments electronically deposited into your bank account.
- **Secure** – Access your account through our Provider Portal to view (and print if needed) remittances and transaction details.

Please Note:

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
- <LAST NAME>*<FIRST NAME>
- REF*6P*<NUMBER>
- The NM1*PR (COB carrier), NM1* GB (other subscriber information from other payer) and REF*6P (other insurance group number)

Please complete the form located on our payment processing vendor, ECHO Health Inc. website. Providers may also call ECHO support at 1-888-834-3511 for assistance with registration.

Electronic Claim Submission

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

Clearinghouse

CareSource prefers electronic claim submission. To submit claims electronically, providers must work with an electronic claims clearinghouse. CareSource currently accepts electronic claims from Wisconsin providers through the clearinghouse listed below. Please contact the clearinghouse to begin electronic claims submission.

Clearinghouse	Phone	Website
Availity	1-800-282-4548	www.availity.com

Please provide the clearinghouse with the CareSource payer ID number: 77170.

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 October 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).

Procedure and Diagnosis Codes

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

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

National Provider Identifier and Tax ID Numbers

Your NPI number and Tax ID are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

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

- CMS 1500: Box 24J for the rendering 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

Professional Claims

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

- 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 Tax Identification Number (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

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 (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

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 methods you may choose from:

- 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.*

You can enroll with ECHO for payment and choose EFT as your payment preference for CGHC or you complete the form on the ECHO Health Inc. website, or call ECHO Customer Support at 1-888-834-3511.

If a payment option with ECHO is not chosen, then payment will default to either virtual card or check.

Paper Claim Submissions

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 Claim Submission"** section of this manual.

Paper claim forms are only encouraged for services that require clinical documentation or other forms to process.

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

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

- CMS 1500 Form Instructions: www.nucc.org
- UB-04 (CMS 1450) Form Instructions: www.nucc.org

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

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
- UB-04 (CMS 1450): Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

All claims (EDI and paper) must include:

- Patient (member) name
- Patient address
- Insured's ID number – Be sure to provide the complete CareSource member ID number of the patient. For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.
- Patient's birth date – Always include the patient's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.

- Place of service – Use standard CMS (HCFA) location codes
- ICD-10 diagnosis code(s)
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable
- Units, where applicable (anesthesia claims require minutes)
- Date of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain From/To formats. Please enter each date individually.
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information.
- Federal tax ID number or physician social security number – Every 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.

National Drug Code (NDC)

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 the following address:

Wisconsin
CareSource Attn: Claims Department P.O. Box 1305 Dayton, OH 45401

No Surprises Act

Effective January 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 January 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 of ‘E’, ‘I’, ‘A’ or ‘Z’ 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 ‘E’ or ‘I’ 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

For in-network providers, claims must be submitted within the timely filing period outlined in your contract. For out-of-network providers, claims must be submitted within 365 days from the date of service or from the date that the non-participating provider was furnished with the correct name and address of CareSource, if applicable. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim, as the claim will be denied. If this happens a corrected claim may be submitted with corrected information, but this is still considered an initial claim and will be subject to the filing limits listed above, from original date of service or discharge.

The initial submission of a claim is subject to the timely filing guidelines expressed in your agreement with CareSource. If a claim is rejected for improper submission (for example, coding errors or incomplete information), a resubmission must be completed within the filing limit outlined in the provider agreement. Please note that when a claim is not filed by the contractual deadline, your rights to reimbursement from CareSource for that claim are forfeited and you may not pursue payment from the member for those services.

Claim Processing Guidelines

If an initial claim is filed timely and is denied, the provider has the following options:

- If a claim denial is due to a provider's incorrect or inaccurate claim information, the provider may resubmit the claim with corrections.
- For adjudication purposes, a denied claim that is resubmitted with corrected information is considered to be an adjusted/corrected claim and, as such, is subject to the timely limit expressed in your agreement with CareSource.
- For adjudication purposes, a denied claim resubmitted without corrected information is considered to be a duplicate claim and will continue to deny for the same reasons. Resubmitted claims with no correction will be subject to the timely filing limit expressed in your agreement with CareSource and will not be accepted as "reasonable and continuous attempts to resolve a claim problem" for consideration to waive or extend the timely filing limit.
- If a claim denial is not due to a provider's incorrect or inaccurate claim information, but the provider disagrees with the denial, the provider should refer to the provider appeal section of this manual for further information.
- If a line item on a claim is denied, that line item should be resubmitted separately, unless the claim details are dependent on one another for payment. For example, all surgical services for the same member, same date and same provider must be submitted on one claim form and cannot be separately processed. To rebill a surgical procedure, a claim adjustment must be requested.

If an initial claim is filed timely and is paid, including claims partially paid, or paid at zero, the provider has the following options:

- If a claim paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider may submit a corrected claim. The corrected claim must be filed in accordance with the timeline outlined in your contract; or for non-contracted providers within 90 days from the date of the initial determination.
- If a claim payment disagreement is not due to a provider's error, refer to the provider appeal section of this manual.
- If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment upon receipt of the primary carrier's EOP in accordance with the timeline outlined in your contract; or for non-contracted providers within 90 days from the date of the primary carriers EOP.
- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's Explanation of Payment (EOP) for paper claims or primary carrier's payment information for EDI claims within the time frame specified within the providers contract or within 90 days from the date of the primary carrier's EOP.

- If the initial timely filing period has elapsed, the EOP must be submitted to us in accordance with the timeline outlined in your contract; or for non-contracted providers within 90 days from the primary payer's EOP date. If a copy of the claim and EOP is not submitted within the required time frame, the claim will be denied for timely filing. When the patient is discharged, the provider will be required to submit a final bill, which includes the entire bill from date admitted to date discharged. CareSource is not able to determine correct payment unless the full, final bill is submitted. The provider must follow the timeline outlined in the contract to submit the complete bill. If this information is not submitted within the timely filing guidelines, the claim will be denied, and previous payments will be recouped.

All claims for newborns must be submitted using the newborn's MID. Do not submit newborn claims using the mother's MID; the claim will deny. Claims for newborns must include the birth weight. The same timely filing guidelines apply for newborns. Newborns receiving **retroactive** eligibility are not subject to timely filing requirements.

CareSource requires that all services billed be appropriately documented in the patient's medical record in accordance with CareSource's medical records policy. If the services billed are not documented in the patient's medical record, in accordance with the policy, they will not be considered reimbursable by CareSource. CareSource's medical records policy can be found on our website.

FACILITY PREVENTABLE ADVERSE EVENTS (PAE) POLICY

There are major PAE or Never Events that, should they occur to a member, the provider shall not be reimbursed from any source, including CareSource and their members.

HOSPITAL ACQUIRED CONDITIONS (HACS)

CareSource Healthcare Cooperative will follow all current and future CMS recognitions of HACs. All inpatient facility claims must be populated with the current and valid POA indicators as defined by CMS. When an HAC occurs, all inpatient facilities shall identify the charges and/or days that are a direct result of the HAC. These charges and/or days shall not be billed to CareSource or the member. The facility shall remove all charges related to the HAC prior to billing.

Claim Status

You can access the CareSource Provider Portal at **CareSource.com** > Providers > Provider Portal.

Claim status is updated daily on our Provider Portal, and you can check claims that were submitted for the previous 24 months from the date of service (DOS). You can search by ID, CareSource Member ID, member name and date of birth, claim number, check number, or patient number.

You can find the following claim information on the Provider Portal:

- Claim history available up to 24 months from the date of service
- Submission of claim appeals and disputes
- Reason for payment, denial or adjustment
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date

- 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

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.

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) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to Medicare: cms.gov.

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

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

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

Any specific claim is subject to current CareSource claim logic and other established coding benchmarks. Any consideration of a 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.

CMS Fee Schedule Status Indicators and CareSource Reimbursement Policy

CMS Status Indicator	Description	CareSource Reimbursement Policy
A	Active Code	These codes are reimbursable under the professional fee schedules, if considered by CareSource as a Covered Service under the Member's Health Benefit Plan, subject to all other terms and conditions of the Member's Plan, this Provider Manual, and the Provider's contract with CareSource.
B	Bundled Code	Payment for covered services is always bundled into payment for other services not specified. No separate reimbursement is warranted.
C	Carriers price the code	When the services are considered by CareSource as a Covered Service under the Member's Health Benefit Plan, CareSource will utilize an industry standard gapfill fee schedule (such as the Optum Essential RVU file) to price the code per the Provider's Contract, should the industry standard gapfill fee schedule not have the necessary information to price the code CareSource would utilize the applicable contract default in those cases. Note: Unlisted codes per this Provider Manual require submission of Medical Records and a comparable code, for which reimbursement will be based on the comparable code provided.
D	Deleted Codes	These codes are deleted, should not be submitted by providers and no reimbursement is warranted.
E	Excluded from Physician Fee Schedule by regulation	When the services are considered by CareSource as a Covered Service under the Member's Health Benefit Plan, CareSource will reimburse per the providers contract at the agreed upon fee or the applicable contract default percentage.
F	Deleted/Discontinued Codes	These codes are deleted, should not be submitted by providers and no reimbursement is warranted.
G	Not valid for Medicare purposes	CareSource does not recognize these code(s) as valid for billing and reimbursement. Please resubmit the claim with the corrected code.
I	Not valid for Medicare purposes	CareSource does not recognize these code(s) as valid for billing and reimbursement. Please resubmit the claim with the corrected code.

CMS Status Indicator	Description	CareSource Reimbursement Policy
M	Measurement codes	Used for reporting purposes only, not subject to any reimbursement from CareSource and/or it's Members.
N	Non-covered Services	When the services are considered by CareSource as a Covered Service under the Member's Health Benefit Plan, CareSource will utilize an industry standard gapfill fee schedule (such as the Optum Essential RVU file) to price the code per the Provider's Contract, should the industry standard gapfill fee schedule not have the necessary information to price the code CareSource would utilize the applicable contract default in those cases. Note: Unlisted codes per this Provider Manual require submission of Medical Records and a comparable code, for which reimbursement will be based on the comparable code provided.
P	Bundled/Excluded Codes	Payment for covered services is always bundled into payment for other services not specified. No separate reimbursement is warranted.
R	Restricted Coverage	When the services are considered by CareSource as a Covered Service under the Member's Health Benefit Plan, CareSource will utilize an industry standard gapfill fee schedule (such as the Optum Essential RVU file) to price the code per the Provider's Contract, should the industry standard gapfill fee schedule not have the necessary information to price the code CareSource would utilize the applicable contract default in those cases. Note: Unlisted codes per this Provider Manual require submission of Medical Records and a comparable code, for which reimbursement will be based on the comparable code provided.
X	Statutory Exclusion	When the services are considered by CareSource as a Covered Service under the Member's Health Benefit Plan, CareSource will utilize an industry standard gapfill fee schedule (such as the Optum Essential RVU file) to price the code per the Provider's Contract, should the industry standard gapfill fee schedule not have the necessary information to price the code CareSource would utilize the applicable contract default in those cases. Note: Unlisted codes per this Provider Manual require submission of Medical Records and a comparable code, for which reimbursement will be based on the comparable code provided.

Unusual Procedure (Modifier 22)

Surgeries or other procedures for which services performed are significantly greater than usually required may be billed with Modifier 22. Modifier 22 is only reported with procedure codes that have a global period of 0, 10, or 90 days; other procedures are ineligible for Modifier 22. Supporting documentation is required to consider additional reimbursement.

Unrelated Evaluation and Management (E/M) Service by the Same Physician During Global Period (Modifier 24)

Reimbursement is considered independent of services in which they are not a component.

Significant, Separately Identifiable E/M Service (Modifier 25)

Significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service require billing with Modifier 25. To report Modifier 25, the patient's condition must require a significant, identifiable E/M service above and beyond the other service provided or services beyond the usual preoperative and postoperative care associated with the procedure that was performed and billed in accordance with the appropriate level of the E/M service.

Professional Component-Outside of Office (Modifier 26)

Claims for clinical laboratory services that do not have an associated professional component will not be reimbursed when reported with modifier -26. According to CMS, it is inappropriate for pathologists to bill for laboratory oversight and supervision with modifier -26. Reimbursement for laboratory oversight and supervision is included in the reimbursement to a hospital or independent laboratory instead.

Preventive Service Indicator (Modifier 33)

Modifier 33 is used to indicate preventive (wellness) services provided to members. When the primary purpose of the service is in accordance with the US Preventive Services Task Force or other preventive services identified in preventive mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Bilateral Procedures (Modifier 50)

Modifier 50 is used to indicate a bilateral procedure when reported on a single line on the claim form. CareSource utilizes Medicare Rules and payment indicators to determine appropriate application and payment of this modifier. CareSource will pay 150% of the fee schedule amount for services Medicare deems to be bilateral and where the 50 modifier is appropriate even when indicated by providers utilizing RT or LT modifiers instead. Bilateral procedures may be subject to the multiple procedure reimbursement logic.

Bilateral status is determined before applying multiple procedure adjustments. When a procedure is billed utilizing Modifier 50 the procedure occupies both the first and second surgical slot, meaning any additional surgical procedures will be considered to have occupied the third and subsequent slots from a multiple procedure reduction perspective and are subject to reduced reimbursement.

Multiple Procedures/Multiple Surgery Reduction (Modifier 51)

In cases where multiple surgical procedures are planned, be sure to obtain all required authorizations for each procedure. CareSource utilizes CMS published Multiple Procedure Status Indicators to determine when a code is subject to a multiple procedure reduction. Reimbursement for multiple procedures indicated with a 2 or 3 status by CMS will be reduced when performed during a single encounter as follows: CareSource will pay the primary procedure at 100% of the allowable fee, the second procedure at 50%, and the third procedure at 25%. There will be no reimbursement beyond the third procedure.

Reimbursement for multiple procedures indicated with a 4 status by CMS will be reduced when performed during a single encounter as follows: When the procedures are billed with a TC modifier, CareSource will pay the primary procedure at 100% of the allowable fee, the second and all subsequent procedures at 50% of the allowable fee. When the procedures are billed with a 26 modifier, CareSource will pay the primary procedure at 100% of the allowable fee, the second and all subsequent procedures at 95% of the allowable fee.

Reimbursement for multiple procedures indicated with a 5 status by CMS will be reduced when performed during a single encounter as follows: CareSource will pay the primary procedure at 100% of the allowable fee, the second and all subsequent procedures at 80% of the allowable fee. Reimbursement for multiple procedures indicated with a 6 status by CMS will be reduced when performed during a single encounter as follows: When the procedures are billed with a TC modifier, CareSource will pay the primary procedure at 100% of the allowable fee, the second and all subsequent procedures at 75% of the allowable fee. Reimbursement for multiple procedures indicated with a 7 status by CMS will be reduced when performed during a single encounter as follows: When the procedures are billed with a TC modifier, CareSource will pay the primary procedure at 100% of the allowable fee, the second and all subsequent procedures at 80% of the allowable fee. Reimbursement for multiple procedures indicated with a 0 or 9 status by CMS will not be reduced when performed during a single encounter. Multiple procedures should be reported using the Modifier 51 on each line.

Reduced Service (Modifier 52)

Reimbursement will be allowed at 50% of the allowable fee, subject to the provider contracted terms.

Discontinued Procedure (Modifier 53)

Reimbursement will be allowed at 50% of the allowable fee, subject to the provider contracted terms.

Surgical Care Only (Modifier 54)

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported. Reimbursement will be allowed at 70 percent of the allowable fee, subject to provider contracted terms.

Post-Operative Management Only (Modifier 55)

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported. Reimbursement will be allowed at 20 percent of the allowable fee, subject to provider contracted terms.

Pre-Operative Management Only (Modifier 56)

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported. Reimbursement will be allowed at 10 percent of the allowable fee, subject to provider contracted terms when applied to surgical codes except for (1) codes that have 0 days in the Global period; (2) Evaluation & Management services; or (3) in addition to modifiers 54, 55, 80, 81, 82, or AS.

Distinct Procedural Service (Modifier 59)

Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances modifier 59 should be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

- XE – Separate encounter, a service that is distinct because it occurred during a separate encounter.
- XP – Separate structure, a service that is distinct because it was performed by a different practitioner.
- XS – Separate structure, a service that is distinct because it was performed on a separate organ/ structure.
- XU – Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

Surgical Team (Modifier 66)

Each surgeon shall submit a claim for service and append the 66 modifier. Reimbursement shall be 150% of the allowable base fee for that service divided equally amongst the total number of surgeons submitting a claim for that service. For example, if the base fee was $100 and 3 surgeons performed the service, each surgeon would get reimbursed $50 ($100 * 150% = $150 divided by 3 surgeons = $50).

Assistant Surgeons (Modifier 80, 81, and 82)

CareSource will reimburse assistant surgeons at 16% of the contracted rate of the procedure. This reduction is systematically taken based on the modifier (80, 81, or 82) on the claim. CareSource uses the American College of Surgeons (ACS) as the primary source to decide which procedures allow an assistant surgeon. For procedures that the ACS lists as "sometimes," CMS is used as the secondary source.

Assistants-at-Surgery Services Provided "Incident To" a Surgery by Auxiliary Personnel (Modifier AS) CareSource will pay for assistants-at-surgery at 16% of the contracted rate of the procedure only when the person reporting the service is a physician or the person bears the designation of physician assistant, nurse practitioner, nurse midwife or clinical nurse specialist, subject to all terms and conditions of the policy including medical necessity. If the person who assists at surgery is a surgical technologist or bears any title other than those listed, the service is not payable by CareSource.

Co-Surgeon (Modifier 62)

Each co-surgeon shall receive 62.5 percent of the allowable fee. Co-surgeons are defined as two surgeons who work together as primary surgeons performing distinct parts of a surgical procedure. Each surgeon should report his/her distinct, operative work by adding the modifier "62" to the procedure code and any associated add-on code(s) for the procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier "62" added.

Observation Care

Claims should be billed to CareSource at the appropriate level of care for which the patient meets per clinical criteria. Observation Care which exceeds two days/48 hours requires prior authorization and review for appropriate level of care, failure to obtain authorization will result in denial of the entire claim.

Medical Mid-Level Providers

Mid-level providers are defined by CareSource as non-MD/DO providers. These provider types shall be reimbursed 85 percent of the physician's fee.

Unlisted Codes

All unlisted codes require Prior Authorization by CareSource. When a Facility or Provider bills using an unlisted code, CareSource will require the services be submitted with medical records and indication of a comparable code to allow for the service. An unlisted code shall be allowed, when approved through the Prior Authorization process, at the applicable fee schedule rate for the comparable code.

Telehealth Services

CareSource does allow members to receive services via Telehealth. All other limits and plan requirements (i.e., Prior Authorizations) apply when applicable. Providers should bill either with place of service 02 or 10; or with another appropriate place of service and the appropriate modifier (i.e., 95, GT).

Telehealth Modifiers (i.e., 95, GT) should not be used when billing with place of service 02 or 10. It is important to note that the 95 Modifier is only accepted for professional services billed on HCFA and the GT is only accepted for facility services billed on a UB.

Anesthesia Billing

CareSource reimburses anesthesia providers using the ASA standards. Providers will be expected to bill the number of minutes and any applicable patient status indicator(s). Anesthesia services must be submitted with the appropriate anesthesia modifiers. Claims lacking this information will be denied as a billing error.

Anesthesia Rounding: Providers should bill full time and CareSource will calculate timed units based on 15-minute increments and will round down for seven minutes (and fewer) and up for eight minutes (and above) to the nearest whole unit.



PHYSICAL STATUS MODIFIER:

Modifier	CPT/HCPCS Descriptor	ASA Physical Status Classification	ASA Provided Examples (including, but not limited to)	Additional Base Units
P1	A normal healthy patient	ASA I	Healthy, non-smoking, no or minimal alcohol use	0
P2	A patient with mild systemic disease	ASA II	Mild diseases only without substantive functional limitations. Examples include (but are not limited to) current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease	0
P3	A patient with severe systemic disease	ASA III	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI>40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD, undergoing regularly scheduled dialysis, premature infant PCA<60 weeks, history (>3 months) of MI, CVA, TIA or CAD/stents	1
P4	A patient with severe systemic disease that is a constant threat to life	ASA IV	Examples include (but not limited to): recent (<3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis	2
P5	A moribund patient who is not expected to survive without the operation	ASA V	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	ASA VI		0

Medical Supervision by a physician: more than four concurrent anesthesia procedures (Modifier AD)

Services will be reduced to 50% of the Fee Schedule Allowable amount for a bill submitted with this modifier.

Medical Direction of More than One Concurrent Anesthesia Procedures (Modifier QK)

50% of Fee Schedule Allowance. Total reimbursement for CRNA and MD will not exceed the allowed amount otherwise recognized had the service been furnished by the MD alone.

CRNA Service under Medical Direction by an Anesthesiologist (Modifier QX)

50% of Fee Schedule Allowance. Total reimbursement for CRNA and MD will not exceed the Fee Schedule Allowance otherwise recognized had the service been furnished by the MD alone.

Medical Direction of One CRNA by an Anesthesiologist (Modifier QY) 50% of Fee Schedule Allowance

CRNA Service: Without Medical Direction by a Physician (Modifier QZ) 85% of Fee Schedule Allowance, consistent with typical reimbursement by a mid-level nurse practitioner.

Monitored Anesthesia Care (MAC) services (Modifier QS) 100% of Fee Schedule

Modifier Summary Table

The table below lists commonly billed unique modifiers and the reimbursement applied by CareSource. This table is not an all-inclusive list of modifiers available for use.

Modifier	Description	Application
22	Unusual Procedure (with supporting documentation)	Maximum of 110% of the base code allowable
24	Unrelated E&M service by the same physician during post-op period	Pay 100% of the base code allowable
33	Preventive service indicator	Pay 100% of the base code allowable
50	Bilateral procedure	Pay 150% of the base code allowable for a single unit of service
RT/LT	Right/left sides	100% if billed alone, 150% total if billed together
51	Multiple procedures	Based on CMS Status Code Indicators, see full description above
52	Reduced services	Pay 50% of the base code allowable
53	Discontinued procedure	Pay 50% of the base code allowable

Modifier	Description	Application
54	Surgical Care Only	Pay 70% of the base code allowable
55	Post-op Management Only	Pay 20% of the base code
56	Pre-op Management Only	Pay 10% of the base code allowable
59	Distinct procedural service	No reduction if billed alone
62	Co-surgeon	62.5% of the base code allowable
66	Surgical Team	150% of the base code allowable split evenly amongst all providers of service for that service/date
76	Repeat procedure – same physician	Pay 50% of the base code allowable
77	Repeat procedure – different physician	Pay 100% of the base code allowable
78	Unplanned return to the OR	Pay 50% of the base code allowable
79	Unrelated procedure during post op	Pay 100% of the base code allowable
80, 81, 82, AS	Assistant surgeon	16% of the base code allowable
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Pay 50% of the base code allowable
QX	CRNA service with medical direction by a physician	Pay 50% of the base code allowable
QK	Medical supervision of 2, 3, or 4 concurrent anesthesia procedures	Pay 50% of the base code allowable
QS	Monitored Anesthesia Care (MAC) services	Pay 100% of the base code allowable
QY	Medical direction of one CRNA by an anesthesiologist	Pay 50% of the base code allowable
QZ	CRNA service without medical direction by a physician	Pay 85% of the base code allowable
GW	Non hospice diagnosis related service	Pay 100% of the base code allowable

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 biweekly. However, you may not receive an EOP each time they are generated, depending on your claim submission activity. Providers who receive EFT payments may also elect to receive an Electronic Remittance Advice (ERA) and can access it 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 Claim Status

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. A Pended Claim 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.

As a provider by submitting a claim to CareSource, you agree to cooperate with subrogation and COB. Providers must notify us when they receive information for a CareSource member whose claim involves subrogation or COB. In the event provider fails to supply information on subrogation or COB, CareSource may recover funds from provider beyond any applicable contractual terms that may be in place between the provider and CareSource.

As an in-network provider, when CareSource is the primary payer, the combined payments of CareSource, the secondary plan, and the member will not exceed the CareSource rate. When CareSource is secondary to the primary plan, CareSource and the member will pay no more in total than the lesser of the CareSource contracted rate or the remaining members responsibility from the primary plan.

Providers must submit the primary payer's explanation of payment/remittance advice (EOP) along with the claim for proper reimbursement. Claims for members with other primary coverage that are submitted without EOP will be denied for lacking information necessary for adjudication.

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 check COB information for members who have been active with CareSource within the last 12 months.

Claims involving COB will be denied for COB information needed until an Explanation of Benefits/ Payment (EOB/EOP) or EDI payment information has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (zero balance) must still be submitted to CareSource for processing. This is due to regulatory requirements.

Coordination of Benefits Overpayment

If a provider receives a 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.

All claims for services related to work-related injuries or illness should be submitted to the worker's compensation carrier. If claims are denied by the worker's compensation carrier, you may submit the claim along with the denial for consideration by CareSource. All prior authorization guidelines apply in this situation, including need for out-of-network providers to obtain an authorization to render services in advance, which must be initiated by an otherwise in-network provider. You must submit the claim (s) in a timely manner along with the denial as outlined in the timely filing guidelines.

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.

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 financial liability (e.g. deductible, copay, coinsurance), the provider must refund the overpayment to the member. Please refer to the **"Member Disenrollment"** section of this manual 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 (EOB)

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



REFERRALS, PRIOR AUTHORIZATIONS, AND OUT-OF-NETWORK SERVICES

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 in limited situations with prior authorization (PA) from CareSource's Utilization Management (UM) team. Any participating facility/provider requesting prior authorization for an elective admission must obtain prior authorization for the use of any out-of-network RAPHL (Radiologist, Anesthesiologist, Pathology, Hospitalist and Laboratory). Please visit the Provider Portal at **CareSource.com** for the most current information on PA and referral requirements.

Referral Information

Generally, CareSource does not require referrals or PA before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, prior authorizations are needed before CareSource will pay for services from out-of-network providers, except in cases of emergency and other scenarios as defined in the Certificate of Coverage (COC). If you have questions about referrals, please call our Utilization Management Department at **1-833-230-2101**.

Out-of-Network Authorization Procedures

CareSource offers Exclusive Provider Organization (EPO) benefits. For services to be considered Covered Health Services, members must seek those services from in-network providers ONLY, except under very limited circumstances. These limited circumstances include the following situations:

- Emergency health services performed at an out-of-network facility or by an out-of-network provider. Once the emergency has been stabilized, ongoing hospitalization and any follow up care must be transitioned to and provided by in-network providers and facilities.
- Medically necessary urgent care services at out-of-network providers outside CareSource's 13 county service area, such as while traveling. Any follow-up care must be provided by in-network providers and/or facilities.

- If specific covered health services are not available from an in-network provider or there is not a qualified in-network provider, the member may be able to obtain the services with an approved authorization which must be initiated by an in-network provider to see an out-of-network provider. The authorization must be approved by CareSource prior to services being rendered. Such authorization must be submitted to CareSource on CareSource's Marketplace Referral form, linked below. Any services the out-of-network provider recommends must comply with all provisions of the member's policy, including but not limited to the need to obtain additional prior authorizations, which may be done using the same form directly submitted by the out-of-network provider to the Plan. If providers and/or members fail to obtain an approved authorization for out-of-network care prior to treatment, NO benefits are available and therefore NO payment will be made for those services. If the authorization is approved retroactively after services are rendered (except in cases of an emergency), the penalty listed in the Prior Authorization section may apply.
- For a covered dependent on a member's policy, who attends school outside of CareSource's 13 county service area, only out-of-network emergency medical services and/or out-of-network urgent care services will be covered. Follow-up care or services not considered to be emergent or urgent must be provided by in-network providers and facilities.
- For a covered dependent on a member's policy, who attends school outside of CareSource's 13 county service area, but inside the State of Wisconsin, a clinical assessment by an out-of- network provider and up to five visits of outpatient behavioral healthcare or addiction treatment will be covered. Members qualifying for this benefit should contact CareSource Member Services at 1-877-514-2442, prior to receiving such services as CareSource reserves the right to direct the member to a specific provider of our choosing.

As an in-network provider, it is important that if services are not available within the network and therefore a member is recommended to seek care from an out-of-network provider, that you complete the Marketplace Provider Prior Authorization Request Form.

Please keep in mind that CareSource requires all in-network providers options to be exhausted before an approval will be granted for an out-of-network provider/facility.

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

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

- The provider must be a participating provider. If not, a prior authorization must be obtained to send the patient to a non-participating provider.

Request Prior Authorization	
Online/Provider Portal* *preferred method	Visit our Provider Portal at **CareSource.com** > Providers > Provider Portal
Phone	Please call **1-833-230-2101** and tell our IVR that you need to submit an authorization request.
Fax	Please fax the prior authorization form to 1-844-676-0372. The Prior Authorization Form can be found on **CareSource.com** > Providers > Tools & Resources > Forms
Mail – Prior Authorizations	CareSource Attn: Utilization Management Department P.O. Box 1307 Dayton, OH 45401-1307
Mail – Behavior Health Prior Authorizations	CareSource Attn: Behavioral Health Utilization Management Department P.O. Box 1307 Dayton, OH 45401

- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.



Prior Authorization Information for Utilization Management

Prior Authorization Procedures

The Provider Portal is the preferred method to request prior authorizations for health care services. You get immediate approval or a pending status for some services, and you can also check pending claim status. Prior authorizations for health care services can be obtained by contacting the Utilization Management department online, by phone, fax or mail. If submitted by mail or fax, please use the appropriate prior authorization form. Copies of prior authorization forms can be found on **CareSource.com** > Providers > Tools & Resources > Forms.

Copies of prior authorization forms can be found on **CareSource.com** > Providers > Tools & Resources > 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

Prior Authorization Criteria

CareSource requires timely submissions of prior authorization requests for inpatient admissions. If the service is an acute inpatient emergent admission CareSource expects the facility to submit the authorization request within 72 hours of admission, not including Saturdays, Sundays, or legal holidays. However, if it is a planned admission, CareSource expects that the physician submits a prior authorization request prior to admission.

Please Note: Below is not a comprehensive listing and other criteria may be associated with other items requiring prior authorization.

- If the provider fails to obtain prior authorization for non-emergency services, neither the plan nor a covered person will be required to pay for those non-emergency services.
- If the request is for **inpatient admission** (whether it is elective, urgent or emergent), 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 prior to the planned surgery.
- If the request is for **outpatient surgery**, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs prior to the planned surgery.
- Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and coverage/benefit limitations.
- When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent

month, authorization is given contingent upon member eligibility on the date of service and adherence to other terms and conditions of the Certificate of Coverage, such as benefit limits. 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 prior authorization as soon as it is known that the service is needed.

- All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the provider. CareSource will notify you of prior authorization determinations via mail to the provider's address on file.
- For standard prior authorization decisions, CareSource provides notice to the provider and member as expeditiously as the member's health condition requires, but no later than 15 calendar days following receipt of the request for service. Members can track their prior authorization status in their CareSource MyLife account so they know where their request stands, what to expect next, and when they can move forward with care.
- Urgent prior authorization decisions are made within 72 hours of receipt of request for service. 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. If an authorization is being appealed for medical necessity, a member consent form must also be submitted.
- If prior authorization is not obtained, where required, in advance of the services being provided, services may be denied, or penalties applied. As a provider, your failure to secure necessary prior authorizations may jeopardize your reimbursement and/or continued participation in CareSource's network. In most cases, CareSource will not allow more than a 30-day authorized quantity, and reimbursement for such supplies shall only be made on a month-by-month basis.

Services that Require Prior Authorization

- Please visit **CareSource.com** > Providers > Provider Resources > Prior Authorization for the most up-to-date information of services that require prior authorization.

Determination Time Frames

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

Review Type	Time for plan to respond when all information is present
Inpatient Notification (DEMO)	N/A
Inpatient Initial	3 calendar days
Inpatient Continued Stay Review	3 calendar days
Outpatient/Elective Non-Urgent	15 calendar days
Outpatient/Elective/URGENT	72 hours
Retrospective	30 calendar days

Billing for Services Denied Prior Authorization

CareSource may permit billing members for services that require authorization, but for which authorization is denied, if certain safeguards are in place and are followed by the provider:

- The provider must establish that authorization has been requested and denied before rendering the service.
- The provider can request CareSource review of the authorization decision. CareSource must inform providers of the contact person, the means for contact, the information required to complete the review and procedures for expedited review, if necessary.
- If CareSource maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that the authorization has been denied.
- The member must be informed of the right to contact CareSource to file an appeal if the member disagrees with the decision to deny authorization.
- The provider must inform members of member responsibility for payment if the member chooses to or insists on receiving the service without authorization.
- If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:
- The waiver is signed only after the member receives the appropriate notification stated in requirements three and four.
- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
- Providers must not use nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that fall under the scenario of non-covered services.
- The waiver must identify the specific procedure to be performed, and the member must sign the consent before receiving the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that CareSource did not authorize the service.

The waiver must include the right to appeal any denial of payment by CareSource for denial of authorization.

UTILIZATION MANAGEMENT

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

We also monitor the coordination of medical care to ensure its continuity and refer members to CareSource's Care Management department, if needed. CareSource's UM criteria are available in writing by fax, mail and via the Provider and Member webpages.

CareSource	Fax	Mail
	1-877-676-0372	CareSource P.O. Box 1307 Dayton, OH 45401-1307

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

Criteria

CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation, and skilled nursing facility admissions. These criteria are designed to assist providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients.

CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. CareSource also has medical policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available to discuss individual cases with attending physicians upon request.

You can review our provider policies, by visiting **CareSource.com** > Providers > Provider Policies.

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 when an adverse decision has been rendered. You may request the information by calling or faxing the CareSource Utilization Management department. If you would like to discuss an adverse decision with a CareSource Clinical Peer Reviewer, please call the Utilization Management department at 1-833-230-2168. This request for the discussion with the Clinical Peer Reviewer needs to occur within seven business days of the determination. After this deadline, you must follow the appeals process.

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. Prior authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a participating provider.

To request prior authorization for observation services as a non-participating provider or to request authorization for an inpatient admission, please visit the Provider Portal to request a prior authorization. You may also call our Utilization Management department regarding post-stabilization authorizations. During regular business hours, your call will be answered by our Utilization Management department. If calling after regular business hours, the call will be answered by 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.

Access to UM Staff

Providers may call our Utilization Management department at **1-833-230-2101** with any questions.

Staff Availability

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

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



PHARMACY

CareSource provides prescription drug coverage when obtained from an in-network retail pharmacy, mail-order pharmacy, or specialty pharmacy. Some drugs administered in the patient's home may also be covered under the pharmacy benefit.

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 Wisconsin Marketplace and Commercial plans to provide continuity for provider offices and CareSource members.

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 copay for a preferred brand-name drug and an even higher copay for a non-preferred drug. A drug's cost-share will never exceed the actual cost of the drug itself.

For specialty pharmacy, a coinsurance is often applied, depending on the member's plan. Coinsurance is a percentage of the drug's cost. When members pay a percentage, their cost may be higher than expected for many reasons:

- The cost of the drug may be high. For example, assume the coinsurance is 30 percent. In this case, a $250 drug will be more costly than a $25 drug.
- The drug may not be on a preferred tier on the formulary, so the member pays a higher tier's cost-share.
- The member may be buying a more expensive brand-name drug when there is a generic equivalent available for lesser cost, if authorized.

Prescribing providers for CareSource's plan members must contact the plan for medication prior authorizations.

You can find a complete list of drugs available by visiting **CareSource.com** > Providers > Tools & Resources > Drug Formulary. Members may also confirm coverage and cost of a specific drug using the CareSource Find My Prescriptions tool at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions.

Tiered Medications

Every drug covered on the CareSource Drug Formulary is in one of the tiers below. Typically, the higher the cost-sharing tier number, the higher the cost for the drug:

Tier 0: Prescription drugs in this tier are preventive medications. No cost-sharing amounts (copay, deductible and/or coinsurance) apply to these drugs.

Tier 1: Prescription drugs in this tier are low-cost generic drugs. The member's cost-share will be the lowest for drugs in this tier.

Tier 2: Prescription drugs in this tier are preferred single- or multi-source brand-name drugs. They will have a higher cost-share than drugs in tier 1.

Tier 3: Prescription drugs in this tier are non-preferred single- or multi-source brand-name drugs. They will have a higher cost-share than drugs in tier 1 or 2.

Tier 4: Prescription drugs in this tier are specialty drugs. This tier will have the highest cost-share for the member.

Note: Oral chemotherapy drugs may have a designated copayment or coinsurance to meet the oral chemotherapy parity laws.

Drug Formulary

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

CareSource uses a Drug Formulary of covered drugs. 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 also by alphabetical index so that therapeutic interchanges for most drug classes are easier to compare. You can learn more about how to use our pharmaceutical management procedures by visiting 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. You can find the most up-to-date formulary, by visiting **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 normal manufacturers' recommended dosing frequencies and long-term safety considerations, diagnosis and best practices. 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 be tried and failed prior to the approval of a second step 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 members from unnecessary financial burden.

Generic or Biosimilar Substitution

A pharmacy will provide a generic or interchangeable biosimilar drug if available in place of a brand name drug or reference biologic. Members and providers can expect the generic or biosimilar drug to produce the same effect and have the same safety profile as the brand name drug or reference biologic. If a brand name drug or reference biologic is requested when an equivalent generic or biosimilar drug is available, you may need to request a prior authorization. Also, members may pay additional costs for brand name drugs or reference biologics when an equivalent generic or biosimilar is available.

For more information about generic substitution, please refer to the FDA Orange Book. For more information about biosimilar substitution, please refer to the FDA Purple Book.

Prior Authorization

Medications administered under the pharmacy benefit may require prior authorization before they are 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 Formulary Drug Exceptions below).

Prior authorization requests for medications covered under the pharmacy benefit may be submitted electronically via the CoverMyMeds or SureScripts 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 administered in an outpatient setting by a clinician and billed under a member's medical benefit may also require prior authorization.

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

Note: All oncology medication treatment regimen requests must be submitted and reviewed through the EVITI Connect Portal.

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

For all prior authorization 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.

Pharmacy prior authorization requests are reviewed, and determinations are made within:

Review Type	Decision Turnaround Time
Pharmacy Benefit (Standard)	72 Hours
Pharmacy Benefit (Expedited)	24 Hours
Medical Benefit (Standard)	15 Calendar Days
Medical Benefit (Expedited)	72 Hours
Medical Benefit (Retrospective)	30 Calendar Days

Pharmacy prior authorization requests are reviewed, and determinations are made within:

Formulary Drug Exceptions

Exceptions are requests for drugs not listed on the health plan's Drug Formulary. Typically, our formulary includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be as effective or considered a treatment standard of care equal to or better than the drug you are requesting, we will generally 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 formulary drugs causing hospitalization or submission of a MedWatch notice to the FDA, or the member has failed all available formulary options.

As mentioned previously, drugs that are on the formulary may have utilization management applied for reasons of cost, safety, allowances by state laws and more. All documentation to request an exception must establish the necessity of the requested drug over the available drugs listed on the Drug Formulary as per each policy.

CareSource has an exception process that allows the member, the member's representative or the prescriber to make a request for a formulary coverage exception, or an exception to utilization management. The member, member's representative or prescriber may initiate the request by calling Member Services or by filling out a Member Exception Request Form. The prescriber may also submit electronically via the SureScripts or CoverMyMeds portals or by fax at 1-866-930-0019. In emergent situations, requests may also be accepted via phone at **1-833-230-2101**. If requested by the member or member's representative, CareSource will reach out to the prescriber to obtain the appropriate clinical documentation.

Note: All oncology medication treatment regimen requests must be submitted and reviewed through the EVITI Connect Portal.

CareSource will provide a decision no later than 72 hours after the request is received, or within 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 (IRO). The external review process is outlined in the "Member Grievances and Appeals" chapter of this manual.

Other Medical Supplies and Durable Medical Equipment

Limited durable medical equipment (DME) may be covered on the Drug Formulary. You can find the most up-to-date formulary, by visiting **CareSource.com** > Providers > Tools & Resources > Drug Formulary.

Medications Administered in the Provider's Clinical Setting

Medications that are administered in a provider setting, such as a physician's office, hospital outpatient department, clinic, dialysis center or infusion center, will be billed to the health plan through the member's medical benefit. Prior authorization requirements exist for many injectable medications. Refer to the Procedure Code Lookup Tool to determine which drugs need prior authorization and the prior authorization submission methods listed above.

Medication Therapy Management Program

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

Network Pharmacies

Our Find a Pharmacy tool 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. You can visit our website for a complete list of network pharmacies at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions.



MEMBER ENROLLMENT AND ELIGIBILITY

The Health Insurance Marketplace is responsible for determining whether applicants enrolled directly through the Marketplace 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. CareSource is responsible for determining whether applicants enrolled in CareSource's Commercial plans (off-exchange) are eligible for benefits under the plan.

Members must enroll in a CareSource plan every year. Members enrolled through Healthcare.gov 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 Eligibility Verification

Providers are expected to verify member eligibility each time a service is rendered.

Providers may use the Provider Portal to verify member eligibility. Upon logging in to the Provider Portal, providers will be able to view member eligibility with:

- 24 months of history
- Member span information
- Multiple member look-up (up to 500)

You can also verify eligibility with CareSource by calling our Provider Services at **1-833-230-2101**.

Member ID Cards

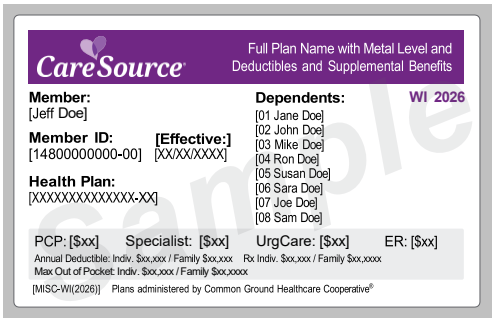
The member ID card is used to identify a CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their ID card. Therefore, it is important to verify member eligibility prior to each service rendered.

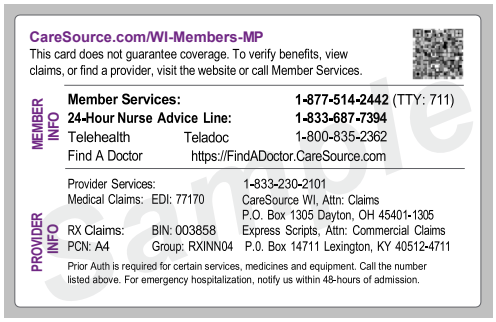
Providers may use our secure Provider Portal or call Provider Services at **1-833-230-2101** to check member eligibility:

- Click on "Member Eligibility" on the left, which is the first tab. Make sure to enter the full 11-digit member ID number 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.

Sample Member ID Card





ID Card Elements

- **Member plan** – Member's plan choice will be included in this area
- **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.
- **Dependents** – This is the member specific suffix & name. When checking eligibility and/or submitting claims for dependents, please ensure you replace the subscriber suffix (last two digits, usually 00) of the Member ID number with the dependent suffix from the ID card.
- **Member Services phone number**
- **24/7 Nurse Advice Line**
- **Provider Services phone number**
- **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. Please ensure that when referring members for these related services, you are leveraging these resources.
- **Address to submit medical claims**
- **Deductibles and Maximum Out-of-Pocket (MOOP)** – These are listed as the individual amount for plans with only a single member and the family amount for plans with multiple members. Members will be only responsible for satisfying their individual deductible or MOOP which is half of the family amount.
- **Pharmacy numbers**

New Member Welcome Kits

Once a member has paid to effectuate their coverage, they will receive a Welcome Letter with their ID card that includes quick start instructions. A member will also receive HIPAA Privacy Practices, Women's Health and Cancer Rights Act, New Borns' and Mothers' Health Protection Act, Non-Discrimination and Notice of Availability of Language Assistance resources.

Finding a Doctor

Members are generally referred to our online Find-a-Doctor directory tool. The online Provider Directory, which lists participating CareSource providers and facilities within a certain radius of the member's residence, provides the latest information on our provider network. A current list of providers can be found at any time on CareSource's website, **CareSource.com**.

Members will only receive a printed copy of our Provider Directory if they requested one at the time of enrollment or by returning a request postcard included in their new member kits. As the contents of the printed directory are subject to change, we encourage members to call CareSource or to use the online provider directly to confirm they are in network.

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 enrolled through the Marketplace (on-exchange) have a federally mandated 90-day grace period if they are receiving advanced premium tax credit (APTC). All Commercial (off-exchange) members and Marketplace (on-exchange) members not receiving APTC have a 30-day grace period in which to make their payment.

- This is not applicable for their initial payment
- For APTC-receiving members, 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 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 claims that are pended during the grace period and reserves the right to recover any amounts paid in this period.



COVERED SERVICES AND EXCLUSIONS

This section describes some of the services and exclusions to benefits that are provided to our CareSource members. CareSource requires all covered services to be medically necessary. Covered services may require prior authorization. Please visit the Provider Portal at **CareSource.com** for the most up-to-date list of services that require prior authorization.

Exclusions and Limitations Summary

CareSource will not pay benefits for any services, treatments, items, or supplies described in the exclusions and limitations section of the policy, even if either of the following is true:

- The health service is recommended or prescribed by a physician or clinical provider.
- The health service is the only available treatment for the condition.

The services, treatments, items, or supplies listed in the exclusions and limitations section are not covered health services unless specific provisions apply.

Certain benefits are subject to limitation and CareSource will not pay for any services, treatments, items, or supplies that exceed benefit limitations.

Covered Services

CareSource's Marketplace product is compliant with the Affordable Care Act in terms of benefit offerings and cost share applications. You can see our Certificate of Coverage and Schedules of Benefits at **CareSource.com** > Plans > Plan Documents for more detail.

Please refer to our website and the **"Prior Authorizations and Out-of-Network Services"** chapter of this manual for more information about referral and prior authorization procedures.

Covered services must be medically necessary as defined by the Certificate of Coverage, provided in the most conservative manner, be the least costly of alternative options and not experimental/investigational (except as described in the clinical trial section of the policy). The fact that a provider prescribes or recommends a service, treatment, or supply does not make it medically necessary or a covered health service and does not guarantee payment.

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**.

Any services rendered in excess of the benefit limits will be denied.

Prior Authorizations and Determinations

Some services require prior authorization. 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 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 through a network of directly contracted providers. The benefit covers eye exams (no cost), eyewear including glasses or contact lenses, as well as other value add services such as low vision exams/aids and discounts on a wide array of materials and services, subject to benefit limits outlined in the member's Certificate of Coverage.

Routine Hearing Exams and Hearing Aids

All CareSource members will have access to a routine hearing exam and one set of hearing aids per 36 months, as described in the member's Certificate of Coverage.

Optional Adult Vision

CareSource's vision plan provides adult members (19 years and older, except as stated below) the ability to access the following benefits:

Vision – One adult routine vision exam annually for members who select these enhanced plans with added vision benefits.



MEMBER SUPPORT SERVICES AND BENEFITS

CareSource provides a wide variety of support and educational services 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 MyLife℠

CareSource MyLife is a member exclusive application that can be downloaded or used on the internet. Members can see their health information, billing information, explanations of benefits and more using this secure app, 24 hours a day. If a member is using our Care Management services, they can see their Care Manager, their phone number and their care plan.

CareSource Member Services

Representatives are available by telephone Monday through Friday, except on observed holidays. Members access Member Services by calling at **1-877-514-2442** from 8 a.m. to 5 p.m. CT and telling our interactive voice response (IVR) system what their question is regarding.

24-Hour Nurse Advice Line

Members can call our nurse advice line 24 hours a day, seven days a week. With our nurse advice line, 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.

Advice line 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.

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, behavioral health professionals 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 treatment adherence, reinforcing medical instructions and assessing social and safety needs, as well as educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We have a specialized Mom and Baby Beginnings team that serves pregnant women and a NICU team that works with infants who experienced complications after birth. We also offer individualized education and support for many conditions.

Care Management Referrals

Direct Access to Case Management referrals and assistance with member needs is available by phone 1-833-230-2037 or by fax 937-396-3648. Providers can also make electronic case management referrals on the Provider Portal.

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, behavioral health professionals, and nurse care managers provides a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care and education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional community resources, such as housing and food resources. Our Care Management team can also assist members and providers with discharge planning for inpatient stays, or other transitions of care.

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

- Asthma
- Depression
- Weight loss
- Diabetes
- High blood pressure and cholesterol
- Chronic Kidney Disease
- Heart disease
- Pregnancy
- End-Stage Renal Disease

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.

MyResources

The MyResources search engine is a social service and community resource search tool. The MyResources Tool connects members with local low-cost and no cost community-based programs and social services. The tool is easy to use and allows our staff and members to search for a wide category of resources like food, housing, transportation, and job training programs by simply entering a zip code from anywhere in the United States.

The search information is provided in real time and includes distance from the zip code entered with other locations nearby. More than 100 languages are supported, and resources can be updated and new resources suggested directly from the site. Other features include the ability to send a resource to a friend via email or text.

Health Needs Assessment (HNA)

CareSource asks that all members complete the Health Needs Assessment (HNA). Through a few questions about their health and well-being, CareSource can help identify health, housing, education and employment concerns where we may be able to help.

CareSource wants members to complete an HNA when they join CareSource and each year after. Members answer questions about their health and habits. This tool helps identify members' health needs. It shows CareSource how they can help members get and stay healthier.

Completing the HNA is simple! Members can complete the HNA in one of the following ways:

- Visit CareSource MyLife at MyLife.CareSource.com/guest/find-my-assessment.
  - Click on the Health tab at the top of the navigation bar
  - Scroll and click on the 'Health Risk Assessment'
- Call our Member Assessment Team at **1-833-230-2094 (TTY: 711)** Monday through Friday, 8 a.m. to 5 p.m. CT

Tobacco Cessation Program

In an effort to help members maintain a healthy lifestyle, CareSource would like to remind providers of resources available for tobacco cessation. This includes not using tobacco products as well as prevention. The Tobacco Quitline aims to increase members' knowledge of the risks associated with tobacco use and the benefits of cessation. The program provides regular health coaching as well as information on how to obtain pharmacotherapy, from a provider, to assist with quitting. For more information, please contact the Tobacco Quitline at 1-800-QUIT-NOW (800-784-8669).

Mom and Baby Beginnings Team

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

Referrals to the Mom and Baby Beginnings program can be made via phone at **1-833-230-2034**, or email at **MBB@CareSource.com**.

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:

- Their MyLife account, where they can find health programs that focus fitness, nutrition, stress support and more. Members can complete activities that help them reach their health goals and support their well-being.
- Educational materials with helpful tips and information to manage their disease, promote self-management skills, and provide additional resources.
- One-to-one care management

Members with specific chronic conditions are identified by criteria or triggers such as emergency room visits, hospital admissions, and the health assessment. All ages (children, teens and adults) are eligible. These members are automatically mailed quarterly condition-specific newsletters. The materials are available in English and other predominant languages upon request. Any member may self-refer or be referred into the Disease Management Program to receive condition-specific information or outreach. If a member does not wish to receive newsletters or outreach, they can contact CareSource to update their contact preferences.

Disease Management Benefits to Members and Health Partners

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.

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

Emergency Department Diversion Program

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

We instruct members to call their PCP or our 24-Hour 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.

Member ED utilization is tracked closely. If there is frequent ED utilization, members are referred to our Case Management department for analysis or intervention. Members are contacted by phone or mail. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Interpreter Services

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

Immunization Schedule

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

Immunization Codes

Please bill CareSource with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. Please refer to the code tables located on the CMS website at www.cms.gov/medicare/coding-billing/icd-10-codes. You can also get CMS coding guidelines at www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

Health Education

CareSource members receive health and preventive care information and reminders from CareSource through a variety of communication vehicles including brochures, phone calls and personal interaction. CareSource MyLife gives members access to health, benefit and wellness content that can supplement education provided by their care team. Providers can also encourage members to use CareSource MyLife as an ongoing source of information and resources.



MEMBER GRIEVANCES AND APPEALS

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

Members can use CareSource MyLife to file and track grievances and appeals. They also may contact Member Services at **1-877-514-2442** with any questions they have about benefits, including any questions about coverage and benefit levels, annual deductibles, coinsurance, copayment and annual out-of-pocket maximum amounts, specific claims or services they have received, our network, and our authorization requirements.

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

Definitions and Responsibilities

For purposes of this section, the following definitions apply:

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

Authorization – a determination by us that a health care service has been reviewed and, based upon the information provided to us, are covered services.

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

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

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

Internal Appeal – the review by the Plan of an Adverse Determination.

Predetermination – An authorization that the member voluntarily requests prior to or during the course of receiving a health care service. We will review the COC to determine if there is an exclusion for the health care service. If there is a related clinical coverage guideline, then the benefit coverage review will include a review to determine whether the health care service meets the definition of medical necessity under this Plan or is experimental/investigative as that term is defined in this Plan.

Prior Authorization –An authorization that must be obtained prior to the member receiving a health care service.

Retrospective Medical Review – A review of whether a health care service that has already been received by a member is a covered service. A review may only be deemed a Retrospective Medical Review if our prior authorization was not required and a predetermination review was not performed. Retrospective Medical Reviews are typically initiated by us. Retrospective Medical Reviews do not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

Responsibilities

Providers should know which services require prior authorization and should obtain any required prior authorization or request a predetermination if they feel it is necessary. The ordering provider must contact us to request prior authorization or a predetermination review. We will work directly with Providers regarding such prior authorization request. However, the member may designate an authorized representative to act on their behalf for a specific request.

We will utilize our clinical coverage guidelines in determining whether health care services are covered services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

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

The Grievance Process

We have put in place a grievance process for the quick resolution of grievances submitted by the member to the Plan that are unrelated to benefits or benefit denials. For purposes of this grievances process, we define a grievance as an expression of unhappiness or dissatisfaction in writing, concerning any matter relating to any aspect of the Plan's operation. If the member has a grievance concerning the Plan, then the member may contact us.

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

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

Note: The Adverse Benefit Determination Appeal Process below addresses issues related to benefits, benefits denials or other Adverse Benefit Determinations. The Adverse Benefit Determination Appeal Process, described below, is separate and distinct from the grievance process.

Initial Benefit Determinations

In processing claims, the Plan reviews requests for (1) prior authorization, (2) predetermination and (3) retrospective medical review to determine whether requested health care services are covered services. This managed care process is described below. If the member has any questions regarding the information contained in this section, then the member may call Member Services at **1-877-514-2442**.

Providers should know which services require prior authorization and should obtain any required prior authorization or request a predetermination if they feel it is necessary. The ordering provider must contact us to request prior authorization or a predetermination review. We will work directly with providers regarding such prior authorization requests.

We will utilize our clinical coverage guidelines in determining whether health care services are covered services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

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

Categories of Prior Authorization, Predetermination and Medical Requests:

- **Urgent Review Request** – A request for review of any medical care or treatment where the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care of treatment that is subject of the review.
- **Prospective Review Request** – A request for prior authorization or a predetermination that is submitted prior to the member receiving a health care service.
- **Concurrent Review Request** – A request for authorization that is submitted during the course of receiving a health care service.
- **Retrospective Review Request** – A request for medical review that is submitted after the health care service has been received.

Timing of Initial Benefit Determinations

We will make our benefit decisions within the time frames set forth below. Please call Provider Services at **1-833-230-2101** with any questions.

Review Request Category	Time Frame for Making Decision
Urgent Review Request	CareSource has 72 hours to respond.
Prospective Review Request	Within 15 calendar days of our receipt of the request.
Concurrent Review Request	Within 24 hours from the receipt of the request.
Retrospective	30 calendar days from the receipt of the request.

Notification of Initial Benefit Determination

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

- **Verbal:** Oral notification given to the covered person via telephone (for urgent or concurrent requests only), followed by written notification.
- **Written:** Mailed letter or electronic means (including email and fax) given to, at a minimum, the requesting provider and the covered person or his or her authorized representative.

If we approve the request for benefits or health care services, then we will provide the member with notice of our decision. However, even if the Plan gives prior authorization for a health care service, such prior authorization does not guarantee that the Plan will provide benefits for such health care service. In order for the Plan to provide benefits for the health care service at issue:

- The member must be eligible for coverage under the Plan;
- The health care service must be a covered service;
- The member may not have exceeded any applicable limits described in this Certificate of Coverage (COC); and
- The health care service may not be subject to an exclusion under the Plan.

If we deny the request for benefits or health care services, then we will provide the member or their authorized representative with an Adverse Benefit Determination notice.

Internal Appeal Process

Adverse Benefit Determination Appeals

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

If the member or their authorized representative wishes to appeal an Adverse Determination, then the member or their authorized representative must submit the member's Internal Appeal to us within three (3) years of receiving the Adverse Determination. All Internal Appeal requests must be in writing, except for an Internal Appeal request involving Urgent Care, which may be requested in writing, electronically or orally by calling **1-833-230-2101**.

The member or their authorized representative may send a written request for an Internal Appeal of Adverse Determination to:

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

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

1. The covered person's name and identification number as shown on the ID card;
2. The provider's name;
3. The date of the medical service;
4. The reason the member disagrees with the coverage denial; and
5. Any documentation or other written information to support the member's request.

Internal Appeals

The Internal Appeal will be reviewed by the CareSource Grievance and Appeals Committee. This committee will evaluate the appeal along with all relevant information gathered during the investigation. The member and an authorized representative have the right to participate in the committee meeting by phone. The provider involved in the review will be a specialist who typically manages the medical condition, procedure or treatment in question. Additionally, the provider reviewing the internal appeal may conduct an interview with the member or the designated representative during the committee.

The plan will acknowledge receipt of the appeal. If additional information is needed, the plan may outreach to the member, authorized representative or provider requesting the information that is needed to review the appeal and the time frame for submission. Please note: in the case of urgent requests, there is limited time to submit information to the plan.

We will thoroughly review all submitted materials, and the CareSource Grievance and Appeals Committee will review the Appeal request and all of the relevant information collected. We will send the Committee's decision to the member in writing within 30 calendar days of our receipt of the member's Appeal.

If the Plan denies the member's Internal Appeal, then the Plan will notify the member or their authorized representative via a Final Adverse Determination notice. If we approve the request for benefits, then we will provide the member, their attending physician or their ordering provider with the appropriate notice.

Expedited Appeals

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

- Health care services or treatment where non-urgent time periods for making determinations:
  - Could seriously jeopardize the member's life or health or their ability to regain maximum function.
  - Except as provided below, whether a request meets the above conditions in order to be eligible for expedited Internal Appeal will be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

- Any claim that a physician with knowledge of the member's medical condition determines is a claim involving Urgent Care Services.
- Any Adverse Determination involving an admission, availability of care, continued stay or health care service where the member received emergency services, but have not been discharged from a facility.

We will complete an expedited appeal as soon as possible given the member's medical needs, but not later than 72 hours unless the resolution time frame is extended. The plan will make reasonable attempts to notify the member or authorized representative via phone of the expedited appeal outcome and will provide a written notice of the appeal decision.

Extending an Appeal

CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days only if more time is needed due to circumstances beyond our control or if the member or authorized representative requests an extension.

Exhaustion of the Internal Appeals Process

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

We agree to waive the exhaustion requirement when:

- The member did not receive a written decision of our Internal Appeal within the required time frame;
- We failed to meet all requirements of the Internal Appeal process unless the failure was minor and did not cause – and is not likely to cause – prejudice or harm to the member so long as the Plan demonstrates that the violation was for good cause or due to matters beyond our control and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the member. This exception will not be available if the violation is part of a pattern or practice of violations by the Plan; or
- An expedited External Review is sought simultaneously with an expedited Internal Appeal.

External Review Process

External Review of the Final Adverse Benefit Determination Notice

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

The member will not be subject to retaliation for exercising their right to request an independent External Review. External Reviews are conducted by MAXIMUS Federal Services.

A written request must be submitted to MAXIMUS Federal Services within four months of the date on the letter containing the appeal denial decision. The member or their authorized representative must request an External Review in writing. This can be done in the following ways:

Online submission: externalappeal.cms.gov/

Call: 1-888-866-6205

Mail: MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Fax: 1-888-866-6190

Email: ferp@maximus.com

Member Questions

The member may contact us by mail or phone. Please call Member Services at **1-877-514-2442**. The member may also send correspondence to:

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

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

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

Wisconsin Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Phone: (608) 266-0103
Toll Free: (800) 236-8517

Fax: (608) 264-8115

Online: oci.wi.gov/Complaints





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. 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 families.

Member rights are as follows:

- Receive information about CareSource, its services, its practitioners and providers and member rights and responsibilities.
- Be treated with respect and dignity by CareSource employees, contracted providers, vendors and health care professionals.
- Privacy and confidentiality regarding their health, their care and financial records.
- Participate with practitioners in making decisions about their health care.
- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or concerns about CareSource or any of its network providers.
- Appeal any decision made by CareSource and receive a response within a reasonable amount of time.
- Make recommendations regarding CareSource's member rights and responsibilities policy.
- Choose an advance directive to designate the kind of care they wish to receive should they become unable to express their wishes.
- Have a safe, secure, clean and accessible health care environment.
- Have access to emergency health care services in cases where a "prudent layperson" acting reasonably would believe that an emergency existed.

Members of CareSource are also informed of the following responsibilities:

- Comply with all provisions of the policy outlined in the Certificate of Coverage, including prior authorization requirements.

- Know and confirm their benefits before receiving treatment.
- Show their ID card before receiving health care services.
- Follow agreed upon instructions and guidelines for care.
- Understand their health problems and develop mutually agreed upon treatment goals, to the degree possible.
- Provide accurate information, to the extent possible, that CareSource and their practitioner require to care for them or to make an informed coverage determination.
- Use practitioners and providers affiliated with their health plan for health care benefits and services, except where services are authorized or allowed by their health plan or in the event of emergencies.
- Pay appropriate co-payments, coinsurance and deductibles to participating practitioners and providers when services are received.
- Pay charges incurred for non-covered services.
- Pay full charges for out-of-network services.

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 CGHC organization. The notice also informs members on how they may obtain a statement of disclosures or request their medical claim information. CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members.

As a provider, please remember to follow the same HIPAA regulations as a covered entity and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment, and health care operations. Thank you for your assistance in protecting member PHI.

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 Provider Portal at **CareSource.com** 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 the patient's health information on the Provider Portal.

Please encourage your CareSource patients who have not consented to complete a 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 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

The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications.

The CareSource provider network 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 section 1557 of the Affordable Care Act will maintain capacity to deliver services in a manner that accommodates the needs of its members.

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





CARESOURCE HEALTH AND SOCIAL PARTNERSHIPS

At CareSource, we are dedicated to the communities we serve and to making a positive impact in the lives of our members through the elimination of barriers in health care access and optimal health outcomes that adversely affect our members and partnering with community stakeholders to carry out this work.

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

In consideration of cultural differences, including religious beliefs and ethical principles, we will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the United States Department of Health and Human Services (HHS).

Cultural Competence

Cultural competence within CareSource is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population.” It is the use of a system’s perspective which values differences and is responsive to differences at all levels in an organization.

Cultural competence is developmental, community focused and family oriented. In particular, it is the promotion of quality services through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Participating providers are expected to deliver services in a culturally competent manner, which includes removing all language barriers to service and accommodating the unique ethnic, cultural and social needs

of the member. 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.

Providers can address gaps in health care with an awareness of cultural needs and improving communication with their growing numbers of diverse patients. CareSource recognizes cultural differences, including religious beliefs and ethical principles. In accordance with this, providers are not required to perform any treatment or procedure that is contrary to their religious or ethical principles.

CareSource does not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of the member who is his or her patient for the following:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
- Any information the Member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or non-treatment.
- The member's autonomy and right to participate in decisions regarding the member's health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- The member may be responsible for non-covered item(s) and/or service(s) only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received by the member that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the member will be financially responsible for the item(s) and/or service(s).

CLAS Standards: National Culturally & Linguistically Appropriate Standards

The Office of Minority Health (United States Department of Health & Human Services, 2018), created National Culturally and Linguistically Appropriate Standards (CLAS) to provide a blueprint for implementing culturally and linguistically appropriate services for health and health care organizations to:

- Support needs related to social drivers of health
- Improve quality
- Help eliminate barriers to care

CareSource recognizes language and cultural differences have the potential to negatively impact interactions between providers, members and employees.

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

- Principal Standard: Provision of effective, equitable, understandable and respectful quality care and services that are response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs
- Governance, Leadership and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement & Accountability Network providers must ensure that:
- Members understand that they have access to free medical interpreter services in their native language, including Sign Language. No cost TDD/TTY services are available to facilitate

communication with hearing impaired members. Health care is provided with consideration of the members' cultural background and how cultural norms and preferences 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. The 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 U.S. Department of Health and Human Services Office of Minority Health website. Their Cultural Competency Resources website found at: thinkculturalhealth.hhs.gov/ provides toolkits and educational resources. Included on the site is Culturally and Linguistically Appropriate Services – Think Cultural Health. This self-directed e-learning program equips providers to better understand and treat diverse populations.





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 uses a population health lens to monitor and evaluate the quality of the care and service delivered to our members emphasizing:

- Accessibility and availability to medical, behavioral health and other care
- Equitable delivery of service
- Quality of care and member safety
- Internal monitoring, review and evaluation of program areas, including but not limited to Utilization Management, Case Management 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
- Qualified Health Plan (QHP) Enrollee Experience Survey scores
- Member feedback captured via surveys, inclusion in advisory workgroups and collection by member facing employees
- Review of accessibility and availability standards
- Utilization trends

CareSource assesses our performance against goals and objectives that are in keeping with industry standards. Annually, we complete an evaluation of our QI Program. We submit the evaluation which includes identified priority areas for improvement and the degree to which improvement was achieved for each priority year to the appropriate accrediting bodies.

CareSource is fully accredited by NCQA for our Georgia, Indiana, Ohio, West Virginia and Wisconsin 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.

Provider Responsibility

In-network providers are contractually obligated to comply with the CareSource QI program and are expected to cooperate with and assist CareSource, other participating providers and members in adhering to all applicable laws, regulations and accreditation standards.

The key components of the QI Program with which participating providers are required to comply include (but are not limited to):

- Ensuring that care is appropriately coordinated and managed
- Cooperation with on-site audits and medical record requests
- Cooperate with the CareSource's QI activities which can include collection and evaluation of data and participation in the CareSource's QI programs
- Cooperation with the member grievance process (e.g., supplying information necessary to assess and respond to a grievance)
- Responding to inquiries by CareSource QI staff
- Allow CareSource to use practitioner/provider performance data

All network providers are required to cooperate with CareSource in the accurate and timely claims submissions and data sharing, which may include medical record reviews. CareSource collects performance data according to the HEDIS® and/or risk adjustment specifications and will work with providers to establish and maintain bi-directional data sharing processes.

Program Scope

CareSource supports an active, ongoing and comprehensive QI program across the organization. Performance goals are developed to measure the components of our program, including performance against national benchmarks.

CareSource uses HEDIS® as one method to determine the quality of care delivered to members. HEDIS® is one of the most widely used means of health care measurement in the United States. HEDIS® data collection and reporting is developed and maintained by NCQA. HEDIS® 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 research and address significant health priorities in the United States.

CareSource uses the annual member survey, Qualified Health Plan Enrollee Experience Survey (QHPEES), to capture how a member views the quality of health care received. The QHPEES is a program overseen by the United States Department of Health and Human Services–Agency for Healthcare Research and Quality (AHRQ). Potential measures include:

- Helpful and courteous customer service
- Getting care quickly, for example, getting timely care for an illness or an injury
- Ease of access in obtaining needed care
- Providers' ability to communicate and show respect to member
- Ratings of all health care, health plan, personal, doctor, and specialists

The CareSource Quality Improvement Program oversees quality assessment and performance improvement activities for our CGHC plan members to maintain a robust QI program.
Our scope includes:

- Support needs related to social drivers of health and help eliminate barriers to care.
- Ensure regulatory and accrediting agency compliance.
- Perform HEDIS® compliance audit and performance measurement.
  - Ensure compliance with NCQA accreditation standards.
  - Establish safe clinical practices throughout our network of providers.
  - Provide quality oversight of all clinical services, including addressing all quality-of-care concerns.
  - Advocate for members across settings, including review and resolution of quality-of-care concerns.
  - Meet member access and availability needs for physical and behavioral health care.

Using interventions for HEDIS® overall rate improvement to increase preventive care rates and facilitate support of member acute and chronic health conditions and other complex health, safety or welfare needs.

- CareSource uses the annual member QHPEES results and other enrollee experience surveys to assess member perspectives on health care quality and establishes interventions based on results to enrich member and provider experience and satisfaction.
- Use of the Institute for Healthcare Improvement (IHI) model for improvement methodologies and Six Sigma, where appropriate, to evaluate initiatives and effect change.
- Ensure CareSource is effectively serving our members with cultural and linguistic needs, as well as identified disparities that may impact member receipt of health care services and achieving positive member outcomes.
- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings ensure that CareSource is effectively serving members with complex health needs.
- Ongoing assessment of member population health characteristics.
- Regularly assess the geographic availability and accessibility of primary and specialty care providers
- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings.
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies.
- Conduct regular Provider Satisfaction Survey with results driving improvement initiatives and education development.

Our commitment to the QI program is aligned with Wisconsin's State Health Improvement Plan which sets goals for Wisconsin's public health system.

Quality Strategy

CareSource seeks to advance a culture of quality and safety that begins with our executive and senior leadership and is cultivated throughout the organization. CareSource utilizes the Institute of Healthcare Improvement (IHI) framework developed to optimize health system performance, as well as the CMS National Quality Strategy, which is a national effort to align public-and private-sector stakeholders to achieve better health and health care.

Institute for Healthcare Improvement Quintuple Aim for Populations

CareSource aligns with the IHI framework to:

- Enhance the experience and outcomes of the member
- Improve the health of populations
- Reduce the per capita cost of health care
- Improve provider satisfaction
- Support needs related to social drivers of health and help eliminate barriers to care

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 adheres to the following quality measures as part of our QI program:

- Achieve and maintain NCQA accreditation
- Assure compliance with NCQA accreditation standards
- Receive scores based on HEDIS® measures that reflect a high level of performance
- Receive scores on CMS Quality Rating System (QRS) based on HEDIS® measures that reflect a high level of performance
- Receive scores on Qualified Health Plan (QHP) Enrollee Survey that reflect a high level of performance
- Develop and maintain a Quality Improvement Strategy (QIS) as outlined by CMS
- Develop and maintain a comprehensive population health management program
- Develop and maintain a comprehensive provider engagement program
- Assure CareSource is meeting all state requirements for a quality improvement and management program CareSource continually assesses and analyzes the quality of care and services provided to our members through the use of objective and systematic monitoring and implementation of quality improvement initiatives.

Member Health, Safety and Welfare

CareSource recognizes that patient safety is the cornerstone of high-quality health care, contributing to the overall health and welfare of our members. Our CareSource Patient Safety program evaluates patient safety trends with the goal of reducing avoidable harm. Our patient safety program is developed in the context of our population health management approach and includes regulatory/accreditation, policies and procedures, training and implementation, continuous monitoring and program evaluation and improvement. Safety events are monitored through retrospective review of quality-of-care concerns and real-time reporting of claims data. Data analysis of our provider and health system network ensures situational risks can be identified in a timely manner, reviewed, and mitigated by proactive corrective action or performance improvement steps.

Clinical Practice Guidelines and Preventive Guidelines

CareSource approves and adopts evidence-based nationally accepted standards and guidelines and promotes them to practitioners and members to help inform and guide clinical care provided to members.

Member health resources are available in their CareSource MyLife account **(MyLife.CareSource.com)** and on the website and cover a broad range of wellness, preventive health and chronic disease management topics. The guidelines are reviewed quarterly and updated, if indicated. They may be found at **CareSource.com** > Providers > Education > Patient Care > Health Care Links.

These guidelines assist in improving member health outcomes. Review and approval of the guidelines are completed by the CareSource Provider Advisory Committee (PAC) and Enterprise PAC. The Quality Enterprise Committee (QEC) is notified of guideline approval. Topics for guidelines are identified through analysis of Marketplace plan members. Guidelines may include, but are not limited to:

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

Guidelines may be promoted to practitioners and providers through 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 may be made available to members via member newsletters, the CareSource member website or upon request.

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

Medical Records

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.

Providers are required to maintain member records on paper or in an electronic format. Member medical records shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records and other documentation sufficient to disclose

the quantity, quality, appropriateness and timeliness of services provided under the contract. Medical records shall be signed by the provider of service.

The medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information, on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school name and telephone numbers (if no phone, contact name and number) of emergency contacts, consent forms, identification of language spoken and guardianship information
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions and known allergies noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses (for children, past medical history includes prenatal care and birth information, operations and childhood illnesses [e.g., documentation of chickenpox])
- Identification of current problems
- The consultation, laboratory and radiology reports in the medical record shall contain the ordering provider's initials or other documentation indicating review
- Documentation of immunizations
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or the Department for Public Health
- Follow-up visits provided and (secondary) reports of emergency room care
- Hospital discharge summaries
- Advance medical directives, for adults
- All written denials of service and the reason for the denial
- Record legibility to at least a peer of the writer (records judged illegible by one reviewer shall be evaluated by another reviewer)

A member's medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's physical/behavioral health, including mental health and substance abuse status
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services addressed from previous visits
- Plan of treatment including:
  - Medication history, medications prescribed, including the strength, amount, directions for use and refills
  - Therapies and other prescribed regimen
  - Follow-up plans including consultation and referrals and directions, including time to return

- A member's medical record shall include the following minimal detail for hospitals and mental hospitals:
  - Identification of the beneficiary
  - Physician name
  - Date of admission and dates of application for and authorization of Medicaid benefits, if application is made after admission; the plan of care (as required under 42 CFR 456.172 (mental hospitals) or 42 CFR 456.70 (hospitals)
  - Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)
  - Reasons and plan for continued stay if applicable
  - Other supporting material the committee believes appropriate to include
- For non-mental hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable



Access Standards

CareSource promotes access to care by partnering with health care providers to 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 time frames and to offer 8 a.m. 5 p.m. Monday through Friday CT to their CareSource patients that are no less (in number or scope) than the 8 a.m. 5 p.m. Monday through Friday CT offered to non-CareSource members.

Primary Care Providers

Appointment Type	Marketplace Standard[1]
Routine/Preventive Visit	Not to exceed 15 business days
Urgent Care*	Within 48 hours
Emergency Care	Immediately upon presentation

[1] Providers should see members as expeditiously as the member's condition and severity of symptoms warrant.

For Primary Care (PCP) and Behavioral Health* Providers only: Provide 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PCP or a back-up 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.**

* BH providers may refer their patients to the 988 Suicide & Crisis Hotline if a provider is not available for the call.

Non-PCP Providers (Specialists)

Appointment Type	Marketplace Standard[1]
Routine Specialist Care	Within 30 business days
Urgent Care Providers	Within 48 clock hours
Emergency Care	Immediately upon presentation

Behavioral Health (BH) Providers, Prescribing and Non-Prescribing

Appointment Type	Marketplace Standard[1]
Initial Visit for Routine Care	10 business days
Follow-Up Routine Care	30 calendar days
Urgent Needs	48 hours
Non-Life-Threatening Emergency	Not to exceed 6 hours
Emergency Needs	Seen immediately

Dental Providers

Appointment Type	Marketplace Standard[1]
Regular/Routine Care	6 weeks
Urgent Needs	48 clock hours

It is expected that if a provider is unable to see the member within the appropriate time frame, 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. CareSource follows the State of Wisconsin statute regarding continuity of care (§609.24, Wis. Stats.), as well as those required by applicable accreditation bodies.

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

Provider Changes

Our Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Providers > Provider Portal, entering your login credentials and selecting Provider Maintenance from the left-hand navigation. For more information on this process, go the **"Submitting Provider Changes"** section of this manual.

Quality of Care Reviews

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

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

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

All providers are expected to return medical record requests related to quality-of-care concerns within 14 days from initial receipt of the request, unless otherwise defined by program guidelines or state or federal law requirements. If a state, federal or regulatory agency, or if the health and safety of a member requires that medical records must be submitted under a shorter time frame, 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 time frame 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.

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 see below 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

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 Provider Portal.
- The dispute must be submitted within the time frames for adjustments to payments as specified within your Provider Agreement or if you are a non-participating provider, within 90 calendar days of the date the claim was initially paid and/or processed.

Appeal of Claim Denials

If you do not agree with the decision of the processed claim or dispute, you will have the timely filing guidelines expressed in your agreement with CareSource to file a claim appeal. If the appeal is not submitted in the required time frame, the claim will not be considered, and the appeal will be denied. If the appeal is denied, providers will be notified in writing. If the appeal is approved, payment will show on the provider's Explanation of Payment (EOP).

Please Note: If you believe the claim processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim; you do not need to file an appeal. Providers are subject to the timely claims filing guidelines expressed in your agreements with CareSource.

How to Submit Appeals

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

Online

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

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

Writing

Use the "Standard Appeal Form" located at **CareSource.com** > Providers > Forms. Please include:

- The member's name and the CareSource member ID number.
- The provider's name and ID number, located in your provider welcome number.
- The code(s) and reason why the determination should be reconsidered.
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or electronic data information (EDI) for reconsideration.

- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.

CareSource Provider Medical Necessity Appeals

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 for a review of an Adverse Benefit Determination.

Timeline for Medical Necessity 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 on behalf of a member with written authorization from the member – within three years from the receipt of the Notice of an Adverse Benefit Determination.
- Member – three years from the receipt of the Notice of an Adverse Benefit Determination.

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 three years and will be resolved within 30 calendar days of receipt or as expeditiously as the member's condition warrants for pre-service appeals and 30 calendar days for post-service appeals. Appeals on behalf of the member must include written authorization to appeal on the member's behalf.

Expedited Appeals

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

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

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

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

Notification of Resolution

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

Extending an Appeal

CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days only if more time is needed due to circumstances beyond our control.

Dissatisfaction of Medical Necessity Appeals – Member External Reviews

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

Opportunity for External Review

You may use the "Standard Appeal Form" located at **CareSource.com** > Providers > Forms, but this form is not required. Appeal requests should include:

- The member's name, CareSource member ID number and date of birth
- The provider's name and CareSource provider billing number
- The place, date and type of service that had a non-certification determination for clinical appeals
- The reason why the determination should be reconsidered
- Any additional available medical information to support your reasons for reversing the determination
- Written authorization from the member allowing you to file the appeal on their behalf

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

All appeal requests and associated information are reviewed by the Grievance and Appeals Committee, which includes a clinician previously uninvolved with the case. You will be notified in writing of the outcome of your appeal request.

How to Submit Medical Necessity Appeals

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

Online:

CareSource.com > Providers > Provider Portal

Fax:

Standard Appeals/Disputes: 1-937-396-3492
Expedited Appeals: 1-937-396-3507

In Writing:

CareSource
Attn: Provider Appeals – Clinical
P.O. Box 1025
Dayton, OH 45401-1025



PRIMARY CARE PROVIDERS

Primary Care Provider Concept

All members may, though are not required to, choose a PCP upon enrollment in the plan. PCPs should help facilitate a medical home for members. This means that PCPs will help coordinate health care for the member and provide additional health options to the member for self-care or care from community partners.

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

Primary Care Provider Roles and Responsibilities

PCP care coordination responsibilities include the following:

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

Primary Care Providers are responsible for:

- Treating CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plan and Wisconsin Department of Community Health.
- 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.
- Use best commercial efforts to collect required copayments for services rendered to applicable members.
- Ensuring demographic and practice information is up to date for directory and member use.
- Reporting suspected fraud and/or abuse.

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

Prenatal and Postpartum Care Documentation

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

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

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered as needed. CareSource endorses the same recommended childhood immunization schedule that is recommended by the Center for Disease Control and approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (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 to 15 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/24-Hour Access

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



Expectations of Participating Providers

- 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"** section of this manual.

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

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

Submitting Provider Changes

Type of Visit	Notice Required Please notify CareSource of the change prior to the time frames 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

Advance written 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. Ways to submit changes include:

Provider Portal *preferred method:*	**Fax:**	**Mail:**
Information updates can be submitted on the CareSource Provider Portal at **CareSource.com** > Providers > Provider Portal.	937-396-3076	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.

Please contact our Provider Services team at **1-833-230-2101** if you have any questions.

Provider Directory Information Attestation

State and Federal regulations require Health Plans to validate and update published information regarding their contracted provider network monthly. This validation ensures we have the most accurate information for claims payment and provider directories. 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. **Providers are required to attest to directory information every 90 days.**

Accurate provider directory information ensures we can connect the **right patients** to the **right provider**.

Quest Analytics & BetterDoctor

BetterDoctor is the Quest Analytics Accuracy solution that outreaches to providers to collect attestations for CareSource. The goal is to improve the quality of provider data. BetterDoctor is performing this outreach for us to providers like you, to ensure our provider directory is as accurate as possible. All outreach efforts are made under the BetterDoctor name.

What happens if I do not attest to my information?

CMS require health plans to verify the accuracy of provider directory information every 90 days. Not attesting to your information and/or providing updated information when applicable can result in claims payment issues and inaccurate provider data in our online and printed directories. With the No Surprises Act in effect as of January 1, 2022, providers who do not attest quarterly risk being suppressed in impacted provider directories.



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 Payment is 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. CareSource has the right to recoup improper payments.

Examples of Fraud, Waste and/or Abuse

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.

Note: This is not an all-inclusive list.

Examples of Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower Medicaid/Medicare reimbursement rates
- Billing for services not provided
- Requiring members to pay for CareSource covered services
- 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
- Not checking member ID numbers, resulting in claims submitted for non-covered persons
- 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
- Billing drugs for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark Law violations
- Not reporting overpayments or overbilling including those made in error by CareSource
- Preventing members from accessing covered services resulting in underutilization of services offered
- Failing to comply with federal and/or state laws

Note: This is not an all-inclusive list.

Examples of Pharmacy Fraud, Waste and/or Abuse:

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

Note: This is not an all-inclusive list.

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

Note: This is not an all-inclusive list.

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

Examples of Vendor Fraud, Waste and/or Abuse:

- Falsifying business reports
- Not reporting or acting 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

Note: This is not an all-inclusive list.

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.
It is important for you to tell us if a CareSource stakeholder acts inappropriately.

Corrective Actions

The CareSource Program Integrity department routinely monitors for potential fraud, waste and abuse. We review claims data and medical records to look for billing discrepancies. When found, an investigation is initiated and, if warranted, corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension

- Recovery of overpaid funds
- Member disenrollment
- Contract termination
- Employee disciplinary actions
- Reporting to one or more applicable state and federal agencies
- Legal actions

Refer to your Provider Agreement for specific information on each type of provider termination/suspension. Also, refer to the Provider Participation Plan for information on the appeal process. The CareSource Provider Participation Plan is available at **CareSource.com** > Providers > Provider Resources > Provider Disputes or Appeals. The "Provider Participation Plan" provides information on an appeal process for specific corrective actions.

Network providers are to report and return to CareSource any overpayment as soon as identification occurs and/or within the time frames specified in your Provider Agreement or according to state and federal requirements. Providers must 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* present, or cause to be presented, a false or fraudulent claim for payment or approval
- Knowingly* make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim
- Conspire to commit a violation of any other section of the False Claims Act
- Have possession, custody or control of property or money used, or to be used, by the government and knowingly deliver, or cause to be delivered, less than all of that money or property
- Are 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, make or deliver the receipt without completely knowing that the information on the receipt is true
- Knowingly* buy, or receive 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* make, use, or cause 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 conceal or knowingly and improperly avoid or decrease 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 of the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.

Wisconsin-Specific False Claims Act:
While Wisconsin has not passed its own false claims statute, there is liability under various Wisconsin laws regarding false or fraudulent claims, including:

a) Fraudulent Insurance Acts, Wisconsin Statute 601.41(12): no person may commit a fraudulent insurance act. The commissioner may refer results of fraud investigations to the Department of Justice or District Attorney.

b) Fraudulent Insurance and Employee Benefit Program Claims, Wisconsin Statute 943.395: establishes criminal penalties for false claims.

c) Compliance Program Requirements, Wisconsin Administrative Code Insurance 9.42: requires insurers to establish and operate compliance programs.

Protection for Reporters of Fraud, Waste or Abuse (Whistleblowers)

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. Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement.

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 five percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us immediately by emailing Provider Maintenance at **ProviderMaintenance@CareSource.com**.

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 providers are subject, and in accordance with accepted practices.

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:** 1-844-415-1272
- **Write:** CareSource
  Attn: Program Integrity
  P.O. Box 1940
  Dayton, OH 45401-1940
- **Web Reporting Form:** secure.ethicspoint.com/domain/media/en/gui/78536/index.html

Options for Reporting That Are Not Anonymous:

- **Fax:** 1-800-418-0248
- **Email:** Fraud@CareSource.com

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

*Most email systems are not protected from third parties. Please do not use email to send confidential information. If you will be sending confidential or health information, please use the form or phone number to report your concerns to help protect your privacy.

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.

CMS provides training on their website.

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



FREQUENTLY ASKED QUESTIONS

How can I reach CareSource?

Call Provider Services at **1-833-230-2101** to reach CareSource. Provider Services is available Monday through Friday from 8 a.m. to 5 p.m. CT.

How do I check member eligibility?

It is important to verify member eligibility before providing services. Patients must be eligible CareSource members at the time of service in order for services to be covered. CareSource offers several ways to check member eligibility, including by phone or our secure Provider Portal.

How do I submit a claim?

CareSource accepts paper and electronic claims. We encourage you to submit electronic claims for quicker processing. Please see the **"Claim Submission"** section of this manual for more information.

How do I optimize my claim payment time frame?

Claims submitted electronically are typically received and processed more quickly than paper claims. Providers may submit claims electronically through the CareSource Provider Portal or through Electronic Data Interchange (EDI) clearinghouses listed in the **"Claim Submission"** section on of this manual.

For paper claim submissions, we require the most current form versions as designated by the Centers for Medicare & Medicaid Services (CMS), National Uniform Billing Committee (NUBC) and the American Dental Association (ADA). We cannot accept handwritten claims or superbills.

How do I file a claim appeal?

We hope you will be satisfied with CareSource and the service we provide. However, providers who are unhappy with CareSource's action concerning a medical necessity decision or a claim payment may appeal it. Please see our **"Member Grievances and Appeals"** section of this manual for more information.

How do I obtain a prior authorization?

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

Online: Visit **CareSource.com** and select the Provider Portal option from the menu

Phone: 1-833-230-2101 and follow the appropriate menu prompts for the authorization requests, depending on your need.

Fax: Fax the prior authorization form to 866-930-0019 or 888-399-0271 for drugs under medical benefit. The Prior Authorization Form can be found on **CareSource.com** > Providers > Forms.

How do I file a claim appeal?

We hope you will be satisfied with CareSource and the service we provide. However, providers who are unhappy with CareSource's action concerning a medical necessity decision or a claim payment may appeal it. Please see our **"Member Grievances and Appeals"** section of this manual more information.

What benefits does CareSource offer its members?

Please visit the CareSource website at **CareSource.com** for information on services, the member's coverage status and other information about obtaining services.

CareSource

CareSource.com

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