

Provider Appeals Procedures



Appeals of Claims Denials or Adverse Decisions

If you do not agree with the decision of the processed claim, you will have 365 days from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required 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 have 365 days from the date of service or discharge to submit a corrected claim.

How to Submit Appeals

Claims Appeals:

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

Provider Portal: <https://providerportal.caresource.com/OH/>

Under the Provider Portal, click on the "Claims Appeals" tab on the left.

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

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

CareSource

Attn: Provider Appeals
P.O. Box 2008
Dayton, OH 45401-2008

Fax: (937) 531-2398

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.

CareSource Medicaid Provider Appeals/Clinical Appeals

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

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

Timeline for Clinical Appeals

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

- Provider – within 180 days from the date of denial, date of discharge or date of service
- Provider on behalf of a Member with written authorization from the Member – within 90 days of receipt
- Member – within 90 days of receipt

Additional Details about Clinical Appeals

Timing for Medical Necessity Appeals

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

Appeals Filed on Behalf of the Member

Medical necessity appeals filed by Members or Providers on behalf of a Member must be submitted to CareSource within 90 days and will be resolved within 15 calendar days of receipt or as expeditiously as the Member's condition warrants. Appeals on behalf of the Member must include written authorization to appeal on their behalf. All other medical necessity appeals will be resolved within 30 calendar days of receipt.

Expedited Appeals

An expedited appeal should be considered if the Provider feels that the patient's life or health is at risk if a decision about care is not made in a timely manner. Requests may be a verbal request and should be submitted to the Grievance and Appeals Department by calling **1-800-488-0134**.

CareSource will make a determination within one (1) working day of the expedited appeal request whether to expedite the appeal resolution. CareSource will make reasonable efforts to provide prompt verbal notification to the Member of the decision to expedite or not expedite the appeal resolution. This attempt will be made by phone. If the Member is in a facility, the Provider or facility will be notified on the same business day of the decision. The Member will be informed of the limited time available for presentation of evidence and allegations of fact or law in person or in writing.

The Member and Provider will be notified in writing of the determination to process as a standard appeal within two (2) calendar days of receipt of the appeal, including information that the Member can appeal the decision. In the event that CareSource denies the request for an expedited appeal, the appeal will be resolved within 15 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

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

Expedited appeals will be resolved and verbal notification will be made within 72 hours of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution time frame is extended.

Notification of Resolution

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

Extending an Appeal

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

Dissatisfaction of Medical Necessity Appeals – One Level of Appeal

If you are dissatisfied with any medical necessity decision made by CareSource, we offer one level of appeal as mandated by ODM. Members have the right to a state hearing as a first or second level of appeal (See "State Hearings" in the "Member Support Services and Benefits" section of this manual for more information).

You may use the "Provider Appeal Request Form" on www.caresource.com to submit your appeal, but this form is not required.

If you are dissatisfied with any medical necessity decision made by CareSource, we offer one level of appeal as mandated by ODM.

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

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

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

Retrospective Reviews

Services not previously reviewed for medical necessity are categorized as retrospective reviews and are reviewed and determination is made by the Medical Management Department within 30 calendar days of receipt. (Please see "Retrospective Reviews" in the "Referrals and Prior Authorization" section for more details.)

How to Submit Clinical Appeals

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

Provider Portal: <https://providerportal.caresource.com/OH/>

Fax: 937-531-2398

Writing: CareSource
Attn: Provider Appeals – Clinical
P.O. Box 1947
Dayton, OH 45401-1947

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CareSource Advantage Provider Appeals/Clinical Appeals

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

Clinical Appeals submitted by or for the CareSource Advantage member follows the same process as the Medicaid process (see above process).

For appeals on behalf of the Member, please refer to the CareSource Advantage Member's Evidence of Coverage. The Evidence of Coverage is located on our website at www.caresource.com. Search "Evidence of Coverage."

Level 1: Appeal – Reconsideration

A Member starts the appeal process by making an appeal. It is called the first level of appeal or a Level 1 Appeal.

Level 1 Appeal Details

The Member contacts CareSource Advantage and makes the appeal. If their health requires a quick response, they must ask for an expedited appeal. To start an appeal, the Member, their representative or in some cases their Provider must contact CareSource Advantage. Appeal requests must be within 60 calendar days from the date on the written notice sent concerning a coverage decision. If the Member wishes, their Provider may give additional information to support the appeal.

A standard appeal must be in writing and completed within 30 calendar days after being received by CareSource Advantage.

Expedited Appeal

An expedited appeal can be a verbal or written request and must be completed within 72 hours after being received by CareSource Advantage.

Level 2: Independent Review Entity – IRE

If CareSource Advantage says no to the Level 1 Appeal, the case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision

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made during the first appeal. This organization decides whether the decision made should be changed.

Steps of the Level 2 Appeal Process

Step 1: The Independent Review Organization reviews the appeal. The Independent Review Organization is an outside independent organization that is hired by Medicare. This organization is not connected with CareSource Advantage and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work. CareSource Advantage will send information about the appeal to this organization. This information is called the “case file.” The Member has the right to ask for a copy of the case file. The Member has a right to give the Independent Review Organization additional information to support their appeal. Reviewers at the Independent Review Organization will take a careful look at all of the information related to the appeal. If there was an “expedited” appeal at Level 1, there will also be an “expedited” appeal at Level 2.

Level 3: Administrative Law Judge – ALJ

The notice received from the Independent Review Organization will tell the Member in writing if the case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage being requested must meet a certain minimum. If the dollar value of the coverage being requested is too low, the Member cannot make another appeal, which means that the decision at Level 2 is final.

Level 4: The Medicare Appeals Council

The Medicare Appeals Council will review the Member’s appeal and give the Member an answer. The Medicare Appeals Council works for the federal government.

If the Member’s Level 4 appeal is approved, or if the Medicare Appeals Council denies CareSource Advantage’s request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over. CareSource Advantage will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), CareSource Advantage has the right to appeal a Level 4 decision that is favorable to the Member. If CareSource Advantage decides not to appeal the decision, CareSource Advantage must authorize or provide the Member with the service within 60 days after receiving the Medicare Appeals Council’s decision. If CareSource Advantage decides to appeal the decision, CareSource Advantage will let the Member know in writing.

If the Member’s Level 4 appeal is denied or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over.

If the Member decides to accept this decision, the appeals process is over. If the Member does not want to accept the decision, the Member might be able to continue to the next level of the review process. If the Medicare Appeals

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Council says no to the Member's appeal, the notice the Member receives will tell the Member whether the rules allow the Member to go on to a Level 5 Appeal. If the rules allow the Member to go on, the written notice will also tell the Member who to contact and what to do next if the Member chooses to continue with the next level of review.

Level 5: A Judge at the Federal District Court

A judge at the Federal District Court will review your appeal if permitted based on the Level 4 response. This is the last stage of the appeals process.