2015 KENTUCKY 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 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 71 of this document.
Submit a Claim	• Refer to the Health Partner Quick Reference Guide at: **https://www.caresource.com/providers/kentucky/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 **1-855-852-5558**, 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.*

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 Kentucky Health Benefit Exchange.**

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/**.

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

Section	Location
Health Partner Quick Start Guide	Inside Front Cover
Welcome Letter	i
Table of Contents	ii
About CareSource Just4Me™	Pages 1-4
Claims Submissions	Pages 5-14
Communicating with CareSource	Pages 15-18
Covered Services and Exclusions	Page 19
Credentialing and Recredentialing	Pages 20-26
Fraud, Waste and Abuse	Pages 27-32
Key Contract Provisions	Pages 33-35
Member Enrollment and Eligibility	Pages 36-37
Member Support Services and Benefits	Pages 38-46
Member Complaints & Appeals Procedures	Pages 47-56
Pharmacy	Pages 57-59
Primary Care Providers	Pages 60-62
Hospital Responsibilities	Page 63
Cultural Competency	Page 64
Health Partner Appeals Procedures	Pages 65-68
Quality Improvement Program Goals	Page 69
Quality Measures	Page 70
Referrals and Prior Authorizations	Pages 71-76
Medical Records	Pages 77-78

About CareSource Just4Me™

Welcome

We strive to work with our health partners as 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 issuer in the Kentucky Health Benefit Exchange. 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 health insurance needs. 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
- 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)
- CareSource24 (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 Area
CareSource Just4Me™ serves members in the following Kentucky counties:

Boone	Jessamine
Bourbon	Kenton
Bullitt	Madison
Campbell	Oldham
Clark	Pendleton
Fayette	Scott
Grant	Shelby
Jefferson	Woodford

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 **1-855-852-5558**.

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 how PII will 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.

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

Billing Methods

CareSource accepts paper and electronic claims.

Electronic Claims

We encourage providers 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

Submitting Electronic Claims

To submit claims electronically, health partners must work with an approved 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: KYCS1

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. 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

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).

Paper Claims
For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. However, 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)
- CMS 1450 (UB-04), formerly UB92 form for Facilities

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

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 health partner practice (e.g., legal business entity) has a different Tax ID number.
- Signature of Physician or Supplier – The health partner'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

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.

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 Health Partner NPI, TIN and Member ID Number on Professional Claims

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

- 2010AA Loop – Billing Health Partner Name
- 2310B Loop – Rendering Health Partner Name
  - 2010AA Loop – Billing Health Partner Name
    - Identification Code Qualifier – NM108 = XX
    - Identification Code – NM109 = Billing Health Partner NPI
  - 2310B Loop – Rendering Health Partner Name
    - Identification Code Qualifier – NM108 = XX
    - Identification Code – NM109 = Rendering Health Partner NPI

The Billing Health Partner TIN (Tax Identification Number) must be submitted as the secondary health partner identifier using an 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 Health Partner TIN or SSN

Institutional Claims

On 837I institutional claims (005010223A2), the Billing Health Partner NPI should be in the following location:

- 2010AA Loop – Billing Health Partner Name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing Health Partner NPI

The Billing Health Partner TIN (Tax Identification Number) must be submitted as the secondary health partner identifier using an 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 Health Partner TIN or SSN

On all electronic claims, the CareSource Member ID number should go on:

- 2010BA Loop – Subscriber Name
  NM109 = Member ID Number

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.
- 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.
- **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.**

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

CareSource
Attn: Claims Department
P.O. Box 824
Dayton, OH 45401-0824

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 this happens, health partners have 365 calendar days from the date of service or discharge to submit a corrected claim or 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 original date of payment notification or denial to file an 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 ninety (90) days from the date in which the health partner receives an explanation of payment from the member's primary payer.
- 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 are not submitted within the required time frame, the claim will be denied for timely filing.

Electronic Funds Transfer

CareSource 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.

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 health partners
- **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.

Enrolling in EFT: 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 health partners to enroll in EFT. Free EFT training is also available to CareSource health partners through InstaMed during the enrollment process. You can view the training by visiting **www.instamed.com/aha-eraeft**.

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 partners 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 **http://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.
- Claims submitted with a Coordination of Benefits (COB) will 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 care partner.

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

CareSource Health Partner 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 health

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

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

CareSource pays claims in accordance with the Kentucky Prompt Pay Act, which establishes various time frames for the processing and payment of claims, as set forth in detail below:

1. CareSource reimburses health partners for clean claims, or sends a written or an electronic notice denying or contesting the claim, within thirty (30) calendar days from the date the claim is received by CareSource or any entity that administers or processes claims on behalf of CareSource; except that clean claims involving organ transplants are paid, denied, or contested within sixty (60) calendar days from the date the claim is received by CareSource or any entity that administers or processes claims on behalf of CareSource.
2. Within the applicable claim payment time frame, CareSource shall: (a) pay the total amount of the claim in accordance with any contract between CareSource and the health partner; (b) pay the portion of the claim that is not in dispute and notify the health partner, in writing or electronically, of the reasons the remaining portion of the claim will not be paid; or (c) notify the health partner, in writing or electronically, of the reasons no part of the claim will be paid.
3. Within 48 hours of receiving a claim submitted electronically or within 20 days of receiving a claim submitted by mail, CareSource must notify the health partner of: (a) receipt of the claim; (b) all information that is missing from the billing instrument; (c) any errors in the billing instrument; and/or (d) any other circumstances which preclude it from being a clean claim.
4. Once the health partner submits a corrected claim, if the claim is now a clean claim, CareSource shall pay the claim in accordance with (1) above.

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. Claim status is updated daily, 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. Check **CareSource.com** for a sample EOP.

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

Note: 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.

Other Coverage – Coordination of Benefits (COB)

Coordination of Benefits
Health partners are responsible for asking CareSource members for all health care insurance information at the time of service. This information helps CareSource ensure that it is paying claims appropriately.

COB Overpayment
If a health partner 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
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.

CareSource Just4Me™ is a commercial product; like other commercial health plans, members will be responsible for copays, coinsurance and deductibles. Health partners are responsible for collecting the appropriate payments. 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-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 health partners 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.

Questions
If you have questions about claims submissions, please call **1-855-852-5558**.

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.

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 1-855-852-5558
Provider Services 1-855-852-5558
Prior Authorizations 1-855-852-5558
Claims Inquiries 1-855-852-5558
Credentialing 1-855-852-5558
CareSource Just4Me™ Member Services 1-888-815-6446
CareSource24 - Nurse Triage Line 1-866-206-7879
Fraud, Waste and Abuse Hotline 1-855-852-5558
Pharmacy 1-855-852-5558
TTY for the Hearing Impaired ..... 1-800-648-6056 or 711

Fax Numbers

Case Management Referral	1-877-946-2273
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 Provider 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 Provider section of the site you will find commonly used forms, newsletters, updates and announcements, our health partner manual, claims information, frequently asked questions and much more.

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

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 – Health partners can track benefit limits electronically in real time before services are rendered for: Chiropractic, Occupational Therapy, Physical Therapy, Speech Therapy
- Care Treatment Plans – Health partners 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.

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 **1-855-852-5558**.

How to Communicate with CareSource by Mail

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

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 824
Dayton, OH 45401-0824

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 health partners 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 under way 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 health partner from your practice, helps us keep our records current and is 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

CareSource covers all medically necessary covered services for members. Please visit the CareSource website at **CareSource.com** for information on medical services, the member's coverage status, excluded services, and other information about obtaining services.

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 **1-855-852-5558**.

Medical Necessity Determinations

Covered services may require prior authorization. Please refer to our website and the "Referrals and Prior Authorizations" section of this manual for more information about referral and prior authorization procedures. An updated list of services that require prior authorization is available at **CareSource.com**.

If a request for authorization is submitted, CareSource will notify the health partner and member in writing of the determination. 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.

Appointment Accessibility Standards

CareSource follows the accessibility requirements set forth by applicable regulatory and accrediting agencies and CareSource monitors compliance with these standards on an annual basis.

TYPE OF APPOINTMENT	SCHEDULING TIME FRAME
Primary Care Health Partners	
Routine, non-urgent, or preventive care visits	Within 30 days
Urgent care	Within 48 hours
Emergency or emergency visits	Immediately upon presentation
Specialty Care	
Routine, non-urgent, or preventive care visits	Within 30 days
Urgent care	Within 48 hours
Behavioral Health Services	
Emergency care with crisis stabilization	Within 24 hours
Urgent care	Within 48 hours

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.

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 Kentucky Code and Kentucky Department of Insurance

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 promote 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 partners 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 health partners 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 Provider.
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 Provider Agreement and Provider Manual.

Debarred Health Partner 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.

Health partners must offer a list that identifies all health care 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.

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 Health Partner 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).

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 health partners
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)

In addition to the Urgent Care and Ambulatory Surgical facilities being credentialed, the Medical Director or senior health partner 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

Recredentialing

To comply with accreditation standards, health partners are recredentialed at least every three years from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status which may affect ability to perform services the health partner is under contract to provide. CareSource considers information regarding performance to include complaints, safety and quality issues identified through the quality improvement program, and information regarding sanctions collected from the NPDB, Medicare and Medicaid Sanctions and Reinstatement Reports, Medicare Opt-Out and the HHS/OIG. Health partners will be considered recredentialed unless otherwise notified.

A health partner's agreement may be terminated if at any time it is determined by CareSource that credentialing requirements are no longer being met.

Delegation of Credentialing/Recredentialing

CareSource will only enter into agreements to delegate credentialing and recredentialing with entities accredited to perform credentialing functions by the NCQA. The entity must also utilize an NCQA-accredited Credentials Verification Organization ("CVO") and successfully pass a pre-delegation audit demonstrating compliance with NCQA, federal, and state requirements. Any organization that performs credentialing and recredentialing on CareSource's behalf will apply criteria consistent with this Health Partner Manual and any other information CareSource disseminates to health care partners regarding credentialing and recredentialing.

The pre-delegation audit 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 health partner 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. Our 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 to a participating health partner if he/she has been affected by an adverse determination unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan. To submit an appeal request, the following steps apply:

Step 1 – Submit to the Vice President/Senior Medical Director an appeal reconsideration 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 appeal 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 first appeal 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 do not have appeal rights. However, they 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 provider 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 Family of Companies 2014 Fair Hearing Plan unless an exception applies. Exceptions are set forth in the CareSource Family of Companies 2014 Fair Hearing Plan.

Council for Affordable Quality Healthcare (CAQH) Application

CareSource is a participating organization with CAQH. Please make sure that we have access to your application prior to submitting your CAQH number:

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)

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.

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 partner.

Physicians whose boards require periodic recertification will be expected but not required to be recertified, although failed attempts at recertification 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 member of ABMS, 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.

Health Partner Rights

- CareSource shall notify an applicant of its determination regarding a properly submitted application for credentialing within sixty (60) days of receipt of an application containing all information required by CareSource and the most recent version of the CAQH credentialing form. Health partners will be considered recredentialed unless otherwise notified.
- 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).

Fraud, Waste and Abuse

Health care fraud, waste and abuse hurt 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, including any definition of fraud included in Chapter 304, Subtitle 47 of the Kentucky Revised Statutes Annotated.

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, health partner 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 health partners 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 Provider 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 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 partners termination with or without cause
- Health partners 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.

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 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, health partners 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 fraud, waste and abuse 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, health partners 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:** 1-855-852-5558 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 health partners 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 health partner 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 days of the date of service or date of discharge. If health partner was denied authorization or reimbursement due to not obtaining a required prior authorization, then the health partner must file a claim appeal within one hundred eighty (180) days from the date of service or 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 from your practice, helps us keep our records current and is critical for claims processing.

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a health partner from your practice, helps us keep our records current and is 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.*)
Adding new health partners or deleting health partners	Immediate
Health partner leaves 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 partner 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. This information is also reportable to Medicaid and Medicare.

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, health partners 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 Kentucky Health Benefit Exchange 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 Kentucky Health Benefit Exchange every year. They must inform the Kentucky Health Benefit Exchange if they become pregnant, have a baby, change address or phone number, have a change in income or marital status, or become eligible for other health care coverage.

Members must enroll in the Kentucky Health Benefit Exchange every year. They must inform the Kentucky Health Benefit Exchange 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.

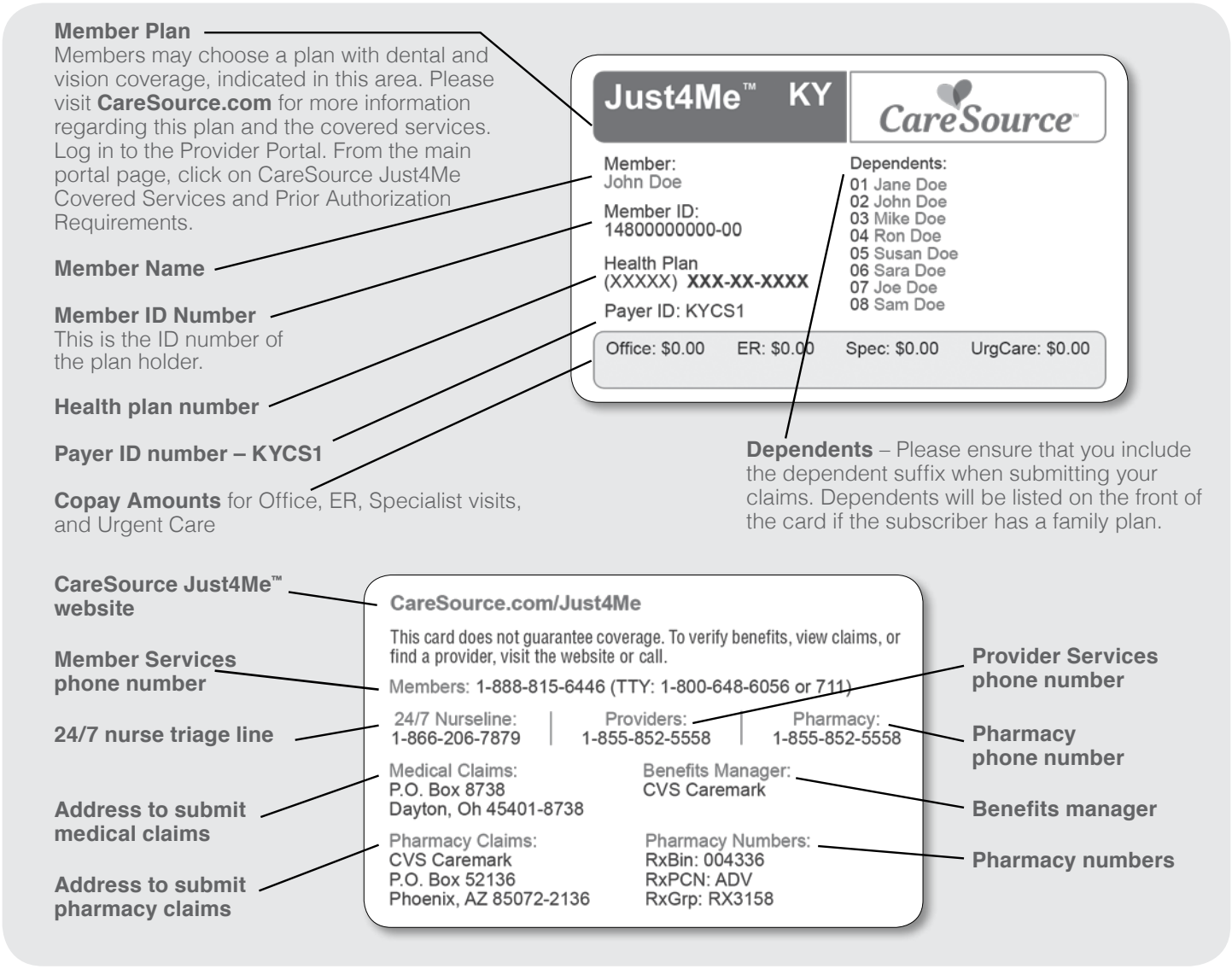
Health Partners may use our secure Provider Portal on our website to check member eligibility, or call Provider Services.

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

Provider Services: Call 1-855-852-5558 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 Kentucky Health Benefit Exchange.

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.

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

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.

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 health partner 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, **1-888-815-6446**, 7 a.m. - 7 p.m. (TTY for the hearing impaired: 1-800-648-6056 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 CareSource24, 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. CareSource24 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 Provider (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 **1-855-202-0385**.

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 patient's care management programs. In addition, we invite and encourage you to direct and participate in the development of a care plan individualized to the needs of your patient. We believe communication and coordination are integral to ensure the best care for these patients. 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 health partner.

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 1-855-202-0385.

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 CareSource24 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. 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 **1-855-202-0385** when a member with a high-risk pregnancy has been identified.

Eyeglass Frames

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

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.

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.

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

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 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 partner is not in compliance with the ADA?

A. If a health care 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

Telephone Arrangements/24-Hour Access

CareSource PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A health partner's office phone must be answered during normal business hours
- Answer the member's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
  - After hours telephone care for non-emergent, symptomatic issues within 30 minutes
  - Same day for non-symptomatic concerns
  - Crisis situations within 15 minutes
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a health partner's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record

- During after-hours calls, a health partner must have arrangements for the following:
  - Office phone is answered after hours by an answering machine service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of 30 minutes
  - Office phone is answered after hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the health partner has designated to return the call within a maximum of 30 minutes; and
  - Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of 30 minutes.

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.

Members 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 in CareSource's network. If a qualified health partner is not able to see you, then CareSource must set up a visit with a health partner not in our network.

Members 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.

Health Partner Communications with Members about Treatment and Financial Arrangements

Health partners must inform members of all information relevant to the member's medical condition or treatment options, and any other information the health partner deems to be in the member's best interest. Health partners will not be penalized for discussing such information with members.

Health partners must also answer members' questions regarding the financial incentives and financial arrangements between the health partner and CareSource. Health partners will not be penalized for providing such information to the member.

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 about 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 health partner, 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 Complaints and Appeals Procedures

Members may contact Member Services at **1-888-815-6446** 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 Complaint Process and the Internal and External Appeals procedures 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 Complaint Process

We have put in place a Complaint Process for the quick resolution of Complaints members submit to us that are unrelated to Benefits or Benefit denials. For purposes of this Complaint Process, we define a Complaint as an expression of unhappiness or dissatisfaction, orally or in writing, concerning any matter relating to any aspect of the Plan's operation. If members have a Complaint 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

They may also submit a Complaint by calling us at 1-888-815-6446. They may arrange to meet with us in-person to discuss the Complaint.

Within thirty (30) calendar days of our receipt of a Complaint, we will investigate, resolve, and respond to the Complaint and send a letter explaining the Plan's resolution of the Complaint.

Please note that the Adverse Benefit Determination Appeal Process below addresses issues 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 **1-888-815-6446**.

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 partner regarding such Prior Authorization request. However, they may designate an Authorized Representative to act on their behalf for a specific request.

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

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.

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

- **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.
- **Urgent Review Request** – A request for Prior Authorization or Predetermination that in the opinion of the treating health partner 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 **1-888-815-6446** with any questions.

Review Request Category	Review Request Category
Prospective Urgent*	Within twenty four (24) hours of the request but not greater than seventy-two (72) hours from the receipt of request if additional information is necessary for the determination.
Prospective Non-Urgent*	Within two (2) Business Days after receiving all of the information.
Concurrent Urgent when request is received at least 24 hours before the expiration of the previous authorization or no previous authorization exists*	Within twenty-four (24) hours from the receipt of the request and not greater than seventy two (72) hours prior to the time the prior authorization will expire.
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists*	Within twenty-four (24) hours from the receipt of the request and not greater than seventy two (72) hours prior to the time the prior authorization will expire.
Concurrent Non-Urgent*	As soon as possible taking into account medical exigencies, but not later than seventy-two (72) hours from the receipt of request unless additional information is necessary for the determination, which notice will be given within twenty-four (24) hours of receipt of the claim. If additional information is requested, the decision will be made within forty-eight (48) hours after the end of the period given to provide the information or receipt of the information by the Plan whichever is less.
Retrospective*	30 calendar days from the receipt of the request.

* The timelines above do not apply if the Plan does not receive sufficient information to determine whether or not Health Care Services are Covered Services. For Prospective Urgent Review Requests, the Plan will notify you or your 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 24 hours of the Plan's receipt of the Prospective Urgent Review Request. You or your health partner shall submit such information to the Plan within 48 hours of the Plan's request. The Plan shall then issue a notification within

48 hours of the Plan's receipt of such information or the end of the period afforded to you or your health partner to provide the specified additional information. In all other cases, if additional information is needed to make a benefit determination about our decision, we will notify the requesting health partner and send written notification to you or your Authorized Representative of the specific information necessary to complete the review in accordance with applicable laws. If we do not receive the specific information requested or if the information is not complete by the timeframe identified 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 members with a Notice of an Adverse Benefit Determination. The Notice of an Adverse Benefit Determination will include the specific reason or reasons for the Adverse Benefit Determination; the reference to the specific Plan provisions on which the Adverse Benefit Determination is based; a description of any additional material or information necessary for the member or provider to perfect the claim for Benefits; and a description of our review procedures and the time limits applicable to such procedures.

Members have 180 calendar days after receiving the Notice of an Adverse Benefit Determination to file an Appeal with us.

Adverse Benefit Determination Appeals

If we make an Adverse Benefit Determination, we will provide the member or Authorized Representative with a Notice of an Adverse Benefit Determination, as described above. An Adverse Benefit Determination is a decision by us to deny Benefits because services are not covered, are excluded, or limited under the Plan, or because the member is not eligible to receive the Benefit. The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

For Adverse Benefit Determinations related to Concurrent Service Requests or Prospective Service Requests, members or their Authorized Representatives may request that we reconsider the Adverse Benefit Determination. We will reconsider the Adverse Benefit Determination within three (3) business days after the request for reconsideration. The reconsideration must be conducted between the health partner rendering the Health Care Service and the reviewer who made the Adverse Benefit Determination; provided, however, that if the Plan's reviewer is not available, such review may designate another reviewer. For requests for reconsideration related to an Urgent Care Service Request, the Plan shall review such request in a timeframe that takes into account the medical exigencies. Reconsideration is not a prerequisite to an internal or External Review of an Adverse Benefit Determination.

If a member wishes to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, the member or Authorized Representative must submit an appeal in writing within one hundred eighty (180)

calendar days of receiving the Adverse Benefit Determination. They do not need to submit Urgent Care appeals in writing. This communication 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 Authorized Representative disagrees with the denial; and
5. Any documentation or other written information to support the request.

The member or Authorized Representative may send a written request for an appeal to:
CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401-1947

The member or Authorized Representative may also submit an Adverse Benefit Determination Appeal by calling us at **1-888-815-6446**.

For Urgent Care requests for Benefits that have been denied, members or their health partner can call the Plan at **1-888-815-6446** to request an appeal.

The Plan offers one (1) level of appeal. The Plan must notify the members of the appeal determination within fifteen (15) calendar days after receiving the completed appeal for a pre-service denial and thirty (30) days after receiving the completed post-service appeal.

Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. CareSource will review all claims in accordance with the rules established by the Superintendent and the United States Department of Labor. In life-threatening circumstances, members are entitled to an immediate appeal to an Independent Review Entity ("IRE").

CareSource's decision after exhaustion of this internal appeal process will be final and considered the Final Internal Adverse Benefit Determination.

When a member, a person acting on the member's behalf, or the member's health partner of record expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, CareSource or a utilization review agent will treat that expression as an appeal of an Adverse Benefit Determination.

Within five (5) business days after we receive an appeal of an Adverse Benefit Determination, we will send to the appealing party a letter acknowledging the date the Plan received the appeal and a list of documents the appealing party must submit. If the appeal was oral, the Plan will enclose a one-page appeal form clearly stating that the form must be returned to CareSource for prompt resolution. The Plan has thirty (30) calendar days from receipt of a written appeal of Adverse Benefit Determination or the appeal form to complete the appeal process and provide written notice of the appeal decision to the appealing party. The appeal will be reviewed by a health partner not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure, or treatment under review.

Notice of our Final Internal Adverse Benefit Decision on the appeal will include the dental, medical, and contractual reasons for the resolution; clinical basis for the decision

and the specialization of health partner consulted. A denial will also include notice of the member's right to have an IRE review the denial and the procedures to obtain a review.

Separate schedules apply to the timing of claims appeals, depending on the type of claim. The types of claims are:

- Urgent Care Services Requests for Benefits – A request for Benefits provided in connection with Urgent Care Services, as defined in Section 13 "Glossary"
- Prospective Service Requests for Benefits or Pre-Service Requests – A request for Benefits which the Plan must approve or in which you must notify us before non-Urgent Care Services are provided; and
- Retrospective Post-Service – A a claim for reimbursement of the cost of non-Urgent Care Services that have already been provided.
- Concurrent Service Requests for Benefits – A a request for Benefits 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.

Expedited Review of Internal Appeal

Expedited Review of an internal appeal may be started orally, in writing, or by other reasonable means available to the member or health partner. We will complete expedited review of an appeal within 24 hours but no later than seventy-two (72) hours after our receipt of the request and will communicate our decision by telephone to your attending Physician or the ordering health partner. We will also provide written notice of our determination to the member, attending Physician or ordering health partner, and the Facility rendering the service. We maintain records of requests for External Review for a minimum of three (3) years.

Members may request an expedited review 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 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.
- Except as provided above, a claim involving Urgent Care Services 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.

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
Pursuant to KRS 304.17A-600 to 304.17A-633, CareSource, as a health plan, must provide a process that allows the members the right to request an independent External Review of an Adverse Benefit Determination.

An External Review will be conducted by an Independent Review Entity ("IRE") assigned by the Kentucky Department of Insurance. The member will be assessed a filing fee of $25.00 to be paid to the IRE. This fee may be waived if the IRE determines that the fee creates a financial hardship on the member. The fee shall be refunded if the IRE finds in favor of the member. There is no minimum cost of Health Care Services denied in order to qualify for an External Review; however, you must generally exhaust CareSource's internal appeal process before seeking an External Review. Any exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

Members are entitled to an External Review by an IRE in the following instances:

- The internal appeal process was completed or jointly waived by the member and CareSource, or CareSource failed to make a determination within 30 days of receiving the written appeal or within 72 hours of receiving the request for an expedited appeal; and
- The member was covered on the date of service or, if a prospective denial, the member was eligible to receive benefits on the date the proposed service was requested.
- There are three (3) types of IRE reviews: standard, expedited, and external investigation/experimental. Standard reviews and external investigation/experimental reviews are normally completed within thirty (30) calendar days. An expedited review for urgent medical situations must be complete within 24 hours from receipt of all required information, unless the member and CareSource agree to a 24-hour extension, and can be requested if the member is hospitalized, or if, in the opinion of the treating health partners, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:
  - Placing the health of the member or, with respect to a pregnant woman, the health of the member or her unborn child in serious jeopardy;
  - Subjecting the member to severe pain that cannot be adequately managed;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of a bodily organ.

A member may also request an External Review of an Adverse Benefit Determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit under the Plan. To be eligible for an External Review under this section, the treating physician shall certify that one of the following situations is applicable:

- Standard health care services have not been effective in improving the condition.
- Standard health care services are not medically appropriate for the member.
- There is no available standard health care service covered by the health plan issuer that is more beneficial than the requested health care service.

Additionally, the member may request orally or by electronic means an expedited review under this section if the treating physician certifies that the requested health care service in question would be significantly less effective if not promptly initiated.

NOTE: An expedited External Review is not available for retrospective Final Internal Adverse Benefit Determinations (meaning the Health Care Service has already been provided to the member.)

NOTE: Upon receipt of new information from the IRE, we may reconsider our Adverse Benefit Determination and provide coverage. If we make such reconsideration, we will notify the member, the IRE, and the Kentucky Department of Insurance of our decision within five (5) Business Days.

Request for External Review
The member or the member's authorized representative must request an External Review through us within four (4) months of receiving CareSource's written decision rendered under the internal appeals process. All requests must be in writing, except for a request for an expedited External Review. Expedited External Reviews may be requested electronically or orally.

If the member's request is complete, we will initiate the External Review and notify the member or the member's authorized representative in writing, or immediately in the case of an expedited review, that the request is complete and eligible for External Review. The notice will include the name and contact information for the assigned IRE for the purpose of submitting additional information.

We will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRE. If a request for expedited review is complete, we will immediately provide or transmit all necessary documents and information regarding the Adverse Benefit Determination to the Kentucky Department of Insurance.

If the request is not complete, we will inform the member or the member's authorized representative in writing and specify what information is needed to make the request complete. If we determine that the Adverse Benefit Determination is not eligible for External Review, we must notify the member or the member's representative in writing and provide the member or the member's representative with the reason for the denial and indicate that the denial may be appealed to the Kentucky Department of Insurance.

The Kentucky Department of Insurance may determine that the request is eligible for External Review regardless of the decision by us and require that the request be referred for External Review. The Department's decision will be made in accordance with the terms of the Plan and all applicable provisions of the law.

IREs are assigned by the Kentucky Department of Insurance on a rotating basis so that CareSource does not have the same IRE for two consecutive external reviews.

IRE Review and Decision
The IRE 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: medical records, 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 IRE's clinical reviewers. The IRE is not bound by any previous decision reached by us.

The IRE will provide a written notice of its decision within twenty-one (21) calendar days for a standard review or twenty-four (24) hours for an expedited review of receipt of all required information. For a standard review, an extension of up to fourteen (14) days may be allowed if agreed to by the member and CareSource. For an expedited review, an extension of up to twenty-four (24) hours may be allowed if agreed to by the member and CareSource. This notice will be sent to the member, the treating health partner, us and

the Kentucky Department of Insurance, and must include the following information:

- The findings for either us or the member regarding each issue under review;
- The proposed service, treatment, drug, device, or supply for which the review was performed;
- The relevant provisions in the Policy and how applied; and
- The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

Binding Nature of External Review Decision

An External Review decision is binding on us and the member except to the extent there are other remedies available under state or federal law. Subject to the foregoing, upon receipt of notice by an IRE to reverse an Adverse Benefit Determination, we will immediately provide coverage for the Heath Care Service in question. Members may not file a subsequent request for an External Review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to us. A decision issued by the IRE will be admissible in any civil action related to our coverage decision. The IRE's decision is presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

If You Have Questions About These Rights or Need Assistance

Providers may contact us by mail, fax, or phone. Please call Provider Services at **1-855-852-5558**.

Health partners may also contact the Kentucky Department of Insurance at:

Kentucky Department of Insurance
ATTN: Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602-0517

Toll free (KY only) **1-800-595-6053** or **502-564-3630**
Deaf/hard-of-hearing **1-800-648-6056**
http://insurance.ky.gov

To file a Consumer Complaint, members may go to:
http://insurance.ky.gov/online_complaint.aspx?MenuID=3&Div?id=4

Definitions

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

Adverse Benefit Determination means our denial, reduction, or termination of a Health Care Service, in whole or in part, based on any of the following:

- A determination that the member is not eligible for Benefits under the Plan;
- A determination that a Health Care Service is not a Covered Service;
- 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 Services;
- The imposition of an exclusion or other limitation on Benefits that would otherwise be covered;
- A determination not to issue the member coverage, if applicable to the 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.

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 by an Independent Review Entity (IRE).

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 entity (IRE) 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 Kentucky Health Benefit Exchange 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 copays 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 CareSource health partner 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 **1-855-852-5558** 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. Health partners 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 injectables.

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 **1-855-852-5558**.

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.

Specialists Required to Communicate with PCPs
CareSource encourages specialists to communicate with the member's PCP regarding all assessment, diagnostic testing, and treatment including referral to another specialist or admission to a hospital. This allows the PCP to better coordinate the member's care and makes the PCP aware of the additional services requested.

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, health partner 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:

- Asthma care
- Diabetes care
- Behavioral health
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Healthchek
- 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.

Hospital Responsibilities

CareSource utilizes a network of hospitals to provide services to its members. Hospitals must:

- Obtain authorizations for selected inpatient and outpatient services as listed on the prior authorization list – Emergency room care does not require prior authorization;
- Notify CareSource of emergency hospital admissions, elective hospital admissions and new born deliveries within 48 hours of the admission;
- Notify the PCP within 48 hours after the member's visit to the emergency department; and
- Notify CareSource of members who may benefit from case management services – such as members who may have frequent visits to the emergency room.

CareSource hospitals should refer to their contracts for complete information regarding the hospitals' obligations and reimbursement.

Cultural Competency

Cultural competency within CareSource is defined as "the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population." It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practice important in clinical practice, cross-cultural interactions and systems practices among health partners and staff to ensure that services are delivered in a culturally competent manner.

CareSource is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When health care services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their health care needs in an insensitive environment, reducing effectiveness of the entire health care process.

Network health partners must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the members' race/ethnicity and language and its impact/influence on the members' health or illness
- The office staff that is responsible for data collection make reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify his/her own race/ethnicity and that of his/her children.
- Treatment plans are developed and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physician abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process

CareSource encourages its participating health partners to complete the US Department of Health and Human Services Physician Practical Guide to Culturally Competent Care, which is a free on-line accredited educational program.

Health Partner Appeals Procedures

Appeal of Claims Denials or Adverse Decisions
If you do not agree with the decision of the processed claim, you will have 365 days from the date of service or discharge to file a claim appeal. If the health partner was denied authorization or reimbursement due to not obtaining a required prior authorization, then the health partner must file a claim appeal within one hundred eighty (180) days of the date of service or date of discharge. 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 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. Health partners 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/KY/
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

CareSource Health Partner Clinical Appeals

Health Partner Appealing on Behalf of a Member Standard Medical Necessity Appeals of Non-Certification Determinations

An appeal is defined as a formal request by a member or health partner, including facilities or other health care entities on behalf of a member for a review of an Adverse Benefit Determination.

Timeline for Clinical Appeals

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

- Health partner on behalf of a member with written authorization from the member – within 180 calendar days of receipt of the Notice of an Adverse Benefit Determination
- Member – within 180 calendar days of receipt of the Notice of an Adverse Benefit Determination.

Additional Details about Clinical Appeals

Timing for Medical Necessity Appeals

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days of receipt of the Notice of an Adverse Benefit Determination

Appeals Filed on Behalf of the Member

Medical necessity appeals filed by members or providers on behalf of a member must be submitted to CareSource within 180 calendar days and will be resolved within 15 calendar days of receipt or as expeditiously as the member's condition warrants for pre-service appeals and 30 calendar days for post-service appeals. Appeals on behalf of the member must include written authorization to appeal on member's behalf.

Expedited Appeals

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

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

Requests may be a verbal request and should be submitted to the Grievance and Appeals Department by calling **1-855-852-5558**.

Expedited Review of an internal appeal may be started orally, in writing, or by other reasonable means available. We will complete expedited review of an appeal as soon as possible given the medical needs but no later than seventy-two (72) hours after our

receipt of the request or as expeditiously as the medical condition requires unless the resolution time frame is extended.

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

Extending an Appeal
A member can verbally request that CareSource extend the time frame to resolve a standard or expedited appeal up to 15 calendar days only if more time is needed due to circumstances beyond their control. CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 15 calendar days only if more time is needed due to circumstances beyond our control.

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

Opportunity for External Review
An External Review will be conducted by an IRE assigned by the Kentucky Department of Insurance. The member will be assessed a filing fee of $25.00 to be paid to the IRE. This fee may be waived if the IRE determines that the fee creates a financial hardship on the member. The fee shall be refunded if the IRE finds in favor of the member. There is no minimum cost of Health Care Services denied in order to qualify for an External Review; however, the member must generally exhaust CareSource's internal appeal process before seeking an External Review. Any exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

You may use the "**Health Partner Appeal Request Form**" on **CareSource.com** to submit your appeal, but this form is not required.

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

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

All appeal requests and associated information are reviewed by clinicians previously

uninvolved with the case. You will be notified in writing of the outcome of your appeal request.

Retrospective Reviews
Services not previously reviewed for medical necessity are categorized as retrospective reviews and are reviewed and determination is made by the Medical Management Department within 30 calendar days of receipt.

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

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

Fax: 1-855-795-0088 – toll-free number fax line
1-937-531-2398 – fax line

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

Quality Improvement Program Goals

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 health care delivered by network practitioners and providers. CareSource also monitors member services through practitioners, health partners, 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 health partner 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 health care
- 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 health partner 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 health partners, practitioners, regulatory agencies, and community agencies
- Ensure regulatory and accrediting agency compliance (Center for Medicare and Medicaid Services, Kentucky Department of Medicaid Services, 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 Kentucky Health Benefit Exchange 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 Kentucky Health Benefit Exchange 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

As a function of medical management oversight responsibilities, CareSource monitors over and underutilization of medical services. 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.

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 **1-855-852-5558**.

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 **1-855-852-5558** 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 **1-855-852-5558**.

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

or other health care partner 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 health partner.

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: 1-855-852-5558; 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 health partner, 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, but no later than 72 hours following receipt of the request for service. Please specify if you believe the request is urgent.

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

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 its 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 health care outcomes, CareSource supports and encourages continuity of care and coordination of care between medical care health partners as well as between medical care 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®) measures clinical performance 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 **1-855-852-5558** within five business days of the determination.

Post Stabilization Services

Please call **1-855-852-5558** 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 **1-855-852-5558**. 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 CareSource24, our nurse triage line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

Medical Records

CareSource health partners must keep accurate and complete medical records. Such records will enable health partners to render the highest quality health care service to members. They will also enable CareSource to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. CareSource requires health partners to maintain all records for members for at least seven years.

Required Information

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or health partner, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Health partners must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed, or dictated by the health partner rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with CareSource's guidelines
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis

- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to member
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the PCP to signify review
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of member information and records protected
- Evidence that an advance directive has been offered to adults 18 years of age and older

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned CareSource members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous health partners then this should also be noted in the medical record.

CareSource.com/KY

KY-EXCP-16a
October 2015