2015 INDIANA CareSource Just4Me™ Health Partner Manual

CareSource™
Health Care with Heart

Health Partner Quick Start Guide

You can instantly verify member eligibility, determine covered services, check the status of claims, and more through our CareSource® **Provider Portal** and other online tools. Get started now. Register for the Provider Portal at **https://providerportal.caresource.com**. You must be credentialed with CareSource to create an account. When registering, use your Provider Group name **exactly** as it appears on your CareSource Just4Me welcome letter.

TASK TO COMPLETE	HERE'S HOW
Verify Member Eligibility	**Always** verify member eligibility before rendering services. • Log in to Provider Portal. • Click on Member Eligibility (first tab on left). • NOTE: If a member is behind in premium payment, you will see an alert. A health partner who renders services to this member may be required to invoice the member for payment. • Or, verify eligibility through eligible EDI Clearinghouses (including Emdeon, Relay Health and Dorado Systems).
Verify Covered Services, Prior Authorization Requirements*, Coverage Limits	• Log in to Provider Portal. • On the main portal page, click on CareSource Just4Me Covered Services and Prior Authorization Requirements. • Or, view the appropriate Evidence of Coverage or Medical, Dental and Vision Quick Reference Guides.
Verify Coinsurance, Deductible, Maximum Out of Pocket	• Log in to Provider Portal. • Click on Member Eligibility, and then select Member Financial Responsibility. • Or, verify through EDI Clearinghouses • Member must meet deductible before coinsurance applies, unless noted by plan. • Collect deductible at time of service or wait until receipt of Explanation of Payment (EOP).
Verify Copayment	• Log in to Provider Portal. • Click on Member Eligibility, and then select Member Financial Responsibility. • Or, check copayment amount on member ID card. • Collect copayment at time of service.
Make a Referral to a Network Provider**	• Use the Find a Doctor/Provider Quick Link on CareSource.com. • See page 69 of this document.
Submit a Claim	• Refer to the Health Partner Quick Reference Guide at: **https://www.caresource.com/providers/indiana/just4me/provider-resources/** • Or, see page 5 of this document.
Check Claim Status	• Log in to Provider Portal. • Under Member Search, click on Claim Information. • Search by member ID or claim number to see list of claims. • To see line item detail for a specific claim, click on View Details.

***For 2015, prior authorization requirements for diagnostic tests have changed. Always check prior authorization requirements before rendering services.**

**CareSource Just4Me has no routine out-of-network benefits. To be paid for serving a member, a health partner must be under contract with CareSource Just4Me in the member's state of residence. Before referring patients to specialists for testing or procedures, please check our health partner network using the online Find a Doctor/Provider search tool; a health partner's contracted state(s) will appear next to "Program(s)."

If you need additional assistance, please call Provider Services at **1-866-286-9949**, Monday through Friday, 8 a.m. to 6 p.m. Eastern Standard Time (EST).

This content has been reviewed. However, changes and/or revisions occur frequently and health partners should check our website at CareSource.com for the most current policies and procedures.

CareSource™

Dear CareSource Just4Me™ Health Partner,

Thank you for your participation. CareSource values our relationships with our health partners and is actively working to strengthen our relationship and make it easier for you to deliver quality care to our members.

CareSource has a 25-year history providing Medicaid, Medicare and other managed health care services. We also offer CareSource Just4Me™. **CareSource Just4Me is a Qualified Health Plan issuer in the Health Insurance Marketplace.**

CareSource Just4Me™ members pay any premiums and cost-sharing amounts (deductibles, coinsurance, copayments, etc.) that apply to their coverage and based on their level of income. **Since we have purposely focused on the uninsured, we designed our CareSource Just4Me™ plans with low copayments and deductibles to improve access and reduce uncompensated care.**

The CareSource Just4Me™ Health Partner Manual is intended as a resource for working with our health plan. The manual communicates policies and programs and outlines key information such as claims submission, reimbursement processes, authorizations, member benefits and more to make it easier for you to do business with us.

CareSource communicates updates to our health partner network regularly on our secure provider portal. The most up-to-date information can be found on the CareSource Provider Portal at **https://providerportal.caresource.com/IN/**.

All health partners have an assigned Provider Relations Representative who can help with questions on policy changes, claims or new initiatives. Also, you can reach a member of our External Provider Relations Management Team if you have questions or concerns.

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

Sincerely,

CareSource

Table of Contents

About CareSource Just4Me™

Welcome

We strive to work with our health partners to ensure that we make it easy to do business with us. This strong partnership helps facilitate a high quality of care and respectful experience for our members.

CareSource Just4Me™ is a qualified health plan offered through the Health Insurance Marketplace. CareSource Just4Me™ members:

- Have access to affordable, high-quality health insurance options with no limits due to pre-existing conditions or annual benefit caps
- Are responsible for any deductibles, coinsurance, or copayments that apply to their coverage
- May receive reduced premiums or cost-sharing amounts based on their income

CareSource is a non-profit organization with a 25-year history of serving the health insurance needs of our members. We also offer Medicaid and other managed health care coverage to more than one million members with high member satisfaction rates. We are focused more on people than profits. CareSource Just4Me™ continues the CareSource history of making health care coverage easy to understand and access – it's **Health Care with Heart!**

Our goal is to create an integrated medical home for our members. We focus on prevention and partnering with local health care partners to offer the services our members need to remain healthy. As a managed health care organization, we improve the health of our members by utilizing a contracted network of high-quality participating health care partners.

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

- New members
- Existing members
- New practitioners
- Existing practitioners

About Us

CareSource was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a non-profit, we are mission-driven to provide quality care to our members.

CareSource was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers.

Vision and Mission

- Our **Vision** is transforming lives through innovative health and life services.
- Our **Mission** is to make a lasting difference in our members' lives by improving their health and well-being. At CareSource, our mission is one we take to heart. In fact, we call it our "heartbeat." It is the essence of our company, and our unwavering dedication to our mission is the hallmark of our success.

Our Services

- Provider relations
- Provider services
- Member eligibility / enrollment information
- Claims processing
- Credentialing / recredentialing
- Data analysis
- Quality improvement
- Regulatory
- Compliance
- Special investigations for fraud, waste and abuse
- Member services, including a member call center and a 24-hour nurse triage line

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

- Low, medium and complex Case Management – "No wrong door" referral intake
- Telephonic Case Management
- Disease Management
- Preventive health and wellness assistance with focused health needs/risk assessment
- Emergency Department diversion
  – High Emergency Department utilization focus (targeted at members with frequent utilization)
- CareSource 24 (nurse advice line)
- Maternal and child health
  – Comprehensive prenatal, postpartum and family planning services
  – Outreach programs in partnership with community agencies to target members at greatest risk for preterm birth or complications
- Care Transitions
  – Bridge to Home® (discharge planning and transitional care support)
- Behavioral health and substance abuse – Lock-in programs (targeted at members who are over-utilizing pharmacy benefits and locks them into key health partners to control inappropriate use)
- Comprehensive resource guide
- Collaboration with pharmacy and Medication Therapy Management

For more information on these programs, see the "Member Support Services and Benefits" section.

Service Areas
CareSource Just4Me™ serves members in the following Indiana counties:

Blackford	Hendricks	Orange
Boone	Henry	Scott
Clark	Johnson	Shelby
Delaware	LaPorte	Starke
Franklin	Lawrence	Tippecanoe
Hamilton	Marion	Tipton
Hancock	Monroe	White
Harrison	Morgan	

The CareSource Foundation
CareSource gets actively involved in the communities that we serve, from employees serving on hundreds of nonprofit boards to The CareSource Foundation investing more than $10 million in Ohio communities since its inception. We listen, we learn and we are driven to action. As a result, The CareSource Foundation was launched in 2006 to add another component to our professional services – community response. Areas of focus are closely aligned with the greatest needs of our member demographics. Areas of emphasis include: children's health, special populations such as seniors and individuals with disabilities, the uninsured, and life issues such as hunger, domestic violence and homelessness. While CareSource is committed to serving the communities in which we serve, at this time, the CareSource Foundation is currently providing funding only within Ohio.

The Foundation has responded at significant levels and created strategic partnerships with hundreds of non-profit organizations and other charitable funders who are equally committed to better health for all communities. We are addressing tough issues together.

Compliance and Ethics

At CareSource, we serve a variety of audiences — members, health care partners, government regulators, and community partners. We serve them best by working together with honesty, respect and integrity. We are all responsible for complying with all applicable state and federal regulations along with applicable CareSource policies and procedures.

At CareSource, we serve a variety of audiences – members, health care partners, government regulators, and community partners.

CareSource is committed to conducting business in a legal and ethical environment. A compliance plan has been established to:

- Formalize CareSource's commitment to honest communications within the company and within the community, inclusive of our health partners, members and employees
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state and federal laws and regulations
- Implement a system for early detection and reporting of noncompliance with laws, regulations, and fraud, waste and abuse concerns or noncompliance with CareSource policies or professional, ethical or legal standards
- Allow us to resolve problems promptly and minimize any negative impact on our members, community partners or our business, such as financial losses, civil damages, penalties and sanctions

General Compliance and Ethics Expectations of Health Partners

- Act according to professional ethics and business standards.
- Let us know about suspected violations, misconduct or fraud, waste and abuse concerns by reporting them to us.

- Cooperate fully with any investigation of an alleged, suspected or detected violation of applicable state or federal laws and regulations.
- Let us know if you have questions or need guidance for proper protocol.

For questions about health partner expectations, please call your Provider Relations Representative or call Provider Services at **1-866-286-9949**.

The CareSource Corporate Compliance Plan is posted on the CareSource website at **CareSource.com** for your reference. We appreciate your commitment to compliance and ethics standards and reporting of any identified or alleged violation of such matters.

Personally Identifiable Information
In the day-to-day business of patient treatment, payment and health care operations, CareSource and its health partners 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 that PII be appropriately protected wherever it is stored, processed and transferred in the course of conducting normal business. As a health partner, you should be taking measures to secure your sensitive health partner data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure protected health information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a Few Important Places to Start
- Utilize a secure message tool or service to protect sensitive data sent by email.
- Paper copies of PHI and PII should be limited and only viewable by those who have a business reason to view it. When no longer needed, it must be shredded.
- Encrypt laptop hard drives and other portable media like CD-ROMs and USB flash drives.
- Ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program, and understand the importance of safeguarding patient information.

There may be times when we share patient information with you or ask you to share with us. CareSource, like you, is a covered entity as defined by HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment, or health care operations.

Accreditation

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for Ohio Medicaid. We also earned NCQA Accreditation status for our CareSource Just4Me™ plan. NCQA is a private, non-profit 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.

We also earned Accredited NCQA Accreditation status for our CareSource Just4Me™ plan.

CareSource is accredited by URAC for the Health Call Center Accreditation standards. URAC, an independent, non-profit organization, is known as a leader in promoting health care quality through its accreditation and certification programs.

Claims Submissions

NOTE:

CareSource Just4Me™ is a commercial product. As with other commercial health plans, members will be responsible for copays, coinsurance and deductibles. Health partners 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. **For expedited claims processing and payment delivery, please ensure the address(es) and phone number(s) on file with CareSource are up to date.** You can send an email to **providermaintenance@caresource.com** to update this information.

Billing Methods

CareSource accepts claims in a variety of formats, including paper and electronic claims.

We encourage our health partners to submit routine claims electronically to take advantage of the following benefits:

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

Electronic Funds Transfer

CareSource now offers Electronic Funds Transfer (EFT) as a payment option. Visit the Provider Portal for additional information about the program and to enroll in EFT. Health partners who elect to receive EFT payment will receive an EDI 835 (Electronic Remittance Advice). Health partners can download their Explanation of Payment (EOP) from the Provider Portal or receive a hard copy via the mail.

CareSource offers Electronic Funds Transfer (EFT) as a payment option.

Benefits of EFT:

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

Simply complete the enrollment form, available on the "Claims Payment" page of **CareSource.com**, and fax it back to InstaMed, who will work directly with providers to enroll in EFT. Free EFT training is also available to CareSource providers through InstaMed during the enrollment process. You can view the training by visiting **www.instamed.com/aha-eraeft**.

Electronic Claims 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 health partners. Our EDI system complies with HIPAA standards for electronic claims submission.

EDI Clearinghouses

To submit claims electronically, health partners must work with an electronic claims clearinghouse. CareSource currently accepts electronic claims from health partners through eligible clearinghouses which are listed below. Please contact the clearinghouse of your choice to begin electronic claims submission.

Please provide the clearinghouse with the CareSource payer ID number: INCS1

Please provide the clearinghouse with the CareSource payer ID number: INCS1.

Clearinghouse	Phone	Website
The Consult	(800) 327-1213	www.4ecp.com
CPS (Dental Claims)	(888) 255-7293	www.emdeon.com
Dyserv	(614) 294-6078	www.dyserv.com
Emdeon	(800) 845-6592	www.emdeon.com
Manacon	(937) 746-6685	N/A
Netwerkes	(866) 521-8547	www.netwerkes.com
Practice Insight	(713) 333-6000	www.practiceinsight.com
Quadax	(440) 777-6305	www.quadax.com
RelayHealth	(866) 735-2963	www.relayhealth.com
Zirmed	(877) 494-7633	www.zirmed.com

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 is 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).

NPI and Tax ID Numbers

Your National Provider Identifier (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.

Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claims.

Please note: On paper claims, the NPI number should be placed in the following box(es) based on form type:

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

Location of Provider NPI, TIN and Member ID Number on Professional Claims

On 837P professional claims (005010X222A1), the Provider 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 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

Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. Paper claim forms are encouraged for services that require clinical documentation or other forms to process.

If you submit paper claims, please submit on one of the following claim form types:

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

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

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.cms.hhs.gov/transmittals/downloads/R1104CP.pdf**
- UB-04 Form Instructions: **www.nucc.org**

Please note: On paper claims, the NPI number should be placed in the following box(es) based on form type:

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

All Claims (EDI and paper) Must Include the Following Information:

- Insured's Name (if different from patient).
- Insured's Address (if different from patient).
- Patient (Member) Name.
- Patient Address.
- Insured's ID Number – Be sure to provide the complete CareSource Member ID number of the patient. Please also include the last two digits (the suffix) when you submit a claim. This is listed on the member ID card.
- Patient's Birth Date – Always include the member'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.

What to Include on Claims that Require NDC

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

Instructions for NDC 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:

- EDI claims 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 SuperBills will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.

EDI claims are generally processed more quickly than paper claims.

- 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 in conjunction with your required NPI number (Please refer to sections for Professional and Institutional claim information).
- Federal Tax ID number or physician SSN is required for all claim submissions.

Please send all paper claim forms to CareSource at the following address:

CareSource
Attn: Claims Department
P.O. Box 3607
Dayton, OH 45401-3607

Claim Submission Timely Filing

Claims must be submitted within 365 calendar days of the date of service or discharge. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim. If the claim is denied, then providers have 365 calendar days from the date of service or discharge to file a claim appeal. If the Health Partner was denied authorization or reimbursement due to not obtaining a required prior authorization, then the Health Partner has one hundred eighty (180) days from the date of service or discharge to file a claim appeal.

Claims Processing Guidelines

- Health partners have 365 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after 365 calendar days, the claim will be denied for timely filing.
- If you do not agree with the decision of the processed claim, you will have 365 calendar days from the date of service or discharge to file a claim appeal.
- If the health partner was denied authorization or reimbursement due to not obtaining a required prior authorization, then the Health Partner has one hundred eighty (180) days from the date of service or discharge to file a claim appeal.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a member has other insurance and CareSource is secondary, the health partner may submit for secondary payment within 365 calendar days of the original date of service.
- If a claim is denied for Coordination of Benefits (COB) information needed, the Health Partner must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.

Searching for Claims Information Online

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

Additional Claims Enhancements on the Provider Portal:

- Claims History Available Up to 24 Months from Date of Service
- Reason for Payment/Denial
- Check Numbers/Date
- Procedure/Diagnostic
- Claims Payment Date
- Dental Claims Information
- Vision Claims Information

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

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 health care providers and health plans. Local or proprietary codes are no longer allowed.

- International Classification of Diseases, 9th 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. **Note: The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is October 1, 2015.**
- Current Procedural Terminology. Available at **http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-featured-products.page**
- HCFA Common Procedure Coding System (HCPCS). Available at **http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/medhcpcsgeninfo/** 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 **www.fda.gov/**.

Procedures That Do Not Have a Corresponding CPT 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 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.
- Coordination of Benefits (COB) claims require a copy of the Explanation of Payment (EOP) from the primary carrier.

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 health partner.

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

CareSource Provider Coding and Reimbursement Guidelines
CareSource strives to be consistent with national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA compliant code sets (HCPCS, CPT, ICD-10, and NDC). Specific contract language stipulating the receipt, processing, and payment of specific codes and modifiers is honored as would be any aspect of a health partner 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.

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 insurance 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.

Prompt Payment of Claims

Indiana Code § 27-13-36.2, et seq., establishes various time frames for the processing and payment of claims. The time frames vary depending upon the circumstances.

1. An Health Maintenance Organization ("HMO") shall notify a provider of any deficiencies in a submitted claim not more than 30 days for a claim that is filed electronically and not more than 45 days for a claim that is filed on paper, in which an HMO shall described any remedy necessary to establish a clean claim. If an HMO fails to notify a provider of any deficiencies, the submitted claim will be considered a clean claim.
2. An HMO shall pay or deny a clean claim not more than 30 days after the date the claim is received by the HMO if the claim is filed electrically and not more than 45 days after the date the claim is received by the HMO if the claim is filed on paper. If an HMO fails to pay or deny a claim within the above mentioned timeframe and an HMO subsequently pays the claim, an HMO shall pay a provider interest.
3. An HMO may not be required to correct a payment error to a provider more than 2 years after the date on which a payment on a provider claim was made to the provider by the health maintenance organization.
4. Every subsequent claim that is adjusted by a health maintenance organization for reimbursement on an overpayment of a previous provider claim made to the provider must be accompanied by an explanation of the reason for the adjustment, including: an identification of the claim on which the overpayment was made and if ascertainable, the party financially responsible for the amount overpaid, and the amount of the overpayment that is be reimbursed to the HMO through the adjusted subsequent claim.

Explanation of Payment (EOP)

Explanations of Payment (EOPs) are statements of the current status of your claims that have been submitted to CareSource and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated depending on your claims activity. Health partners who receive EFT payments will receive an Electronic Remittance Advice (ERA) and can access a "human readable" version on the Provider Portal.

Information Included on EOPs

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 health partner's responsibility to resubmit claims with the correct or completed information needed for processing.

Check Claim Status Online

Please remember that you can track the progress of your submitted claims at any time through our Provider Portal. Check **CareSource.com** for a sample EOP.

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

Explanation of Benefits

CareSource Just4Me™ 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 health partner billed, the amount CareSource Just4Me™ reimbursed, and the remaining amount for which the member is responsible.

Other Coverage – Coordination of Benefits (COB)

Coordination of Benefits

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

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

COB 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 health partner, or health partners can issue refund checks to CareSource for any overpayments. Health partners 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 health partner will be advised to submit the charges to Workers' Compensation for reimbursement.

Third-Party Liability / Subrogation

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

Member Financial Liability

A member must first pay an annual deductible before being entitled to covered services. In addition to the deductible, copayments or coinsurance are also applicable for most covered services. It is up to the health partner to collect these amounts at the time of service. If a member overpays his or her coinsurance, the health partner must refund the overpayment to the member.

CareSource is required to provide a 90-calendar day grace period to members for non-payment of their premium. During those 90 calendar days, CareSource will continue to process medical claims and pay providers accordingly.

If the member is terminated for non-payment of premium, CareSource will retroactively terminate the member and all monies for months two and three of delinquency will be recovered from the health partner.

In addition, pharmacy benefits are eliminated when the member has reached 30-day delinquency. Pharmacy benefits will be reinstated if the member becomes current with their premiums within the 90-day grace period.

Communicating with CareSource

CareSource communicates with our health partner network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSource.com** and Network Notifications.

CareSource Hours of Operation

Provider Services			
CareSource Just4Me™	M-F	8 a.m. – 6 p.m. Eastern Standard Time	Provider Services

Member Services			
CareSource24 (All Plans)	24/7/365		Triage
CareSource Just4Me™	M-F	7 a.m. – 7 p.m. Eastern Standard Time	Member Services

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

Phone

To help us direct your call to the appropriate professional for assistance, you will be instructed to select the menu option(s) that best fits your need. Please note that our menu options are subject to change. We also provide telephone based self-service applications that allow you to verify member eligibility.

Phone Numbers

Provider Relations 1-866-286-9949
Provider Services. 1-866-286-9949
Prior Authorizations 1-866-286-9949
Claims Inquiries 1-866-286-9949
Credentialing 1-866-286-9949
CareSource Just4Me™ Member Services. 1-877-806-9284
CareSource 24 - Nurse Triage Line 1-866-206-7880
Care Management. 1-855-202-0415
Fraud, Waste and Abuse Hotline 1-866-286-9949
TTY for the Hearing Impaired . . . . . 1-800-743-3333 or 711

Fax Numbers

Case Management Referral 1-844-676-0364
Credentialing 1-866-573-0018
Contract Implementation 1-937-396-3632
Fraud, Waste and Abuse 1-800-418-0248
Medical Prior Authorization Form 1- 877-716-9480
Pharmacy Prior Authorization Form 1-866-930-0019
Provider Appeals 1-937-531-2398
Provider Maintenance (e.g., office changes, adding/deleting providers) 1-937-396-3076

Website/Online Provider Portal

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

On the health partner section of the site you will find commonly used forms, newsletters, updates and announcements, our Provider Manual, claims information, frequently asked questions and much more.

Provider Portal: https://providerportal.caresource.com/IN/

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

Provider Portal Benefits

- A secure online (encrypted) tool that allows you to easily access time-saving services and critical information
- Available 24 hours a day, 7 days a week
- Free
- Accessible on any PC without any additional software

Provider Portal – Value to You

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

- Payment History – Search for payments by Check Number or Claim Number
- Claim Status – Search for status of claims and claim appeals
- Coordination of Benefits (COB) – Confirm COB for patients
- Prior Authorization – Medical inpatient/outpatient, home health care and Synagis
- Eligibility Termination Dates – View the member's termination date (if applicable) under the eligibility tab
- Case Management Referrals – The case management form is now automated on our Portal for efficiency in enrolling members
- Benefit Limits – Providers can track benefit limits electronically in real time before services are rendered for: Chiropractic, Occupational Therapy, Physical Therapy, Speech Therapy
- Care Treatment Plans – Providers now have the option to view care treatment plans for their patients on our Provider Portal
- Claim History for Vision Benefits
- Monthly membership lists – PCPs can view and download current monthly membership lists
- Member financial status and information – View member payment responsibilities (such as deductible, copay and coinsurance) and monthly premium payment status.

Dental Providers – Please refer to **CareSource.com** for information about the Provider Portal capabilities specifically for dental health partners.

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

1. Click on the "Register Now" button and complete the three-step registration process. Note: You will need to have your Tax ID number.
2. Click the "Continue" button.
3. Note the username and password you create so that you can access the Portal's many helpful tools.
4. If you do not remember your username/password, please call the Provider Services Department at **1-866-286-9949**.

How to Communicate with CareSource by Mail

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

Health Partner Appeals Mailing Address

CareSource
P.O. Box 2008
Dayton, OH 45401-2008

Please visit our website for more information on how appeals can be submitted online.

Member Appeals & Grievances Mailing Addresses

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

Claims Mailing Address

CareSource
Attn: Claims Department
P.O. Box 3607
Dayton, OH 45401-3607

Fraud, Waste and Abuse Address

CareSource
Attn: Special Investigations 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.

Newsletters
CareSource communicates with providers in a variety of ways. Our *ProviderSource* newsletter, produced and mailed three times a year, is available online and contains operational updates, clinical articles and new initiatives underway at CareSource. Please visit **CareSource.com** for the newsletter.

Network Notifications
Network Notifications are published for CareSource health partners to regularly communicate updates to policies and procedures. Network Notifications are found on our website and the CareSource Provider Portal.

Heath Partner Demographic Changes and Updates
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 and are critical for claims processing.

Email: providermaintenance@caresource.com

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

Fax: (937) 396-3076

Covered Services and Exclusions

Covered Services

Please visit the CareSource website at **CareSource.com** for information on services, including dental services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Referrals and Prior Authorizations" section of this manual for more information about referral and prior authorization procedures.

Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Provider Services at **1-866-286-9949**.

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

Medical Necessity Determinations

Some services require prior authorization. If a request for authorization is submitted, CareSource will notify the health partner and member in writing of the determination. If a service cannot be covered, health partners 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 "Appeal Procedures" section of this manual for information on how to file an appeal.

Covered services and exclusions for CareSource Just4Me™ members can be found at CareSource.com.

CareSource Just4Me Dental + Vision!

CareSource Just4Me™ members can choose additional dental and vision coverage through the CareSource Just4Me™ Dental +Vision! plan. Dental benefits include routine (cleanings and exams), basic (X-rays and fillings) and some major dental services. Adult members age nineteen years or older are eligible for CareSource Just4Me Dental + Vision! benefits. CareSource members ages 18 and under have some vision services covered under the basic plan. Please visit **CareSource.com** for more information regarding this plan and the covered services. Log in to the Provider Portal. From the main portal page, click on CareSource Just4Me Covered Services and Prior Authorization Requirements.

CareSource Just4Me™ members can choose additional dental and vision coverage through the CareSource Just4Me™ Dental + Vision! plan.

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.

Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners.

CAQH Application
CareSource is a participating organization with CAQH. Please make sure that we have access to your provider application prior to submitting your CAQH number as referenced above by:

1. Logging onto the CAQH website at **www.CAQH.org** utilizing your account information
2. Selecting the **Authorization** Tab
3. Making sure **CareSource** is listed as an authorized Health Plan
   a. If not, please check the **Authorized** box to add

Please submit a complete Council for Affordable Quality Healthcare (CAQH) Application or CAQH number and National Provider Identifier (NPI) number via one of three vehicles:

- Email: contract.implement@caresource.com
- Fax: 937-396-3632
- Mail: Send by certified mail with return receipt to:
  CareSource
  P.O. Box 8738
  Dayton, OH 45401-8738
  Attn: Contract Implement

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

Please also include copies of the following documents:

- Malpractice Insurance Face Sheet
- Drug Enforcement Administration (DEA) Certificate (current)
- Clinical Laboratory Improvement Amendment (CLIA) Certificate (if applicable)
- Standard Care Arrangement (if an Advanced Practice Nurse or a Physician Assistant)

Debarred Provider Employee Attestation
CareSource verifies that its health partners and the health partners' employees have not been debarred or suspended by any state or federal agency. CareSource

also requires that its health partners and the health partners' employees disclose any criminal convictions related to federal health care programs. "Health partner employee" is defined as directors, officers, partners, managing employees or persons with beneficial ownership of more than 5% of the entity's equity.

CareSource Debarment/Criminal Conviction Attestation
Health partners must offer a list that identifies all of the health partner employees, as defined above, along with the employee's tax identification or social security numbers. Health partners 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 utilizing the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and credentialing as defined in the Indiana Code and Indiana Department of Insurance.

Contracted Health Partners Listed in the Health Partner Directory and the Following are Credentialed:

- Practitioners who have an independent relationship with CareSource. This independent relationship is defined through contracting agreements between CareSource and a practitioner or group of practitioners and is defined when CareSource selects and directs its enrollees to a specific practitioner or group of practitioners.
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Practitioners 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 practitioners who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.
- Covering practitioners (locum tenens).
- Medical Directors of Urgent Care Centers and Ambulatory Surgical Centers.

The Following Health Partners Listed in the Health Partner Directory Do Not Need to be Credentialed:

- Practitioners 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.
- Practitioners 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.
- Practitioners who do not provide care for members in a treatment setting (e.g. board-certified consultants).

Health Partner Selection Criteria
CareSource is committed to providing the highest level of quality of care and service to our members. Our health partners are critical business partners with

us in that endeavor. As a result, we have developed the following health partner selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our health partners.

Quality of care delivery, as defined by the Institute of Medicine, states: "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 health partner 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 health partner 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:

a. Active and unrestricted license in the State issued by the appropriate licensing board.
b. Current DEA certificate (if applicable).
c. Successful completion of all required education.
d. Successful completion of all training programs pertinent to one's practice.
e. For MDs and DOs, successful completion of residency training pertinent to the requested practice type.
f. For dentists and other providers where special training is required or expected for services being requested, successful completion of training.
g. Board Certification is not required for primary care specialties. PCPs who are approved by the CareSource Credentialing Committee will appear in CareSource Health Partner Directories.
h. Health partners approved by the CareSource Credentialing Committee in non-primary care specialties will be listed in the Health Partner Directory as specialists if certified by a specialty board, which is recognized by the CareSource Credentialing Committee.
i. An Advanced Practice Nurse (APN) may be credentialed as a Primary Care Health Partner if that APN maintains compliance with the rules set forth by the Indiana State Board of Nursing defined in "Compilation of the Indiana Code and Indiana Administrative Code, 2013 Edition." The APN is expected to be familiar with these rules. "Advanced practice nurse" means a registered nurse holding a current license in Indiana who:
    i. Has obtained additional knowledge and skill through a formal, organized program of study and clinical experience, or its equivalent, as determined by the board;
    ii. Functions in an expanded role of nursing at a specialized level through the application of advanced knowledge and skills to provide healthcare to individuals, families, or groups in a variety of settings.
j. Education, training, work history and experience are current and appropriate to the scope of practice requested.
k. Malpractice insurance at specified limits established for all practitioners by the credentialing policy.

l. Good standing with Medicaid and Medicare.
m. Quality of care and practice history as judged by:
    i. Medical malpractice history.
    ii. Hospital medical staff performance.
    iii. Licensure or specialty board actions or other disciplinary actions, medical or civil.
    iv. 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.
    v. Other quality of care measurements/activities.
    vi. Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing.
    vii. Lack of issues on HHS-OIG, SAM/ EPLS, or state site for sanctions or terminations (fraud and abuse).
n. Signed, accurate Credentialing Application and contractual documents.
o. Participation with Care Management, Quality Improvement and Credentialing programs.
p. Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
q. Agreement to comply with plan formulary requirements or acceptance of Plan Preferred Drug List as administered through the Pharmacy Benefit Manager.
r. Agreement to access and availability standards established by the health plan.
s. Compliance with service requirements outlined in the Health Partner Agreement and Health Partner Manual.

Organizational Credentialing and Recredentialing – The following organizational Health partners are credentialed and recredentialed:

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

Additional organizational health partners are also credentialed:

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

Additional organizational health partners are also credentialed.

In addition to the Urgent Care and Ambulatory Surgical facilities being credentialed, the Medical Director or senior provider responsible for medical services will be credentialed using the standard credentialing and recredentialing processes.

The following elements are assessed for organizational health partners:

- Health partner is in good standing with state and federal regulatory bodies
- Health partner 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
- Liability insurance coverage is maintained

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

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

Practitioner 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, the practitioner will be notified and given the opportunity to correct this information prior to presenting to the credentialing committee.
- Practitioners have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing Department.

Health Partner Responsibilities — Health partners 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. Health partners 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).

Health partners are monitored on an ongoing basis to ensure continuing compliance with participation criteria.

Recredentialing — Health partners 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. Health partners will be considered recredentialed unless otherwise notified.

Board Certification Requirements

Effective Jan. 1, 2003, physicians applying to become participating health partners 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.

Physicians applying to become participating health partners must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board.

Effective Sept. 10, 2010, Primary Care health partners 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 health partners.

Physicians whose boards require periodic re-certification will be expected but not required to be re-certified, although failed attempts at re-certification may be reason for termination. At the time of recredentialing, if board certification status has expired, a letter will be sent to the physician to request explanation. If the response indicates quality concerns as a reason, the VP, Senior Medical Director, or designated Medical Director will contact the physician and investigate directly.

To be credentialed as a subspecialist physicians must:

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

Delegation of Credentialing/Recredentialing

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

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

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

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

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

Reconsideration and Appeals of Credentialing/Recredentialing Decisions

CareSource may decide that an applying or participating health partner 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 health partner will be notified in writing. Reconsideration and appeal opportunities are available

unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan. To submit a request, the following steps apply:

Step 1 — Submit to the Vice President/Senior Medical Director an appeal request in writing, along with any other supporting documentation.

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

All reconsideration requests must be received by CareSource within 30 calendar days of the date the health partner 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 health partner will be notified in writing of the committee's decision.

Step 2 — If the committee maintains the original decision, an appeal may be made consistent with provisions of the CareSource Fair Hearing Plan unless an exception applies. Any appeal request must be submitted in writing and received by CareSource within 30 calendar days of the date the health partner is notified of the reconsideration decision.

Appeals may be sent to:
CareSource
P.O. Box 8738
Dayton, OH 45401-8738
Attn: Vice President/Senior Medical Director

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

If you would like to review the CareSource Fair Hearing Plan, please see our website at **CareSource.com**. Search "Fair Hearing".

Health Partner Disputes

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

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

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

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

Summary Suspensions

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

Fraud, Waste and Abuse

Health care fraud, waste and abuse hurts everyone including members, health partners, taxpayers and CareSource. As a result, CareSource has a comprehensive fraud, waste and abuse program in our Special Investigations Unit. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

Definition of Terms

Fraud — is defined as, an intentional deception or misrepresentation made by a recipient or a health partner with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

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.

Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

Abuse — is defined as, provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.

Improper Payments:
An 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.

Anyone who identifies an improper payment is encouraged to report it to CareSource using one of reporting methods below.

Examples of Member Fraud, Waste and/or Abuse:

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

Examples of Health Partner Fraud, Waste and/or Abuse:

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

Examples of Pharmacy Fraud, Waste and/or Abuse:

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

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

Examples of Employee Fraud, Waste and/or Abuse:

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

Examples of Vendor Fraud, Waste and/or Abuse:

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

The Special Investigations Unit routinely monitors for potential fraud, waste and abuse. When found, an investigation is initiated and if warranted, corrective action is taken.

Corrective actions can include, but are not limited to:

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

Your Health Partner Agreement provides specific information on each type of health partner termination/suspension. The Fair Hearing Plan, available at **CareSource.com** (search "Fair Hearing Plan"), provides information on an appeal process for specific health partner terminations.

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.

As amended in 2009, the False Claims Act addresses those who:

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

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

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

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

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

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

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.

Protection for Reporters of Fraud, Waste or Abuse

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

Additional information on the False Claims Act and our fraud, waste and abuse policies can be found on **CareSource.com**.

Prohibited Affiliations

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

Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation. If you become aware that your corporate entity, those with more than 5% ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us ***immediately*** utilizing the contact information in the reporting section below.

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 using the contact information in the reporting section below.

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.

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. If you have knowledge or information that any such activity may be or has taken place, please contact our Special Investigations Unit. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting anonymously:
- **Call: 1-866-286-9949** and follow the prompts for reporting fraud
- **Write:**

  CareSource
  Attn: Special Investigations Unit
  P.O. Box 1940
  Dayton, OH 45401-1940

Options for reporting that are not anonymous:
- **Fax:** 1-800-418-0248
- **Email: fraud@caresource.com**

Or you may choose to use the **Fraud, Waste and Abuse Reporting Form** located on **CareSource.com**.

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

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

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

Key Contract Provisions

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

These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved.

Participating health partners are responsible for:

- Providing CareSource with advance written notice of any intent to terminate an agreement with us. This must be done 90 calendar days prior to the date of the intended termination and submitted on your organization's letterhead.
  - **60 calendar days' notice is required if you plan to close your practice to new patients.** If we are not notified within this time period, you will be required to continue accepting CareSource members for a 60 calendar day period following notification.
- **For PCPs only:** Providing 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or a taped message used after-hours, patients should be given the means to contact their PCP or a back-up health partner to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider and only recommends Emergency Room use for after hours.
- Submission of claims or corrected claims should be submitted within 365 calendar days of the date of service or discharge.
- Appeals must be filed within 365 calendar days of the date of service or discharge. An appeal in which the health partner was denied authorization or reimbursement due to not obtaining a required prior authorization must be filed within one hundred eighty (180) days from the date of service or from the date of discharge.
- Health partners should keep all demographic and practice information up to date. Send email updates to **providermaintenance@caresource.com**.

Our agreement also indicates that CareSource is responsible for:

- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the "Health Partner Appeals" section of this manual.
- Offering a 24-hour nurse triage service for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance which involves subtracting the primary payment from the lessor of the primary carrier allowable or the CareSource Just4Me™ allowable. If the member's primary insurer pays a health partner equal to or more than CareSource's Just4Me™ fee schedule for a covered service, CareSource will not pay the additional amount.

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

For Example:

- Participating health partners, 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 health partners 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 "Member Support Services and Benefits" section of this manual.

CareSource expects participating health partners to verify member eligibility and ask for all 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 health partner to your practice helps us keep our records current and are critical for claims processing.

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

Timeline of Provider Changes

Type of Change	**Notice Required** (*Please notify CareSource of the change **prior** to the time frames listed below.*)
New health partners or deleting a health partner	Immediate
Health partner 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
Health Partners 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 health partner Directories are up-to-date, and reduces unnecessary calls to your practice.

How to Submit Changes to CareSource

Email: **providermaintenance@caresource.com**
Fax: 937-396-3076
Mail: CareSource
P.O. Box 8738
Dayton, OH 45401-8738
Attn: Provider Maintenance

Americans with Disabilities Act (ADA) Standards

Additionally, providers will remain compliant with ADA standards, including but not limited to:

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

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

Member Enrollment and Eligibility

Member Enrollment

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

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

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

Member ID Cards

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

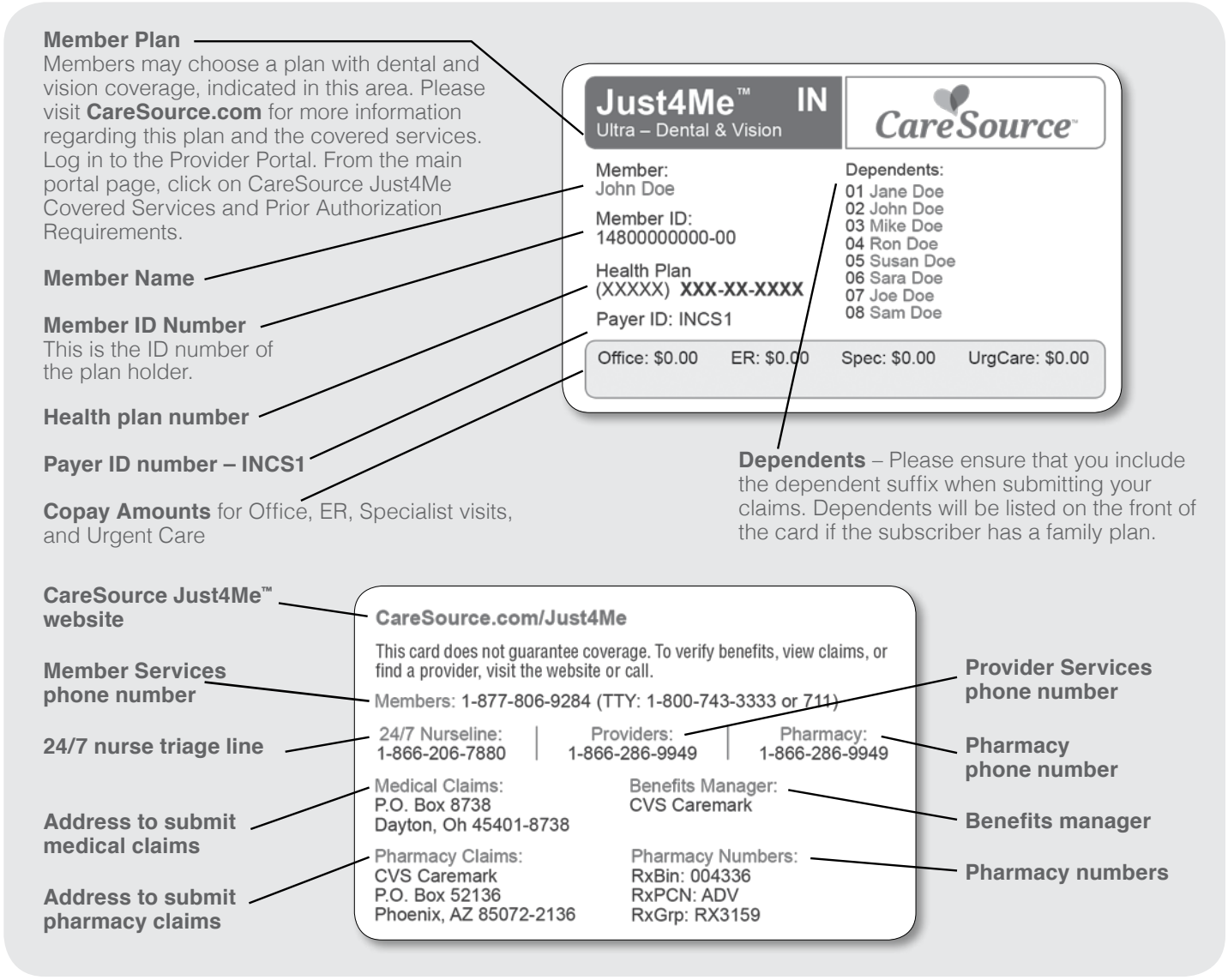
Health partners may use our secure Provider Portal on our website to check member eligibility, or call Provider Services.

Provider Portal: https://providerportal.caresource.com/IN/
Click on "Member Eligibility" on the left, which is the first tab.

Provider Services: 1-866-286-9949 and follow the prompt for eligibility check.

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.

The CareSource Just4Me™ Member ID card contains the following:



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.

Involuntary member disenrollment:

CareSource Just4Me is required to provide a 90 calendar day grace period to members for non-payment of their premium. During those 90 days, CareSource will continue to process medical claims and pay health partners accordingly.

If the member is terminated for non-payment of premium, CareSource will retro-terminate the member and all monies for months two and three of delinquency will be recovered.

Pharmacy benefits are eliminated when the member has reached 30-day delinquency. Pharmacy benefits will be reinstated if the member becomes current with their premiums within the 90-day grace period.

CareSource is required to provide a 90 calendar day grace period to members for non-payment of their premium.

Member Support Services and Benefits

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

CareSource Just4Me™ New Member Identification Cards and Kits
Each new member household receives a new member kit, a welcome letter, and two ID cards that include each family member who has joined CareSource Just4Me™. The new member kits are mailed separately from the ID card and new member welcome letter.

New Member Kit Contains:

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

Members are referred to the Provider Directory which lists health care partners and facilities participating with CareSource Just4Me™. A current list of health partners can be found at any time on CareSource's website, **CareSource.com**, using our "Find A Doctor/Provider" tool.

CareSource Just4Me™ Member Services
Representatives are available by telephone Monday through Friday, except on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the day after, and Christmas Eve and Christmas Day.

Members access Member Services by calling our toll-free number, **1-877-806-9284**, 7 a.m. - 7 p.m. (TTY for the hearing impaired: 1-800-743-3333 or 711) and following the menu prompts.

CareSource24®, Nurse Triage Line

Members can call our URAC-accredited nurse triage line 24 hours a day, seven days a week. With CareSource 24, 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. CareSource 24 nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the Primary Care Physician (PCP) by explaining the importance of their role in coordinating the member's care.

Key features of this service include nurses who:

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

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

Care Management/Outreach

CareSource provides the services of care management medical and behavioral health nurses, social workers and outreach specialists to provide one-on-one, personal interaction with patients. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team. Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging non-compliant patients, reinforcing medical instructions, and assessing social needs, as well as educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many diseases. You can refer a member to Care Management by calling **1-855-202-0415**.

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 and nurse care managers provides a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional community resources.

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

- Asthma
- Diabetes
- Heart disease
- Depression
- High blood pressure and cholesterol

- Low back pain
- Pregnancy
- Weight loss

CareSource encourages you to take an active role in your patients' care management programs and participate in the development of individualized care plans to help meet their needs. Together, we can make a difference.

CareSource Disease Management Program
CareSource Just4Me members with chronic conditions, including asthma and diabetes, will be automatically enrolled into CareSource's enhanced disease management program.

Members enrolled in the program will receive free information to help them better manage their asthma or diabetes. Information sent to members will include care options for them to discuss with their provider.

Each member identified as high risk will have a nurse assigned to his or her case. The nurse will help educate, coordinate and provide resources and tools to assist the member in reaching his/her health care goals.

How to Refer Just4Me Members to Disease Management
If you have a CareSource patient with asthma or diabetes who you believe would benefit from this program and is not already enrolled, call 1-855-202-0415.

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 room (ER) if they feel they have an emergency. CareSource covers all emergency services for our members.

We instruct members to call their PCP or the CareSource 24 nurse triage line if they are unsure if they need to go to an ER. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. We also offer enhanced reimbursement to PCP offices for holding evening or weekend hours to help ensure that our members have alternatives other than the ER available to them when they need medical care outside of normal business hours. Please see the "Primary Care providers" section of this manual for more information.

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

Perinatal Care Management

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 health partners 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 health partners. We encourage our prenatal care health partners to notify our Care Management Department at **1-855-202-0415** when a member with a high-risk pregnancy has been identified.

Eyeglass Frames

Adult members of our health plan (age 19 and over) who have selected our enhanced benefit option (CareSource Just4Me™ Dental + Vision!) can choose from a selection of eyeglass frames for a $25 copay up to $150 per year. These frames must be ordered through one of CareSource's contracted optical labs. Please refer to **CareSource.com** for additional information about vision services.

Children (members up to the age of 19) may receive one set of prescription eyeglasses per year at no cost. Contact lenses are limited to a single purchase of up to a 3-month supply of daily disposables, or a 6-month supply of nondaily disposables, once per year in any 12-month period.

Interpreter Services — Non-Hospital Health Partners

CareSource Just4Me offers language interpreters for members who need assistance to communicate with CareSource. We can also provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services are available at no cost to the member. As a health partner, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately.

Interpreter Services — Hospital Health Partners

CareSource Just4Me requires hospitals, 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
Effective October 1, 2015, CareSource requires health partners to use ICD-10-CM Codes and CPT Codes on claims. Please refer to the Code Tables located on the CMS website:

https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html

You can also get CMS Coding Guidelines at the following website:

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf

Statewide Web-Based Immunization Registry
CareSource encourages all participating health care partners to take advantage of the statewide web-based immunization registry found at **https://chirp.in.gov/main.jsp**.

The registry consolidates immunizations from multiple health partners into one central record and provides reliable immunization history that is electronically accessible from multiple health care practice sites. It also facilitates the introduction of new vaccine protocols and sends immunization reminder/recall notices automatically. The system is designed to save time and money, reduce paperwork, and provide quick and efficient tracking of immunizations.

Health Education
CareSource Just4Me™ members receive health information from CareSource through a variety of communication vehicles including brochures, phone calls and personal interaction. CareSource also sends preventive care reminder messages to members via mail and automated outreach messaging.

Americans with Disabilities Act (ADA)
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. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, health care partners may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities, and follow ADA accessibility standards for new construction and alteration projects. Furthermore, health partners' diagnostic equipment must accommodate individuals with disabilities.

Please see the following pages for information about the ADA. More information on this subject may be obtained at **www.cdihp.org**.

Health care partners may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities, and follow ADA accessibility standards for new construction and alteration projects.

Q. Which health care partners are covered under the ADA?
A. Private hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists and health clinics are among the health care partners covered by the Title III of the ADA. Title III applies to all private health care partners, regardless of size. It applies to health partners of both physical and mental health care. If a professional office is located in a private home, the portion of the home used for public purposes is covered by the ADA.

Hospitals and other health care facilities that are operated by state or local governments are covered by Title II of the ADA.

Health care partners that offer training sessions, health education, or conferences to the general public must make these events accessible to individuals with disabilities.

Policies and Procedures
Health care providers are required to modify policies and procedures when necessary to serve a person with a disability. The ADA, however, does not require providers to make changes that would fundamentally alter the nature of their service.

Q. What kinds of modifications to policies or procedures might be required?
A. Modifying standard policies, practices or procedures can be an inexpensive but effective way to provide access to health care services. This may mean taking extra time to explain a procedure to a patient who is blind or ensuring that a patient with a mobility impairment has access to an accessible exam room.

Effective Communication, Auxiliary Aids and Services
Health care partners must find appropriate ways to communicate effectively with persons who have disabilities affecting their ability to communicate. Various auxiliary aids and services such as interpreters, written notes, readers, large print or Braille text can be used depending on the circumstance and the individual.
Q. Why are auxiliary aids and services so important in the medical setting?
A. Auxiliary aids and services are often needed to provide safe and effective medical treatment. Without these aids and services, medical staff runs the risk of not understanding the patient's symptoms, misdiagnosing the patient's medical problem, and prescribing inappropriate treatment. Similarly, patients may not understand medical instructions or warnings that may have a serious impact on their health.

Q. How does a health care partner determine which auxiliary aid or service is best for a patient?
A. The health care partner can choose among various alternatives consulting with the person and carefully considering his or her expressed communication needs in order to achieve an effective result.

Q. Can a patient be charged for part or all of the costs of receiving an auxiliary aid or service?
A. No. A health care partner cannot charge a patient for the costs of auxiliary aids and services, either directly or through the patient's insurance carrier.

Q. In what medical situations should a health care partner obtain a sign language interpreter?
A. If a patient or responsible family member usually communicates in Sign Language, an interpreter should be present in all situations in which the information exchanged is lengthy or complex (for example, discussing a patient's medical history, conducting psychotherapy, communicating before or after major medical procedures, and providing complex instructions regarding medication).

If the information to be communicated is simple and straightforward, such as prescribing an X-ray or a blood test, the physician may be able to communicate with the patient by using pen and paper.

Existing Facilities / Barrier Removal
Q. When must private medical facilities eliminate architectural and communication barriers that are structural in nature from existing facilities?
A. When the removal of those barriers is readily achievable, meaning easy to accomplish, without much difficulty or expense. Like undue burden, readily achievable is determined on a case-by-case basis in light of the resources available to an individual health partner.

Q. How does one remove "communication barriers that are structural in nature"?
A. For instance, install permanent signs, flashing alarm systems, visual doorbells and other notification devices, volume control telephones, assistive listening systems, and raised character and Braille elevator controls.

Complaints
Q. What if a patient thinks that a health care Health Partner is not in compliance with the ADA?
A. If a health care health partner cannot satisfactorily work out a patient's concerns, various means of dispute resolution including arbitration, mediation, or negotiation are available. Patients also have the right to file an independent lawsuit in federal court, and to file a formal complaint with the U.S. Department of Justice.

Excerpted from and based on "ADA Q and A's" by Deborah Leuchovius, ADA Specialist, PACER (Parent Advocacy Coalition for Educational Rights), 8161 Normandale Blvd., Bloomington, MN 55437

CareSource Just4Me™ Member Rights and Responsibilities
As a CareSource health partner, you are required to respect the rights of our members. CareSource Just4Me™ members are informed of their rights and responsibilities via their Member Handbook. The list of our members' rights and responsibilities are listed below.

All members are encouraged to take an active and participatory role in their own health and the health of their family. Member rights and responsibilities, as stated in the Member Handbook, are as follows.

You have the right to:

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

You have the responsibility to:

- Provide information needed, to the extent possible, in order to receive care.
- Follow the plans and instructions for care that you have agreed to with doctors.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Be enrolled and pay any required premiums.
- Pay an annual deductible, copayments and coinsurance.
- Pay the cost of limited and excluded services.
- Choose network health partners and network pharmacies.
- Show your ID card to make sure you receive full benefits under the plan.

HIPAA Notice of Privacy Practices — Members are notified of CareSource's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CareSource's Notice of Privacy Practices includes a description of how and when member information is used and disclosed within and outside of the CareSource organization. The notice also informs members on how they may obtain a statement of disclosures or request their medical claim information. 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.

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, health care partners 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.

Member Grievances and Appeals Procedures

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 health partner to file an Appeal regarding an Adverse Benefit Determination, written consent from the member is required. **Please see the Health Partner Appeals Procedures section for more information on submitting an appeal related to a claim.**

Members may contact Member Services at **1-877-806-9284** 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 Health Partners.

The Grievance Process

Pursuant to Indiana Code § 27-13-10 et seq., we have put in place a Grievance Process for the quick resolution of Grievances members submit to us that are unrelated to Benefits, Benefit denials, and/or Health Care Services generally. For purposes of this Grievance Process, we define a Grievance as any dissatisfaction expressed, orally or in writing, by the member or their Authorized Representative regarding:

1. The availability, delivery, appropriateness, or quality of Health Care Services;
2. The handling of payment of claims for Health Care Services;
3. Matters pertaining to the contractual relationship between CareSource and the member; or
4. CareSource's decision to rescind member coverage under the Plan.

If members have a Grievance concerning the Plan, they may contact us by sending a letter at the following address:

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

Members may also submit a Grievance by calling us at **1-877-806-9284 (TTY: 1-800-743-3333 or 711)**. They may arrange to meet with us in-person to discuss their Grievance.

We will acknowledge all Grievances submitted by the member or their Authorized Representative, orally or in writing, within three (3) business days of our receipt of the Grievance.

We will investigate, resolve, and make a decision regarding the Grievance within not more than twenty (20) business days after the Grievance was filed by the member. We will send the member and/or their Authorized Representative a letter explaining the Plan's resolution of the Grievance within five (5) business days after completing our investigation.

If the member or their Authorized Representative is unsatisfied with our decision regarding the Grievance, the member or their Authorized Representative may Appeal of our Grievance decision, orally or in writing, within 180 days of receiving notice of our Grievance decision. We will acknowledge receipt of the Appeal within three (3) business days after receiving the Appeal request. The Appeal will be resolved not later than forty-five (45) days after the Appeal is filed, and we will send the member and/or their Authorized Representative written notice of the resolution of the Appeal within five (5) business days after completing the investigation.

NOTE:
Please note that the Adverse Benefit Determination Grievance and Appeal Process below addresses Grievances related to Benefits, Benefits denials, or other Adverse Benefit Determinations.

CareSource Managed Care

In processing claims, CareSource reviews requests for Prior Authorization, Predetermination and Medical Review for purposes of determining whether requested Health Care Services are Covered Services. This managed care process is described below. Members with questions regarding the information contained in this section may call Member Services at **1-877-806-9284 (TTY: 1-800-743-3333 or 711)**.

- **Prior Authorization** – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date pursuant to the terms of this Plan.
- **Predetermination** – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. We will review your EOC to determine if there is an Exclusion for the Health Care Service. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the Health Care Service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.
- **Medical Review** – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Prior Authorization and did not have a Predetermination review performed.
  Medical Reviews occur for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Most Network health partners know which services require Prior Authorization and will obtain any required Prior Authorization or request a Predetermination if they feel it is necessary. The ordering Network health partner will contact us to request Prior

Authorization or a Predetermination review. We will work directly with Network health partners regarding such Prior Authorization request.

We will utilize our clinical coverage guidelines in determining whether Health Care Services are Covered Services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

Members are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact Member Services at **1-877-806-9284**.

The following define the categories of Prior Authorization, Predetermination and Medical Requests:

- **Review Request for a Claim Involving Emergent Care** – a request for Prior Authorization or Predetermination that in the opinion of the treating provider with knowledge of the Covered Person's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function or subject the Covered Person to severe pain that cannot be adequately managed without such care or treatment. If an urgent care review request is not approved, the Covered Person may proceed with an Expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.
- **Prospective Review Request** – a request for Prior Authorization or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent Review Request** – a request for Prior Authorization or Predetermination that is conducted during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.
- **Retrospective Review Request** – a request for Prior Authorization that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Timing of Decisions and Notifications

We will issue our benefit decisions and related notifications within the timeframes set forth below. Please call Member Services at **1-877-806-9284 (TTY: 1-800-743-3333 or 711)** with any questions.

Review Request Category	Timeframe
Pre-Service Claim Involving Emergent Care*	As soon as possible but not later than 72 hours from the receipt of request, whichever is less
Pre-Service Claim (Non-Emergent)*	15 Calendar days from the receipt of request
Concurrent Care for a Claim Involving Emergent Care when request is received at least 24 hours before the expiration of the previous authorization or no previous authorization exists*	24 hours or 1 business day from the receipt of the request, whichever is less
Concurrent Care for a Claim Involving Emergent Care when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists*	As soon as possible but not later than 72 hours from the receipt of request, whichever is less
Concurrent (Non-Emergent)*	As soon as possible but not later than 72 hours from the receipt of request, whichever is less
Post-Service Claims*	20 business days from receipt of the request

* The timelines above do not apply if the Plan is unable to make a decision due to reasons beyond the Plan's control. In such an instance, the Plan shall notify the member or their Authorized Representative, in writing, of the reason for the delay not more than (i) fourteen (14) days after the Plan's receipt of the member's or their Authorized Representative's Review Request for a Pre-Service Claim (Non-Emergent), and (ii) nineteen (19) days after the Plan's receipt of the member's or their Authorized Representative's Review Request for a Post-Service Claim. The Plan shall issue a written decision to the member or their Authorized Representative not more than ten (10) business days after notifying the member or their Authorized Representative of the reason for the delay.

- For Pre-Service Claims (Non-Emergent), the Plan will notify the member, their Authorized Representative or you, as the member's provider, as the case may be, that additional information is necessary to complete the Plan's review, and such notice shall be sent within fourteen (14) business days of the Plan's receipt of the Review Request for a Pre-Service Claim. The member or their Authorized Representative shall submit such information to the Plan within forty-five (45) days of the Plan's request for such information. The Plan shall then issue a decision within fifteen (15) days of the Plan's receipt of such information or the end of the period afforded to the member or their Authorized Representative to provide the specified information.

- For Pre-Service Claims Involving Emergent Care, the Plan will notify the member, their Authorized Representative or you, as the member's health partner, as the case may be, that additional information is necessary to complete the Plan's review, and such notification shall be sent within twenty-four (24) hours of the Plan's receipt of the Review Request for a Pre-Service Claim Involving Emergent Care. The member or their Authorized Representative shall submit such information to the Plan within forty-eight (48) hours of the Plan's request. The Plan shall then issue a decision within forty-eight (48) hours of the Plan's receipt of such information or the end of the period afforded to the member or their Authorized Representative to provide the specified additional information.

- For Post-Service Claims, the Plan will notify the member, their Authorized Representative, or you, as the member's provider, as the case may be, that additional information is necessary to complete the Plan's review, and such notice shall be sent within nineteen (19) business days of the Plan's receipt of the Review Request for a Post-Service Claim. The member or their Authorized Representative shall submit such information to the Plan within forty-five (45) days of the Plan's request for such information. The Plan shall then issue a decision within ten (10) days of the Plan's receipt of such information or the end of the period afforded to the member or their Authorized Representative to provide the specified information.

- If we do not receive the specific information requested or if the information is not complete by the applicable timeframe identified above and in the written notification, a decision will be made based upon the information in our possession.

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 requesting health partner via telephone or via electronic means if agreed to by the health partner.
- **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting health partner and the Covered Person or his or her Authorized Representative.

If we do not approve the Benefits, we will provide the member or their Authorized Representative a notice of an Adverse Benefit Determination. The notification will include our decision, the reasons, policies and procedures that served as the basis for our decision; a description of any additional material or information necessary for the member or their Authorized Representative to perfect the claim for Benefits; notice of the member's right to appeal the decision; and the department, address, and telephone number through which the member may contact a qualified representative to obtain more information about our decision or the member's right to appeal.

Members or their Authorized Representatives have 180 calendar days after they receive the notice of an Adverse Benefit Determination to file an Appeal with us. The Appeal may be filed orally or in writing, and may be submitted by the member or their Authorized Representative. Authorized Representatives must obtain written approval from the member to file appeals. The timing of decisions and notifications related to such Appeals are provided directly below.

Adverse Benefit Determination Appeals

If we make an Adverse Benefit Determination, we will provide the member or their Authorized Representative with a notice of an Adverse Benefit Determination, as described above.

If a member or their Authorized Representative wishes to Appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, they or their Authorized Representative must submit an Appeal orally or in writing within one hundred eighty (180) calendar days of receiving the Adverse Benefit Determination notice. The member or their Authorized Representative not need submit Appeals for Claims Involving Emergent Care in writing.

The Appeal request should include:

1. The Covered Person's name and identification number as shown on the ID card;
2. The health partner's name;

3. The date of the medical service;
4. The reason the member or their Authorized Representative disagrees with the denial; and
5. Any documentation or other written information to support the request.

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

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

They member or their Authorized Representative may also submit an Adverse Benefit Determination Appeal by calling us at **1-877-806-9284 (TTY: 1-800-743-3333 or 711)**.

For Appeals for Claims Involving Emergent Care, the member or their Authorized Representative can call the Plan at **1-877-806-9284** to request an Appeal.

The Plan offers one (1) level of appeal. Within three (3) business days after we receive an oral or written Appeal of an Adverse Benefit Determination, we will acknowledge to the appealing party, orally or in writing, the date the Plan received the Appeal of the Adverse Benefit Determination Notice. The Plan has fifteen (15) calendar days after receiving the Appeal for a pre-service denial or forty-five (45) days after receiving the post-service denial Appeal to complete the Appeal process. We will send the member and/or their Authorized Representative written notice of the resolution of the Appeal within five (5) business days after completing the investigation. The Appeal will be reviewed by a panel of qualified individuals who were not involved in the matter giving rise to the Appeal or in the initial investigation of the Appeal.

The member and/or their Authorized Representative have the right to review your claim file and present evidence and testimony as part of the Appeal process. We will provide member and/or their Authorized Representative, free of charge, with all documents relevant to their claim and Appeal and with any new or additional evidence considered, relied upon, or generated by the panel in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of the our decision is to be provided in order to give you a reasonable opportunity to respond prior to that date.

Before we may issue our final decision regarding the member's Appeal based on new or additional rationale, member and/or their Authorized Representative will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of our decision is required to be provided in order to give member and/or their Authorized Representative a reasonable opportunity to respond prior to that date.

We will provide continued coverage to the member pending the outcome of the Appeal. For Appeals concerning Concurrent Care Claims, benefits for an ongoing course of treatment will not be reduced of terminated without providing advance notice to the member and/or their Authorized Representative and an opportunity for advance review.

Separate schedules apply to the timing of claims Appeals, depending on the type of claim being Appealed.

The time frames which you and CareSource are required to follow are provided below.

Review Request for a Claim Involving Emergent Care. Appeals concerning decisions related to a Review Request for a Claim Involving Emergent Care are referred directly to an Expedited Appeal review process for investigation and resolution. See the "Expedited Review of Internal Appeals" section below for additional information concerning the timing of the resolution of such Appeals.

Members and/or their Authorized Representatives do not need to submit an Appeal of an Adverse Benefit Determination related to Emergent Care in writing. Members and/or their Authorized Representatives should call CareSource as soon as possible to Appeal a decision related to a Claim Involving Emergent Care.

Pre-Service Request for Benefits. Members and/or their Authorized Representatives must Appeal an Adverse Benefit Determination related to Pre-Service Requests for Benefits no later than 180 calendar days after receiving the Adverse Benefit Determination notice. We must notify the member and/or their Authorized Representative of our benefit determination within 15 calendar days after receiving the request for Appeal.

Post-Service Claims. Members and/or their Authorized Representatives must appeal an Adverse Benefit Determination related to Post-Service Requests for Benefits no later than 180 calendar days after receiving the Adverse Benefit Determination notice. We must notify the member and/or their Authorized Representatives of our benefit determination within 45 calendar days after receiving your request for the Appeal.

Concurrent Services Requests. Appeals relating to ongoing emergencies or denials of continued hospital stays (Concurrent Care Claims Involving Emergent Care) are referred directly to an expedited Appeal process for investigation and resolution. See the "Expedited Review of Internal Appeals" section below for additional information concerning the timing of the resolution of such Appeals. Appeals for Concurrent Care Claims (Non-Emergent) will be concluded in accordance with the medical or dental immediacy of the case.

Notice of our Final Adverse Benefit Determination of the Appeal will include the dental, medical, and contractual reasons for the resolution; clinical basis for the decision; notice of the member's right to further remedies under law, including the right to an External Review by an Independent Review Organization ("IRO"); and the department, address, and telephone number through which the member and/or their Authorized Representative may contact a qualified representative to obtain more information about the decision or the member's right to Appeal.

Expedited Review of Internal Appeal

Expedited Review of an Appeal may be started orally, in writing, or by other reasonable means available to the member and/or their Authorized Representative. All necessary information, including our decision, will be transmitted by telephone, facsimile, or other available similarly expeditious method. We will complete the expedited review of your Appeal as soon as possible given the medical needs, but no later than seventy-two (72) hours after our receipt of the request. We will communicate our decision by telephone to the member and/or their Authorized Representative, attending physician or ordering provider, and the facility rendering the service.

Members and/or their Authorized Representatives may request an expedited review of

their Appeal for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
  - Could seriously jeopardize the member's life or health or the member's ability to regain maximum function, or,
  - In the opinion of a Physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Except as provided below, a claim involving Urgent Care Services (Emergent care) is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of your medical condition determines is a claim involving Urgent Care Services (Emergent care), and we shall defer to such determination by the Physician.

Exhaustion of Internal Appeals Process

The internal Appeal process must be exhausted prior to initiating an External Review except in the following instances:

- We agree to waive the exhaustion requirement;
- An expedited External Review is sought simultaneously with an expedited Appeal; or
- We failed to meet all requirements of the 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 the control of the Plan and the violation occurred in the context of ongoing, good faith exchange of information between the Plan and the member and the violation is not part of a pattern or practice of the Plan.

External Reviews

Under Indiana Code § 27-13-10.1, et seq., CareSource, as a health plan, must provide a process that allows the member or their Authorized Representative 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. An Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An External Review will be conducted by an IRO. The member will not pay for the External Review. There is no minimum cost of Health Care Services denied in order to qualify for an External Review.

The member is entitled to an External Review by an IRO in the following instances:

The following determinations made by us or our agent regarding a service proposed by a treating physician:

- An adverse utilization review determination, as outlined in the Managed Care Section above.
- An adverse determination of medical necessity.
- A determination that the proposed service is experimental or investigational.
- Our decision to rescind your coverage under the Plan.

There are two (2) types of IRO reviews: standard and expedited.

Standard External Review. Standard External Reviews and external investigation/ experimental reviews are normally completed within fifteen (15) business days after the External Review is filed. The IRO will notify us and member of its determination of a standard External Review within seventy-two (72) hours after making the determination.

Expedited External Review. An expedited review for urgent medical situations is normally completed within seventy-two (72) hours after the expedited External Review is filed. The IRO will notify us and member of its determination of an expedited External Review within twenty-four (24) hours after making the determination.

An External Review is considered an urgent medical situation and qualifies for expedited External Review if the External Review is related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the member's:

- Life or health; or
- Ability to reach and maintain maximum function.

The expedited External Review process can also occur at the same time as an expedited Appeal for a Claim Involving Emergent Care and a Concurrent Care Claim.

Additionally, the member may request orally or by electronic means an expedited External Review under this section if you, as the member's provider, certify that the requested health care service in question would be significantly less effective if not promptly initiated.

NOTE: Upon receipt of new information from the member that is relevant to our resolution of our Adverse Benefit Determination and was not considered by us, we shall reconsider our Adverse Benefit Determination and the IRO shall cease the External Review process until the reconsideration is complete. If the information submitted to us for reconsideration is related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the member's life or health or the ability to reach and maintain maximum function, we will render a decision within seventy-two (72) hours after the information is submitted or if the information submitted to us for reconsideration is not related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the member's life or health or the ability to reach and maintain maximum function, we will render a decision with fifteen (15) days after the information is submitted. If our reconsideration is still adverse to the member, the member may request the IRO resume the External Review process.

NOTE: If the member has the right to an External Review under Medicare (42 U.S.C. 1395, et seq.), then the member may not request an External Review of an Adverse Benefit Determination under the procedures outlined in the Plan.

Request for External Review

The member or their Authorized Representative must request an External Review through us within one hundred eighty (180) days of the date of Final Adverse Benefit Determination notice. All requests must be in writing, except for a request for an expedited External Review. Expedited External Reviews may be requested electronically or orally.

IRO Assignment

When we initiate an External Review by an IRO, we will select an IRO from a list of IROs that are certified by the Indiana Department of Insurance. We select a different IRO

for each request for external review filed and rotate the choice of IRO among all certified IROs before repeating a selection. The IRO will assign a medical review professional who is board certified in the applicable specialty for resolution of the External Review. An IRO that has a material professional, familial, financial, or other affiliation, or conflict of interest with us, our management, the member, you, the proposed drug, therapy or device, or the Facility will not be selected to conduct the review.

IRO Review and Decision
The IRO must consider all documents and information considered by us in making the Adverse Benefit Determination, any information submitted by the member and other information such as: the member's medical records, the member's attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Plan, the most appropriate practice guidelines, clinical review criteria used by the Plan or our utilization review organization, and the opinions of the IRO's clinical reviewers. . We agree to cooperate with the IRO throughout the External Review process by promptly providing any information requested by the IRO. The IRO is not bound by any previous decision reached by us.

The member is also required to cooperate with the IRO by providing any requested medical information, or by authorizing the release of necessary medical information. The member is permitted to submit additional information relating to the proposed service throughout the External Review process. The member is also permitted to use the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the External Review process.

The IRO will make its decision within fifteen (15) days after a standard External Review request is filed or within seventy-two (72) hours of after an expedited External Review request is filed. The IRO will provide the member and us with written notice of its decision within seventy-two (72) hours after making its determination for a standard External Review and within twenty-four (24) hours after making its determination for an expedited External Review.

Binding Nature of External Review Decision
An External Review decision by the IRO is binding on us. The decision is also binding on the member except to the extent that the member may have other remedies available under applicable state or federal law. The member may file not more than one (1) External Review request of our Adverse Benefit Determination.

An IRO is immune from civil liability for actions taken in good faith in connection with an External Review. The work product and/or determination issued by the IRO will be admissible in any judicial or administrative proceeding. The documents and other information created and reviewed by the IRO or medical review professional in connection with the External Review are not public records, cannot be disclosed as public records, and must be treated in accordance with confidentiality requirements of state and federal law.

If You Have Questions About Your Rights or Need Assistance
Members may contact Member Services at:

CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401
1-877-806-9284
(TTY: 1-800-743-3333 or 711)

Members may also contact the Indiana Department of Insurance at:

Indiana Department of Insurance
Consumer Services Department
311 W. Washington Street
Indianapolis, IN 46204
1-800-622-4461
317-232-2395

Contact IDOI Consumer Services: **http://www.in.gov/idoi/2526.htm**

To file a Consumer Complaint, members may go to: **http://www.in.gov/idoi/2552.htm**

Definitions

Definitions. For purposes of this section, the following definitions apply—

Adverse Benefit Determination means an adverse benefit determination as defined in 29 C.F.R. § 2560.503-1, as well as any rescission of coverage, as described in 45 C.F.R. § 147.128 (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time). An Adverse Benefit Determination is a decision by CareSource to deny, reduce, or terminate a requested Health Care Service or Benefit in whole or in part, including all of the following:

- A determination that the Health Care Service does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
- A determination of your eligibility for Benefits under the Plan;
- A determination that a Health Care Service is not a Covered Service;
- The imposition of an Exclusion or other limitation on Benefits that would otherwise be covered;
- A determination not to issue coverage, if applicable to this Plan; or
- A determination to rescind coverage under the Plan regardless of whether there is an adverse effect on any particular Benefit at that time.

A Claim Involving Emergent or Urgent Care means:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-emergent care determinations:
  - Could seriously jeopardize your life or health or your ability to regain maximum function, or
  - In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Appeal (or internal appeal) means the review by the Plan of an Adverse Benefit Determination, as required in this section.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable State or federal law.

Final Internal Adverse Benefit Determination means an adverse benefit determination that has been upheld by the Plan at the completion of the internal appeals process described in this Section.

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

Pharmacy

Qualified Health Plans in the Indiana Health Insurance Marketplace provide prescription drug coverage. This benefit will provide coverage for prescriptions obtained from a retail pharmacy, mail-order pharmacy or specialty pharmacy, and those that are administered in the patient's home, including drugs administered through a home health agency.

Details of Prescription Drug Coverage

Copayment requirements – Members may be required to pay a copayment for prescription drugs. Some plans offer lower co-pays 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 a still higher copay for a non-preferred drug.

For specialty pharmacy, a coinsurance is applied. Coinsurance is a percent of the drug's cost. When members pay a percentage, their cost may be high for many reasons:

- The cost of the drug may be high. Let's assume the coinsurance is 30%. In this case, a $250 drug will be more costly than a $25 drug.
- The drug may not be on the Preferred Drug List, so the member pays at a higher tier.
- The member may be buying a more expensive brand-name drug when there is a generic equivalent available for less money.

Prescribing health partners for CareSource Just4Me members must contact the plan for medication prior authorizations.

For a complete list of drugs available, visit **CareSource.com/Just4Me**.

Tiered Medications

Every drug on the plan's Preferred Drug List is in one of the tiers below. In general, the higher the cost-sharing tier number, the higher the cost for the drug:

- **Tier 1** Prescription Drugs include preventive medications. These medications are available without a copayment or coinsurance.
- **Tier 2** Prescription Drugs have the lowest coinsurance or copayment. This tier contains low-cost and preferred medications that may be generic drugs or multi- or single-source brand-name drugs.
- **Tier 3** Prescription Drugs have a higher coinsurance or copayment than those in Tier 2. This tier contains preferred medications that may be generic drugs or single- or multi-source brand-name drugs.
- **Tier 4** Prescription Drugs have a higher coinsurance or copayment than those in Tier 3. This tier contains non-preferred and high-cost medications. This includes medications considered generic drugs and single- or multi-source brand-name drugs.
- **Tier 5** Prescription Drugs have a higher coinsurance or copayment than those in Tier 4.

All Tier 4 medications (specialty medications) will require the use of CVS Caremark specialty pharmacy. Please visit our website at **CareSource.com** if you have questions about the medications that are Tier 4 medications.

Preferred Drug List (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 Just4Me uses a Preferred Drug List (PDL) or Formulary. Some drugs require prior authorizations. The online Formulary contains information about prior authorizations, quantity limits and step therapy protocols, and therapeutic interchanges for most drug classes.

Step Therapy and Quantity Limits
Certain medications on the Preferred Drug List are covered if utilization criteria are met. Step therapy is one such utilization technique that requires using a Formulary medication before the non-formulary medication would be approved for use.

Quantity limits are also placed on many medications, based on normal manufacturers' recommended dosing frequencies and safety considerations.

Generic Substitution
Generic substitution occurs when a pharmacy dispenses a generic version rather than a prescribed brand-name product. In the online Formulary, lower case italicized text indicates generic availability. However, not all strengths or dosage forms of the generic name in italicized type may be generically available. In most instances, a brand-name drug for which a generic product becomes available will become non-formulary, with the generic product covered in its place, upon release of the generic product onto the market. However, the Formulary document is subject to state-specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

Generic drugs are usually priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Prescription generic drugs are:

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

When a generic drug is substituted for a brand-name drug, you can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic interchange).

Prior Authorizations
To submit prior authorization requests by phone, call **1-866-286-9949** and follow the prompts, or fax to 1-866-930-0019.

Tell Us the Medical Reasons for Exceptions
Typically, our Preferred Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

CareSource has an exception process that allows the member or the member's representative to make a request for an exception. Reasons for exceptions may include intolerance or allergies to drugs, or inadequate or inappropriate responses to drugs listed on the PDL. The member or member's representative must initiate the request by calling Member Services. CareSource then reaches out to the provider to obtain the appropriate documentation.

CareSource will provide a decision no later than 72 hours after the request is received, or within 24 hours if the member is suffering from a serious health condition. Providers may be asked to provide written clinical documentation as to why a member needs an exception. In determining whether an exception will be given, CareSource will consider whether the requested drug is clinically appropriate.

Other Medical Supplies and Durable Medical Equipment (DME) – To support member access and convenience, other medical supplies, such as wound care supplies and enteral feeds, can continue to be filled by the CareSource Pharmacy Benefit Manager (PBM) through the retail pharmacy as previously done for a limited period of time until a DME provider can be contacted.

Medications Administered in the Health Partner's Setting – Medications that are administered in a health partner setting, such as a physician office, hospital outpatient department, clinic, dialysis center, or infusion center will be billed to the health plan. Prior authorization requirements now exist for many injectable medications.

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 Pharmacy

Our Pharmacy Directory gives members a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website for a complete list of network pharmacies at **CareSource.com**.

CareSource Just4Me™ Questions
For questions pertaining to prior authorization requests, please contact us at **1-866-286-9949**.

Primary Care Providers

Primary Care Provider (PCP) Concept
All CareSource members may 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 select a PCP from our health plan's online Health Partner Directory. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling Member Services.

Members select a PCP from our health plan's online Health Partner Directory. Members have the option to change to another participating PCP as often as needed.

PCP Roles and Responsibilities
PCP care coordination responsibilities include the following:

1. Assisting with coordination of the member's overall care, as appropriate for the member.
2. Serving as the ongoing source of primary and preventive care.
3. Recommending referrals to specialists, as required.
4. Triaging members.
5. 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 on how to refer members for case management.

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

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

PCPs are Responsible For:

- Treating CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plans outlined in this manual.

- Providing 30 days of emergency coverage to any CareSource patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by CareSource patients for emergency or urgent care if notified of the visit.
- Ensuring demographic and practice information is up-to-date for directory and member use.

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 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**.

Immunizations are an important part of preventive care for children and should be administered as needed.

Preventive Guidelines and Clinical Practice Guidelines
These clinical treatment protocols are systematically developed statements that help practitioners and members make decisions regarding appropriate health care for specific clinical circumstances or for specific age ranges. The use of these guidelines allows CareSource to measure the impact of the guidelines on outcomes of care. Treatment protocols are developed with the input of local health care providers who are part of our quality committees and are based on national standards.

Preventive Health Guidelines and Clinical Practice Guidelines are distributed to:

- All new and existing health care partners via Health Partner Manual updates, provider newsletters, **CareSource.com**, Care Management and/or Provider Relations Representatives.
- Updates to health partners will be communicated in writing by mail, fax or email.
- Examples of preventive guidelines include, but are not limited to, recommendations for preventive care for patients in the following age groups:
  – 0-1 year
  – 1-4 years
  – 5-10 years
  – 11-18 years
  – 19-29 years
  – 30-39 years
  – 40-49 years
  – 50-64 years
  – 65+ years

Examples of clinical practice guidelines that may be developed or adopted by CareSource include, but are not limited to:

1. Asthma care
2. Diabetes care
3. Behavioral health
4. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Healthchek
5. Prenatal care

All guidelines are reviewed and updated , as needed, at least every two years. Preventive guidelines and clinical practice guidelines are available on **CareSource.com**. The use of these guidelines allows CareSource to measure the impact of the guidelines on outcomes of care.

Health Partner Appeals Procedures

NOTE:

If you, in your capacity as a member's provider, file an appeal on behalf of a member, please refer to the procedures set forth under the section of this Manual titled "CareSource Just4Me™ Member Grievances and Appeals Procedures."

Appeal of Claims Denials

If you do not agree with the decision of the processed claim, you will have 365 calendar days from the date of service or discharge to file a claim appeal. If the health partner is denied authorization or reimbursement due to not obtaining a required prior authorization, then the health partner has one hundred eighty (180) days from the date of service or date of 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, health care partners will be notified in writing. If the appeal is approved, payment will show on the health partner'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 calendar days from the date of service or discharge to submit a corrected claim.

How to Submit Claim Appeals

Claims Appeals:

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

Provider Portal: https://providerportal.caresource.com/IN/

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 health partner'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.

Just4Me™ Health Partner Claim Submissions

Toll-Free Fax Line: 855-475-3161
Fax Line: 937-487-0702

Just4Me™ Health Partner Claim Appeals

Toll-Free Fax Line: 855-795-0088
Fax Line: 937-531-2398

Mail:

CareSource
P.O. Box 2008
Dayton, OH 45401

Quality Program

CareSource is committed to providing care that is safe, effective, member-centered, timely, efficient and equitable. The scope of the CareSource quality improvement program is comprehensive and includes both clinical and non-clinical services. CareSource monitors and evaluates quality of care, safety and service delivered to our members, with emphasis on accessibility to care, availability of services, and physical and behavioral healthcare delivered by network practitioners and providers. CareSource also monitors member services through practitioners, providers, hospital, utilization management, care management and pharmacy programs. Member satisfaction and health outcomes are monitored through routine health plan reporting, annual HEDIS and CAHPS scores, assessment of provider and member satisfaction, and review of accessibility and availability standards, utilization trends, and quality improvement activities. Performance is assessed against goals and objectives that are in keeping with industry standards. Annually, CareSource completes an evaluation of our QI program.

CareSource supports an active, ongoing, and comprehensive quality improvement program across the enterprise. Major objectives of the QI Program include:

- Advocate for members across settings
- Meet member access and availability needs for physical and behavioral healthcare
- Determine interventions for HEDIS overall rate improvement that increase preventive care rates and facilitate support of members' acute and chronic health conditions and complex needs
- Determine interventions for CAHPS rate improvement that enrich member and provider experience and satisfaction
- Demonstrate enhanced care coordination and continuity across settings
- Meet members' cultural and linguistic needs
- Monitor important aspects of care to ensure the safety of members across health care settings
- Determine practitioner adherence to clinical practice guidelines
- Support member self-management efforts
- Partner collaboratively with network partners, practitioners, regulatory agencies, and community agencies
- Ensure regulatory and accrediting agency compliance (Center for Medicare and Medicaid Services, Indiana Medicaid, URAC, and National Committee for Quality Assurance) and maintain NCQA Accreditation

Quality Measures

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

CareSource uses the Healthcare Effectiveness Data and Information Set (HEDIS®) to measure 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 is developed and maintained by The National Committee for Quality Assurance (NCQA). The HEDIS tool is used by 90 percent of America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence-based care and address the most pressing areas of care. Potential quality measures for the Health Insurance Marketplace are:

- Wellness and Prevention
  - Preventive Screenings (breast cancer, cervical cancer, Chlamydia)
  - Medical Assistance with Smoking and Tobacco Use Cessation
- Chronic Disease Management
  - Cholesterol Management – Patients with Cardiovascular Conditions
  - Comprehensive Diabetes Care
  - Controlling High Blood Pressure
  - Use of Appropriate Medications for People with Asthma
- Behavioral Health
  - Follow-up After Hospitalization for Mental Illness
  - Antidepressant Medication Management
  - Follow-up for Children Prescribed ADHD Medication
- Safety
  - Use of Imaging Studies for Low Back Pain

CareSource uses the annual member survey, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys, to capture member perspectives on health care quality. CAHPS is a program overseen by the United Stated Department of Health and Human Services – Agency for Healthcare Research and Quality (AHRQ). Potential CAHPS measures for the Health Insurance Marketplace include:

- Customer Service
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Ratings of All Health Care, Health Plan, Personal Doctor, Specialist

Referrals and Prior Authorizations

This section describes the referral and prior authorization processes and requirements for services provided to CareSource members. Please visit our Provider Portal at **CareSource.com** for the most current information on prior authorization (PA) and referral requirements.

Just4Me uses a select network of hospitals, physicians and ancillary health partners. Typically, Just4Me does not pay for non-network, non-emergent services; however, these may be provided with prior authorization from Medical Management.

Access to Staff

- Staff are available from 8 a.m. to 5 p.m. Eastern Standard Time (EST) during normal business hours for inbound calls regarding Utilization Management (UM) issues.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff are available to accept collect calls regarding UM issues.
- Staff 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 health partners as well as between behavioral health care health partners.

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 other health partners are subject, and in accordance with accepted practices.

Health Partner Performance and Profiling

CareSource monitors the over and underutilization of medical services as a function of medical management oversight. Health partner profiling is done periodically to measure utilization of common inpatient and outpatient services as preventive services. Healthcare Effectiveness Data and Information Set (HEDIS®) measures clinical performance and pharmacy utilization. Summary reports for these measures are available to individual health partners upon request, and routine periodic reporting is being developed.

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

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

Referrals
If you have questions about referrals and prior authorizations, please call Medical Management at **1-866-286-9949**.

To find network health partners, use our online Find a Doctor/Provider tool at CareSource.com under "Quick Links."

Services That Do Not Require a Referral

Some health care services provided by specialists do not require a referral from a Primary Care Provider (PCP). Members may schedule self-referred services from participating health partners themselves. PCPs do not need to arrange or approve these services for members as long as any applicable benefit limits have not been exhausted.

Referral Procedures

A referral is required for specialty services and for plan members to be evaluated or treated by most specialists. Any treating doctor can refer CareSource members to specialists.

Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists require prior authorization for any services rendered to CareSource members. You can request a prior authorization by calling our Medical Management Department at **1-866-286-9949** and selecting the option to request a prior authorization. Or you can submit a request online at **CareSource.com** and select the Provider Portal option from the menu.

If you have difficulty finding a specialist for your CareSource member, please use our online Find a Doctor/Provider tool at **CareSource.com** under "Quick Links," or call Provider Services at **1-866-286-9949**.

Steps to Make a Referral
Referring Doctor — Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

Specialist — Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure.

Referrals to out-of-plan providers — A member may be referred to out of-plan providers if the member needs medical care that can only be received from a doctor or other health

care provider who is not participating with our health plan. Treating health partners must get prior authorization from our health plan before sending a member to an out-of-plan provider.

Referrals for Second Opinions — A second opinion is not required for surgery or other medical services. However, health care partners or members may request a second opinion.

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

- The health partner must be a participating health partner. If not, prior authorization must be obtained to send the patient to a non-participating health partner.
- The health partner must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The health partner must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the health partner giving the second opinion.

Prior Authorization Procedures

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

Online: CareSource.com and select the Provider Portal option from the menu
Email: mmauth@caresource.com
Fax: Please fax the prior authorization form to **1-877-716-9480**. Copies of prior authorization forms can be found on **CareSource.com**.
Mail: Send prior authorization requests to:
CareSource
P.O. Box 1307
Dayton, OH 45401-1307
Phone: 1-866-286-9949; follow the appropriate menu prompts for the authorization requests, depending on your need.

When requesting an authorization, please provide the following information:

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

If the health partner 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 emergency), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

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

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

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and 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. Health partners 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 health partner. CareSource will notify you of prior authorization determinations by a letter mailed to the health partner's address on file.

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

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

Utilization Management (UM)
Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The Medical 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. Referrals to the CareSource case management team are made, if needed. CareSource makes it's UM criteria available in writing by mail, fax or email and via the web.

Mail: CareSource
P.O. Box 1307
Dayton, OH 45401-1307
Fax: 1-877-716-9480
Email: mmauth@caresource.com

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

Access to Staff
- Staff are available from 8 a.m. to 5 p.m. Eastern Standard Time (EST) during normal business hours for inbound calls regarding Utilization Management (UM) issues.
- Staff can receive inbound communication regarding UM issues after normal business hours.

- Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff are available to accept collect calls regarding UM issues.
- Staff are accessible to callers who have questions about the UM process.

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

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.

Provider Performance and Profiling
As a function of medical management oversight responsibilities, CareSource monitors over and underutilization of medical services. Provider profiling is done periodically to measure utilization of common inpatient and outpatient services as preventive services. Healthcare Effectiveness Data and Information Set (HEDIS®) clinical performance measures and pharmacy utilization. Summary reports for these measures are available to individual providers upon request, and routine periodic reporting is being developed.

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

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 health care partners in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients. CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. CareSource also has a medical policy developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the 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.

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

Our members' health is always our number one priority. Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations. You may request the information by calling or faxing the CareSource Medical Management Department. If you would like to discuss an adverse decision with CareSource's physician reviewer, please call the Medical Management Department at **1-866-286-9949** within five business days of the determination.

Post Stabilization Services

Please call **1-866-286-9949** for any questions related to post-stabilization services. The definition of "Post-Stabilization Care Services" is 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 health partner. To request prior authorization for observation services as a non-participating provider or to request authorization for an inpatient admission please call **1-866-286-9949**. When calling, follow the prompt for post-stabilization. During regular business hours, your call will be answered by our Medical Management Department. If calling after regular business hours, the call will be answered by CareSource 24, our nurse triage line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

CareSource™

Health Care with Heart

CareSource.com/IN

IN-EXCP-07a
November 2014