Annual Notice of Requirements
January 2021

Access and Availability

CareSource has a comprehensive quality program to help ensure our members receive the best possible health care services. It includes evaluation of the availability, accessibility, and acceptability of services rendered to patients by participating providers.

CareSource expects participating providers to have procedures in place to see patients within these timeframes and to offer office hours to their CareSource patients that are no less (in number of scope) than the hours of operation offered to non-Medicaid members. If a provider serves only Medicaid recipients, hours offered to Medicaid members must be comparable to those offered to Medicaid fee-for-service members.

You may access these standards via the Provider Manual, pages 159-160.

Type of Visit	Should be seen…
Primary Care Providers	
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 6 weeks
Specialists	
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 12 weeks
Behavioral Health	
Emergency needs	Immediately upon presentation
Non-life threatening emergency	Not to exceed 6 hours
Urgent care*	Not to exceed 48 hours
Initial visit for routine care	Not to exceed 10 business days
Follow-up for routine care	Not to exceed 30 calendar days based off the condition

After-Hours Care

Telephone Arrangements

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

A provider's office phone must be answered during normal business hours.	A provider's office must answer member's telephone inquiries on a timely basis.
Prioritize appointments.	Schedule a series of appointments and follow-up appointments needed by a member.
Identify special member needs while scheduling an appointment (e.g. wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments).	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 provided coverage in the event of a provider's absence.

After-hours calls should be documented in a written format in either an after-hour call log or some other method and then transferred to a member's medical record.
During after-hours calls, a provider must have the 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. - Office phone is answered after hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the provider has directed to return the call. - 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

You may access After Hours Care requirements via the Provider Manual, pages 164-165.

Americans with Disabilities Act
Providers are required to comply with Americans with Disabilities Act (ADA) standards. CareSource network providers must make reasonable accommodations to ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. CareSource and its network providers will comply with the ADA (28 C.F.R. 35.130) and the Rehabilitation Act of 1973 (29 U.S.C.794) and will maintain capacity to deliver services in a manner that accommodates the needs of its members.

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

You may also access additional information via the Provider Manual, page 153.

Culture Competency
CareSource has a long-standing commitment to addressing the need for culturally competent care in our member populations, as well as looking at those non-clinical needs, or social determinants, that impact member health outcomes.

Consistent with federal mandate 42 CFR 438.206 (2), Access and Cultural Considerations, CareSource participates in efforts to promote the delivery of services in a culturally competent manner to all members. Participating providers must also meet the requirements of this mandate and any applicable state and federal laws or regulations pertaining to provision of services and care.

CareSource prohibits its providers or partners from refusing to treat, serve or otherwise discriminate against an individual because of race, color, religion, national origin, sex, age, gender orientation (i.e. intersex, transgendered and transsexual) or disability

CareSource encourages our participating providers to visit the Office of Minority Health, Cultural Competency Resources website found at: www.ThinkCulturalHealth.hhs.gov for toolkits and educational resources. Included on the site is a free 9 credit Continuing Medical Education (CME) course, A Physician's Practical Guide to Culturally Competent Care. This self-directed e-learning program equips providers to better understand and treat diverse populations.

You may access additional information via the Provider Manual, pages 154 and 155.

Dual Eligibility Billing Reminder
CareSource would like to remind network providers about billing rules applicable to dual-eligible beneficiaries as required under 42 CFR 422.504(g)(1)(iii). Federal law prohibits Medicare providers from collecting Medicare Part A and Part B deductibles, coinsurance or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program. The QMB program is a dual-eligible program which exempts individuals from Medicare cost-sharing liability.

Qualified Medicare Beneficiaries (QMB) billing prohibitions may also apply to other dual-eligible beneficiaries in Medicare Advantage (MA) plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost-sharing. The prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B. Low Income Subsidy copayments still apply for Part D benefits.

For more information regarding this requirement please visit https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB

Fraud, Waste, and Abuse
Health care fraud, waste and abuse hurts everyone, including members, providers, taxpayers and CareSource. As a result, CareSource has a comprehensive fraud, waste and abuse program in our Program Integrity and Investigations department. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

It is CareSource's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act. Federal and state law and CareSource policy prohibit any retaliation or retribution against persons who report suspected violations. If you have knowledge or information that any such activity may be or has taken place, please contact our Program Integrity and Investigations. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for Reporting Anonymously:
Call the Fraud Hotline at 1-800-488-0134 and tell our IVR system that you are calling to report fraud. Our fraud, waste and abuse hotline is available 24 hours a day.

For additional information on Fraud, Waste and Abuse, including additional reporting options, please access our Provider Manual, pages 171-176.

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

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

MyCare and Dual Eligible Special Needs Plan (D-SNP) Model of Care Training
The Model of Care (MOC) training outlines the D-SNP and MyCare MOC and how care is delivered through our care management staff in partnership with our provider network. The Centers for Medicare & Medicaid Services (CMS) requires MyCare Ohio and D-SNP contracted medical providers and staff to receive Model of Care training. The training is also required for out-of-network providers that routinely see dual-eligible members.

CMS requires providers to attest to completing the annual model of care training. To view and attest that you have completed the training and receive credit, please log on to the Provider Portal, which will prompt you to review and attest to completing the model of care training.

Provider Maintenance
Providers must keep all demographic and practice information up to date. Information updates can be submitted on the CareSource Provider Portal.

Type of Change Notice Required
Please notify CareSource of the change within the following timeframes:

Type of Change	Timeframe
New providers or deleting providers	Immediately upon provider notice
Phone number change	Within 10 calendar days
Address change	Within 60 calendar days
Change in capacity to accept members	Within 60 calendar days
Provider intent to terminate	Within 90 calendar days

This information is critical to process your claims. In addition, it ensures our Provider Directories are up to date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare.

Well-Child Care/Early Periodic Screening, Diagnosis and Treatment Program (Healthchek) - Medicaid Only

Well-child/Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a child health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. All children of these ages who are CareSource members must receive a well-child/EPSDT exam. It supports two goals:

- to ensure access to necessary health resources,
- and to assist parents and guardians in appropriately using those resources.

For the complete listing of the American Academy of Pediatrics Preventive Health Guidelines please go to www.aap.org

For more information on Healthchek and the exam components, please visit the "Member Support Services and Benefits" section on pages 53-55 in the Provider Manual

Operational Guidance

Claim Payment Disputes

If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file a dispute or appeal.

If you believe your claim was denied incorrectly or underpaid, you can submit a claim dispute.
At a minimum, the dispute must include:

- Sufficient information to identify the claim(s) in dispute
- A statement of why you believe a claim adjustment is needed
- Pertinent documentation to support the adjustment

The Provider Portal is the most efficient method to file your claim dispute. Claim disputes must be filed within the following timeframes for consideration:

Plan	Timeframe
Medicaid*	Within 90 days of date of denial or date of payment
MyCare*	Within sixty (60) days from the date of service, date of denial, date of discharge, or date of payment denial
Marketplace*	Within 90 days of date of denial or date of payment
D-SNP**	Within sixty (60) days from the date of service, date of denial, date of discharge, or date of payment denial
Medicare Advantage**	Within sixty (60) days from the date of service, date of denial, date of discharge, or date of payment denial

*MyCare, Medicaid and Marketplace providers should use the claims dispute process for all payment issues that are not related to a lack of authorization or an incomplete authorization.
**Medicare providers who are in CareSource's network and are participating for CareSource members must use the dispute process for any claim denials. Appeal rights do not exist for participating Medicare providers.

CareSource will render a Payment Dispute decision letter within thirty (30) calendar days of receipt. If the decision is to uphold the original claim adjudication, providers may appeal the claim adjudication if appeal and timely filing rights still exist.

Provider Appeals

Providers may request the following types of appeals:

Claim appeals: Request reconsideration of a claim denial if you do not agree with a denial on a processed claim.

Claim appeals must be filed within the following timeframes for consideration (unless otherwise specified in your contract):

Plan	Timeframe
Medicaid	Within 365 days from the date of service/discharge
MyCare	Must use Claims Dispute Process
Marketplace	Within 365 days from the date of service/discharge
D-SNP	Must use Claims Dispute Process
Medicare Advantage	Must use Claims Dispute Process

The Provider Portal is the is the most efficient method to submit claim appeals.

Clinical appeals: Request reconsideration of a medical necessity decision if you disagree with a clinical decision we have made regarding medical necessity. A provider must have a denied authorization request to submit a valid clinical appeal. Providers must receive a denial to submit an appeal. If a provider has not received a denial and service has been rendered, the provider must follow the retro-authorization process prior to submitting appeal.

Clinical Appeals must be submitted within the following timeframes for consideration:

Plan	Timeframe
Medicaid	Within 180 calendar days from the date of service, denial or discharge
MyCare	Within 60 calendar days from the date of service, denial or discharge
Marketplace	Within 180 calendar days from the date of service, denial or discharge
D-SNP	Within 60 calendar days from the date of service, denial or discharge
Medicare Advantage	Within 60 calendar days from the date of service, denial or discharge

The Provider Portal is the most efficient method to submit clinical appeals.

For more information about the Claims Dispute and Appeals Process, please refer to our Provider Manual and appropriate plan page(s).

Customer Care

To support our providers, we have dedicated Provider Services teams specialized with each plan to help assist with questions and concerns.

Plan	Contact Number*
Medicaid	800-488-0134
MyCare	800-488-0134
Marketplace	800-488-0134
Medicare Advantage	844-679-7865
D-SNP	833-230-2176

*Monday-Friday 8am-6pm EST

Provider Portal
Our secure online Provider Portal allows you instant access at any time to valuable information. Simply enter your username and password.

Provider Portal Benefits
- Easy access to a secure online (encrypted) tool with time-saving services and critical information
- Available 24 hours a day, seven days a week
- Accessible on any PC without any additional software

Portal Registration
If you are not registered with CareSource's Provider Portal, please follow these easy steps:
1. Visit **CareSource.com** > Provider Portal
2. Click **Register Now** and complete the three-step registration process. You will need your Tax ID number and your CareSource Provider Number, located in your welcome letter.
3. Click **Continue**.
4. Note the username and password you create so that you can access the portal's many helpful tools. If you do not remember your username/password, please call Provider Services.

Assisting you is one of our top priorities in order to deliver better health outcomes for our members.

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

Tool	Function
Payment history	Search for payments by check number or claim number.
Submit claims	Submit Claims online
Claims status	Search for status of claims
Claims attachments	Submit documentation needed for claims processing.
Coordination of Benefits (COB)	Confirm COB for patients.
Prior authorization (PA)	Request prior authorizations and check the status of prior authorizations
Member Eligibility	Check member eligibility
Care Management Referrals	Submit care management referrals for members
Benefit limits	Track benefit limits electronically in real time before services are rendered.
Care treatment plans	Providers can view care treatment plans.

Clinical Practice Registry (CPR)	Filter patient data to identify opportunities for preventive health screenings.
Recovery letters	View and download letters with details on recoupments and reasons for recovery.
Member Profile	Access a comprehensive view of patient medical/pharmacy utilization
Member financial status and information	View member payment responsibilities (such as deductible, copay and coinsurance) and monthly premium payment status.
Claim Dispute	File a claims dispute and check the status of a claim dispute
Appeal	File an appeal and check the status of an appeal

Website
Accessing our website, Caresource.com is quick and easy. On the Provider section of the site you will find commonly used forms, newsletters, updates and network announcements, our Provider Manual, claims information, frequently asked questions, clinical and preventive guidelines and much more.

Thank you for being a valued health partner with CareSource!

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