CareSource

CareSource
Indiana Medicaid Provider Manual

Hoosier Healthwise
Healthy Indiana Plan

This content has been reviewed; however, changes and/or revisions occur frequently. Providers should check our website at **CareSource.com** for the most current version of this manual.

Dear CareSource provider,

Thank you for your participation. CareSource values our relationships with our providers, and we are actively working to make it easier for you to deliver quality care to our members.

CareSource has provided Medicaid and other managed health care services since 1989. Since our first Medicaid managed care pilot, in collaboration with community leaders and health care providers like yourself, we have continued to drive innovation and transformation of Medicaid. CareSource has a strong history of serving under-resourced populations with health and life services, maintaining a unique understanding of our members' needs.

This manual is a resource for working with our Indiana providers. It communicates policies and programs and outlines key information such as claims submission, reimbursement processes, authorizations, member benefits and more to make it more efficient for you to do business with us.

CareSource communicates updates to our provider network regularly at **CareSource.com** Providers > Tools & Resources > Updates & Announcements. You can also find the most up-to-date information found on the CareSource Provider Portal at Providerportal.CareSource.com/IN/. In an effort to better support our providers and offer an immediate response to questions, concerns and inquiries, we offer claims, policy and appeals assistance through our call center by calling **1-844-607-2831**.

To support our providers, we have dedicated Customer Care teams specialized with each plan to help assist with questions and concerns. Additionally, an external team of specialists is available to provide onsite training and work with our providers in their communities.

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

Sincerely,

CareSource

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ABOUT CARESOURCE

Welcome

Welcome and thank you for partnering with CareSource.

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

We are a nonprofit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy.

As a managed health care entity (MCE), we improve the health of our members by utilizing a contracted network of high-quality participating health partners. Preferred medical providers (PMPs) within the network provide a range of services to our members and coordinate patient care by referring them to specialists when needed, ensuring that members have timely access to health care services and receive all appropriate preventive services.

About Us

We founded CareSource on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a nonprofit, we are mission-driven to provide quality care to our members. We offer process efficiencies and value-added benefits for our members and participating providers.

Vision and Mission

Our vision: Transforming lives through innovative health and life services.

Our mission: Making 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 our mission our "heartbeat." It is the essence of our company, and our unwavering dedication to it is the hallmark of our success.

Our Services

- Provider relations
- Provider services
- Member eligibility/enrollment information
- Claim processing
- Credentialing/recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory/compliance
- Special investigations for fraud, waste and abuse
- Member services
- CareSource24® (Nurse Advice Line)

In addition to the above, our care management programs include the following:

- High-risk case management
- Behavioral Health case management
- Onsite case management (clinics and facilities)
- Emergency department diversion
- High emergency department utilization focus (targeted at members with frequent utilization)
- Health home care
- Maternal and healthy baby program
  - Dedicated neonatal intensive care unit (NICU) care management nurses
  - Outreach programs in partnership with community agencies to target members at greatest risk
- Disease management programs for
  - Attention deficit hyperactivity disorder (ADHD)
  - Asthma

  - Autism spectrum disorders
  - Congestive heart failure (CHF)
  - Chronic kidney disease (CKD)
  - Chronic obstructive pulmonary disease (COPD)
  - Coronary artery disease (CAD)
  - Depression
  - Diabetes
  - Hepatitis C
  - Human immunodeficiency virus (HIV)
  - Pregnancy
  - Sickle cell disease
  - Substance Use Disorder (SUD)
- Care transitions
  - Discharge planning and transitional care support

For more information on these programs, see the “Member Support Services and Benefits” section on page 83.

The CareSource Foundation®

CareSource gets actively involved in the communities that we serve, from employees serving on hundreds of nonprofit boards to investing dollars back. We listen, we learn, and we are driven to action. As a result, we launched The CareSource Foundation in 2006 to add another component to our professional services: community response. Focus areas of The CareSource Foundation 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
- Life issues such as hunger, domestic violence, substance use disorder, and homelessness

Indiana Contributions

Through the CareSource Foundation, we have funded numerous grant awards to organizations in Indiana communities, totaling more than $220,000 in charitable support. These organizations have included the United Way of Central Indiana, South Central Indiana Housing Opportunities, Community Food Pantry, the Paramount Schools of Excellence, Prosperity Indiana, and the Second Harvest Foodbank of Central Indiana. In addition, our Indiana employees contribute generously to the United Way of Central Indiana.

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

Compliance and Ethics

At CareSource, we serve a variety of audiences – members, providers, government regulators, community partners and each other. We serve them best by working together with honesty, respect, and integrity. Our corporate compliance plan, along with state and federal regulations, outline the personal, professional, ethical, and legal standards we must all follow.

Our CareSource Corporate Compliance Plan is an affirmation of CareSource's ongoing commitment to conduct business in a legal and ethical environment. It has been established to:

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

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

CareSource's Corporate Compliance Plan is a formal company policy that outlines how everyone who represents CareSource must conduct himself or herself. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as providers, consultants, and vendors. All providers are required to review and comply with CareSource's corporate compliance plan, located at **CareSource.com** > About Us > Legal > Corporate Compliance.

General Compliance and Ethics Expectations of Providers

- Act according to the standards of our compliance plan.
- Notify us about suspected violations or misconduct.
- Contact us if you have questions.

For questions about provider expectations, please call Provider Services at **1-844-607-2831**.

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

- Ethics and Compliance Hotline: **844-784-9583** or CareSource.ethicspoint.com
- Compliance Department: IN_Reglatory_Contact@CareSource.com

Any issues submitted to the Ethics and Compliance Hotline may be submitted anonymously.

The CareSource Corporate Compliance Plan is posted for your reference on **CareSource.com** > About Us > Legal > Corporate Compliance.

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

Personally Identifiable Information

In the day-to-day business of patient treatment, payment, and health care operations, CareSource and our providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that instruct that PII be appropriately protected wherever it is stored, processed, and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your sensitive 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 data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace and shred this content when no longer needed.
- Encrypt laptops 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 under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment or health care operations.

Accreditation

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our Indiana Medicaid and Health Insurance Marketplace plans. NCQA is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency, and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement. Visit www.NCQA.org for more information.

COMMUNICATING WITH CARESOURCE

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

CareSource Hours of Operation

Provider Services		
CareSource Medicaid (Hoosier Healthwise and Healthy Indiana Plan)	Monday to Friday	8 a.m. to 8 p.m. Eastern Time (ET)

Member Services		
CareSource24® (Nurse Advice Line)	Seven days a week, 365 days a year	24 hours a day
CareSource Medicaid (Hoosier Healthwise and Healthy Indiana Plan)	Monday to Friday	8 a.m. to 8 p.m. ET

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

Phone

Our interactive voice response (IVR) system will direct your call to the appropriate professional for assistance. We also provide telephone based self-service applications that allow you to verify member eligibility.

Provider Services	1-844-607-2831
Prior Authorizations	1-844-607-2831
Claim Inquiries	1-844-607-2831
Credentialing	1-844-607-2831
Member Services	1-844-607-2829
CareSource24 – Nurse Advice Line	1-844-206-5947
Fraud, Waste and Abuse Hotline	1-844-607-2831
TTY for the Hearing Impaired	1-800-743-3333 or 711

Fax

Care Management Referral	844-417-6263
Contract Implementation	937-396-3632
Fraud, Waste and Abuse	800-418-0248
Medical Prior Authorization	844-432-8924
Provider Appeals	844-417-6262 937-531-2398
Provider Maintenance	937-396-3076

State of Indiana Contact Information – FSSA

Address:	Indiana Family and Social Services Administration (FSSA) 402 W. Washington St. Room W374, MS07 Indianapolis, IN 46204-2739
Phone:	1-800-403-0864
Website:	www.in.gov/fssa/
Hoosier Healthwise Enrollment	1-800-889-9949
Healthy Indiana Plan Enrollment	1-877-438-4479

Website

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

Provider Portal

URL: ProviderPortal.CareSource.com/IN

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

In accordance with federal and state regulations concerning HIV/AIDS/SUD consent requirements, member data on the CareSource Provider Portal may be incomplete unless a consent is on file. Please contact Provider Services at **1-844-607-2831** if additional information is needed

Provider Portal Benefits

- Free access to important resources
- Availability 24 hours a day, seven days a week
- Secure, convenient access to time-saving services and critical information
- Accessibility on any web browser without any additional software

Provider Portal Tools

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

- **Payment history** – Search for payments by check number or claim number.
- **Claim status** – Search for status of claims, submit appeals and view claim history (including vision benefits).
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior authorization (PA)** – Request authorization for medical and behavioral inpatient/outpatient services, as well as pharmacy authorizations.
- **Eligibility termination dates** – View the member's termination date (if applicable) under the eligibility tab.
- **Care management referrals** – Submit automated care management forms on our Provider Portal for efficiency in enrolling members.
- **Benefit limits** – Track benefit limits electronically in real-time before services are rendered for services like chiropractic visits.
- **Care treatment plans** – View care treatment plans for patients on our Provider Portal.
- **Clinical Practice Registry (CPR)** – Review member gaps in care. View and sort CareSource members into actionable groups for improved focus on preventive care (e.g., well-baby visits, diabetes, asthma and more). Look on the "Member Eligibility" page for alerts to notify you what tests a patient needs.
- **Monthly membership lists** – View and download current monthly panel lists.
- **Member profile** – Access a comprehensive view of patient medical and behavioral health utilization.
- **Information exchange** – Share relevant member information to facilitate better integration of behavioral health, dental and medical care.

Portal Registration

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

1. Visit **CareSource.com** > Login > Provider and select *Indiana*.
2. Click on the "register here" button and complete the registration process. Note: you will need to have your tax ID number and CareSource Provider ID. If you do not remember your username/password, please call Provider Services at **1-844-607-2831**.

How to Communicate with CareSource by Mail

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

Medical Prior Authorization Submission Address

CareSource
Attn: Indiana Utilization Management Department
P.O. Box 1307
Dayton, OH 45401-1307

Behavioral Health Prior Authorization Submission Address

CareSource
Attn: Indiana Behavioral Health Utilization Management Department
P.O. Box 1307
Dayton, OH 45401

Medical and Dental Claims Submission Mailing Address

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

Pharmacy Claims Submission Mailing Address

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Provider Credentialing Mailing Address

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

Provider Claims Dispute Mailing Address

CareSource
Attn: Claim Disputes
P.O. Box 2008
Dayton, OH 45401

Provider Appeals Mailing Address

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

Provider Clinical Appeals Mailing Address

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

Please visit our website at **CareSource.com** for more information on how to submit appeals online.

Member Appeals and Grievances Mailing Address

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

Fraud, Waste and Abuse Address

CareSource
Attn: Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.

Provider Communications

Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway at CareSource.

Network Notifications

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

Provider Demographic Changes and Updates

Advance written notice of status changes, such as a change in address, phone or adding or deleting a physician to your practice helps us keep our records current. Your current information is critical for efficient claims processing.

Please Note: Changes should be made with the state Medicaid agency in addition to CareSource. Claim information submitted for Medicaid reimbursement must meet Indiana Medicaid requirements for reimbursement.

The CareSource Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Provider Portal, entering your login credentials and selecting "Provider Maintenance" from the left-hand navigation.

Email

ProviderMaintenance@CareSource.com

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 Senior Medical Director is responsible for the credentialing and recredentialing program.

Credentialing Process

CareSource has partnered with Aperture to complete credentialing requirements. Aperture may contact you on behalf of CareSource if additional information is required for credentialing to be completed. Aperture offers a web-based credentialing application tool that streamlines the credentialing process for health care professionals. Updates in the Council for Affordable Quality Healthcare's (CAQH) web platform allow for the information to be shared directly with Aperture and CareSource for primary source verification.

Indiana Health Coverage Programs (IHCP) Enrollment

In partnership with the State of Indiana, CareSource must certify that all of its network providers are eligible and enrolled with IHCP. To ensure our providers receive proper reimbursement, we encourage all of our providers to enroll with IHCP via the State's website. For more information on IHCP enrollment, please visit the IHCP Provider Enrollment Application.

Providers involuntarily disenrolled from CareSource will be reported to the IHCP and may subsequently be disenrolled as an IHCP provider. The IHCP is required to report involuntarily disenrolled providers to the Centers for Medicare & Medicaid Services (CMS).

Council for Affordable Quality Healthcare (CAQH) Application

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

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

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current) or Controlled Substance Registration (CSR)
- Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable
- Standard care arrangement (if an advanced practice nurse or a physician assistant)

Debarred Provider Employee Attestation

CareSource verifies that its providers and the providers' employees have not been debarred or suspended by any state or federal agency. CareSource also requires that its providers and the providers' employees disclose any criminal convictions related to federal health care programs. "Provider employee" is defined as directors, officers, partners, managing employees, or persons with beneficial ownership of more than five percent of the entity's equity.

CareSource Debarment/Criminal Conviction Attestation

Providers must offer a list that identifies all of the provider employees, as defined above, along with the employee's tax identification or social security numbers. Providers and their employees must execute the attestation titled, "CareSource Debarment/Criminal Conviction Attestation" (in addition to being subject to and cooperating with CareSource verification activities) as a part of the credentialing and recredentialing process.

CareSource conducts credentialing and recredentialing activities utilizing the CMS, NCQA and credentialing as defined in the Indiana Code and Indiana Department of Insurance.

Who Is Credentialed

Contracted providers listed in the Provider Directory and the following are credentialed:

- Providers who have an independent relationship with CareSource. This independent relationship is defined through contracting agreements between CareSource and a provider or group of providers and is defined when CareSource selects and directs its enrollees to a specific provider or group of providers.
- Providers who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Providers who are hospital-based but see the organization's members as a result of their independent relationship with the organization.
- Dentists who provide care under the organization's medical benefits.
- Non-physician providers who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.

- Covering providers (locum tenens).
- Medical directors of urgent care centers and ambulatory surgical centers.

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

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

Provider Selection Criteria

CareSource is committed to providing the highest level of quality of care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we have developed the following provider selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our providers.

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 providers have the appropriate training and expertise to serve our members from a care delivery and service perspective. CareSource bases selection on quality of care and service aspects, in addition to business and geographic needs for specific provider types in a nondiscriminatory manner.

The following selection criteria have been put in place and are assessed during the credentialing and recredentialing process in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

Selection Criteria:

- Active and unrestricted license in the state issued by the appropriate licensing board.
- Current DEA or CSR certificate (if applicable).
- Successful completion of all required education.
- Successful completion of all training programs pertinent to one's practice.
- For MDs and DOs, successful completion of residency training pertinent to the requested practice type.
- For dentists and other providers where special training is required or expected for services being requested, successful completion of training.
- Board certification is not required for primary care specialties. Primary medical provider (PMP) who are approved by the CareSource Credentialing Committee will appear in CareSource Provider Directories.

- Providers approved by the CareSource Credentialing Committee in non-primary care specialties will be listed in the Provider Directory as specialists if certified by a specialty board, which is recognized by the CareSource Credentialing Committee.
- An advanced practice nurse (APN) may be credentialed as a preferred medical provider if that APN maintains compliance with the rules set forth by the Indiana State Board of Nursing defined in "Compilation of the Indiana Code and Indiana Administrative Code, 2013 Edition." The APN is expected to be familiar with these rules. "Advanced practice nurse" means a registered nurse holding a current license in Indiana who:
  - Has obtained additional knowledge and skill through a formal, organized program of study and clinical experience, or its equivalent, as determined by the board;
  - Functions in an expanded role of nursing at a specialized level through the application of advanced knowledge and skills to provide health care to individuals, families or groups in a variety of settings.
- Education, training, work history and experience are current and appropriate to the scope of practice requested.
- Malpractice insurance at specified limits established for all practitioners by the credentialing policy.
- Good standing with Medicaid and Medicare.
- Quality of care and practice history as judged by:
  - Medical malpractice history.
  - Hospital medical staff performance.
  - Licensure or specialty board actions or other disciplinary actions, medical or civil.
  - Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction.
  - Other quality of care measurements/activities.
  - Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing.
  - Lack of issues on HHS-OIG, SAM/ EPLS, or state site for sanctions or terminations (fraud and abuse).
- Signed, accurate credentialing application and contractual documents.
- Participation with Care Management, Quality Improvement and Credentialing programs.
- Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
- Agreement to comply with plan preferred drug list (PDL) requirements or acceptance of PDL as administered through the pharmacy benefit manager.
- Agreement to access and availability standards established by the health plan.
- Compliance with service requirements outlined in the provider agreement and Provider Manual.
- **Note:** Any pending and/or suspected fraud, waste and abuse investigation(s) or case(s) against the provider may affect the provider's credentialing application.

Organizational Credentialing and Recredentialing

The following organizational providers are credentialed and recredentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Behavioral health facilities providing mental health or substance use services in an inpatient, residential, or ambulatory setting (i.e. Opioid Treatment Facility)
- Free-standing Rural Health Center
- Free-standing Inpatient Psychiatry Health Facility
- Outpatient Infusion Center

Additional organizational providers are also credentialed:

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

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

The following elements are assessed for organizational providers:

- Provider is in good standing with state and federal regulatory bodies.
- Provider has been reviewed and approved by an accrediting body.
- Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body.
- Liability insurance coverage is maintained.
- Clinical Laboratory Improvement Amendments (CLIA) certificates are current.
- Completion of a signed and dated application.

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

Provider Credentialing Rights

- Providers have the right to review information submitted from outside sources (e.g. malpractice insurance carriers and state licensing boards) to support their credentialing application upon request to the CareSource Credentialing department. CareSource keeps all submitted information locked and confidential.
- Providers have the right to correct incomplete, inaccurate, or conflicting information that was submitted to support their application prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, CareSource will request that the provider submit written clarification to the Credentialing Department electronically, by e-mail, fax or by certified mail, return receipt requested and the provider will be given five business days to respond. Nonresponse within that time frame will result in discontinuance on the sixth day.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department. An automated email is sent to providers once their application is submitted via the CareSource Provider Portal. This email directs them to contact Provider Services at **1-844-607-2831** to obtain application status updates. Provider Service Representatives can inform providers if their application is completed and they are showing as participating in the CareSource network, or if their application is still in process while referencing the state-specific time frames. Practitioners also have the ability to check the status of their application by visiting the CareSource.com website, signing into the provider portal, and entering their application and NPI numbers.

Provider Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. CareSource will initiate immediate action in the event that the participation criteria are no longer met. Providers are required to inform CareSource of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification or any event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

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

Board Certification Requirements

Effective as of Jan. 1, 2003, physicians applying to become participating providers must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board, with the exception of general dentists who will have board certification requirements waived in lieu of adequate education and training.

Effective as of Sept. 10, 2010, primary medical providers (PMPs) may be exempted from the board certification requirement if they have successfully completed a primary care residency program and their education and training is consistent with their intended scope of practice.

Physicians who are pursuing certification must be certified within the time frame specified by their respective board. Failure to become certified may result in termination as a participating provider.

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

To be credentialed as a subspecialist, physicians must:

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

Delegation of Credentialing/Recredentialing

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

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

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

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

CareSource may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited CVO. Providers 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 provider may pose undue risk to our members and should be denied participation or be removed from CareSource's network. If this happens, the applying or participating provider will be notified in writing. Reconsideration and appeal opportunities are available unless an exception applies. Exceptions are set forth in the CareSource Provider Participation Plan. To submit a request, the following steps apply:

Step 1

The Participating Provider must request such a hearing, in writing, within fourteen (14) days of receipt of the Notice of Action. The request must be addressed to the Chair of the Credentialing Committee or his or her designee as referenced in the Notice of Action and must be sent via certified mail, return receipt requested. Failure to file such a request within the required time period shall constitute the Participating Provider's complete and final waiver of any right to a hearing, any appellate review, and/or any other procedural due process rights associated with the Action at issue.

Step 2

Upon receipt of a Participating Provider's request for a hearing, the Chair of the Credentialing Committee or his or her designee will promptly arrange for and schedule the hearing. Promptly after the hearing is scheduled, the Chair of the Credentialing Committee or his or her designee will send a notice to the Participating Provider, via certified mail, return receipt requested, of the date, time and place of the hearing, which may be held virtually or in-person.

Step 3

Within seven (7) business days of the conclusion of the hearing, the PHP shall render its decision which shall be deemed full and final and not subject to appeal. A three (3)-business day extension may be granted by the PHP Chairperson. The PHP Decision will be sent to the Chair of the Credentialing Committee. The Chairperson of the Credentialing Committee will, within five (5) business days of receipt of the PHP Decision, send notice via certified mail, return receipt requested, to the Participating Provider, of the PHP Decision.

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

If you would like to review the CareSource Provider Participation Plan, please visit CareSource.com/documents/fhp.

Provider Disputes

Provider disputes for issues that are contractual or non-clinical should be sent to:
CareSource
Attn: Provider Relations
251 N. Illinois Street
Suite 300
Indianapolis, IN 46204

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 provider that is subject to a suspension or termination may appeal the action and request a hearing through the CareSource Provider Participation Plan unless an exception applies. Exceptions are set forth in the CareSource Provider Participation Plan.

Qualified Providers

CareSource encourages our providers to enroll as qualified providers (QPs) to submit presumptive eligibility applications on behalf of an individual without health coverage who may be eligible for Medicaid benefits. QPs may enroll through the fiscal agent's provider enrollment process. Providers who meet the criteria are encouraged to enroll as QPs by completing the QP enrollment in the Web Interchange Provider Maintenance and completing the required training.

Qualified Providers must meet the following regulations:

- Enrolled as a Medicaid provider (an Indiana Health Coverage Programs provider)
- Provides outpatient hospital, rural health clinic or clinic services, as defined in sections 1905 (a)(2)(A) or (B), 1905(a)(9), and 1905(l)(1) of the Social Security Act
- Trained and certified by the State (or designee) to perform PE functions

Qualified Providers must meet the following state requirements:

- Be able to verify pregnancy via a professionally administered pregnancy test (home-administered and over-the-counter tests do not meet this requirement)
- Be able to provide Internet, telephone, printer, and fax access to facilitate the PE and Medicaid application process
- Ability to access Web Interchange

In addition, federal requirements dictate that Qualified Providers be one of the following:

- Family or general practitioner
- Pediatrician
- Internist
- Obstetrician or gynecologist
- Certified nurse midwife
- Advanced practice nurse practitioner
- Federally qualified health care center
- Medical clinic
- Rural health clinic
- Outpatient hospital
- Local health department
- Family planning clinic

After the minimum QP enrollment requirements are met, the state fiscal agent sends an automated email notification of their QP status. A fiscal agent field consultant contacts the approved QP to schedule a training session, which is the final step in the QP enrollment process. After completing the training session, QPs receive certification and are able to provide QP services.

CLAIM SUBMISSIONS

In general, CareSource follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. Claims for services provided to members assigned to CareSource must be sent directly to CareSource, not Gainwell Technologies. For expedited claim processing and payment delivery, please ensure your address(es) and phone number(s) on file with CareSource are up to date. Provider demographic updates must first be submitted to Indiana Health Coverage Programs (IHCP) as CareSource will not make any changes to provider demographics until updated with IHCP. IHCP approved provider demographic changes must then be submitted to CareSource via the CareSource Provider Portal.

Billing Methods

CareSource accepts claims in a variety of formats, including paper and electronic claims. We encourage providers to submit 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

Submit Claims Online Through Provider Portal

Providers may submit claims through the secure, online Provider Portal. Online submission saves you money by eliminating the costs associated with printing and mailing paper claims. Using the portal for claims submission also provides additional benefits:

- Improves accuracy by decreasing the opportunities for transcription errors and missing or incorrect data
- Allows tracking and monitoring of claims through a convenient online search tool

Who Can Submit Claims Via the Portal?

Healthcare provider using the UB-04 or CMS-1500 claim form can submit claims in the Provider Portal.

What Types of Claims Can Be Submitted?

- Professional medical office claims
- Institutional claims

Please Note: Dental claims are submitted to our third-party vendor, SKYGen. Please refer to our Dental Provider Office Reference Manual (ORM) for additional information.

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. Providers who elect to receive EFT payment will receive an Electronic Data Interchange (EDI) 835 (Electronic Remittance Advice). Providers can also download their Explanation of Payment (EOP) from the Provider Portal.

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.

Simply complete the enrollment form, available on **CareSource.com** > Providers > Claims, and fax it back to the vendor, who will work directly with providers to enroll in EFT. Free EFT training is also available to CareSource providers during the enrollment process.

Electronic Claim Submission

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

Clearinghouse

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

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

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

File Format

CareSource accepts electronic claims in the 837 ANSI ASC X12N (005010X ERRATA version) file format for professional and hospital claims.

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This was in preparation to implement ICD-10 CM codes in 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 Payments/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).

National Provider Identifier and Tax ID Numbers

Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) 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 provider's NPI and (if applicable) Box 33A for the group NPI
  - **Please Note:** The NPI submitted on the claim must crosswalk to one Indiana Health Coverage Programs (IHCP) provider ID, or the claim will be denied. Three data elements are used for the standard NPI crosswalk to establish a one-to-one match: billing NPI, billing taxonomy code, billing provider service location zip code +4 on file in CoreMMIS.
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

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

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

- Medicaid: 2010AA Loop – Billing provider name
- Medicare: 2310B Loop – Rendering provider name
- 2010AA Loop – Billing provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing provider NPI

- 2310B Loop – Rendering provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Rendering provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

Institutional Claims

On 837I institutional claims (005010223A2), the billing provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the EIN for organizations or the SSN for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

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

- 2010BA Loop – Subscriber name
- NM109 = Member ID (RID) number

Electronic Payment Processing

CareSource has partnered with ECHO Health, Inc. to deliver provider payments. ECHO offers three payment options:

- Electronic funds transfer (EFT) – preferred
- Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
- Paper check

*Payment processing fees are what you pay your bank and credit card processor for use of payment via credit card.

Enroll with ECHO for payment and choose EFT as your payment preference for CareSource. You can also complete the ECHO enrollment form located on **CareSource.com** > Provider > Claims and fax, email or mail it back to ECHO. For questions, call ECHO Customer Support at **1-888-834-3511**.

Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. For more information on electronic claims, please reference the "Electronic Claims Submission" section of this manual, on page 23.

Paper claim forms are only 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
- AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental Claim Form

CMS 1450 (UB-04) paper claim submission must be done using the most current form version as designated by the Centers for Medicare & Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA).

We cannot accept handwritten claims or SuperBills. Claims that have been modified must be submitted using a new claim form; correction made to a previously submitted claim using white-out or erasable ink, may not be processed.

Detailed instructions for completing each form type are available at the websites below:

- CMS 1500 Form Instructions: www.nucc.org
- UB-04 Form Instructions: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

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

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
  - Three data elements are used for the standard NPI crosswalk to establish a one-to-one match: billing NPI, billing taxonomy code, billing provider service location zip code +4 on file in CoreMMIS
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

All claims (EDI and paper) must include:

- Patient (member) name
- Patient address
- Insured's ID number – Be sure to provide the complete Insured ID number of the patient
- 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
- CD-10 diagnosis code(s)
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable
- Units, where applicable (anesthesia claims require minutes)

- Date of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain from/to formats. Please enter each date individually
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization
- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information
- Federal tax ID number or physician Social Security Number – Every provider practice (e.g., legal business entity) has a different tax ID number
- Signature of physician or supplier – The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field

Please Note: Claims must be submitted in alignment with Indiana Medicaid's requirements. CareSource must match claim data to the enrollment data received by the state Medicaid agency.

The NPI submitted on the claim must crosswalk to one Indiana Health Coverage Programs (IHCP) provider ID, or the claim will be denied. Three data elements are used for the standard CPI crosswalk to establish a one-to-one match:

- Billing NPI
- Billing taxonomy code
- Billing provider service location zip code +4 on file in CoreMMIS

Claims submitted without this information may not meet the state's matching logic, which could result in claim rejection or recoupment of paid claims. Additional information about the state's matching logic and submission requirements can be found in the IHCP provider reference module for Claims Submission and Processing.

Prenatal or Delivery Services Claims

For prenatal or delivery services, the last menstrual period date* is required on professional claims (HCFA 1500). For delivery services, the birth weight is required.

* Last menstrual period may be calculated – For Medicaid providers, CareSource must include the last menstrual period (LMP) date for the mother when we submit encounter data (paid claims information) to regulatory entities. We understand that this information may not always be available to the provider who delivers the baby, especially if the member received prenatal care from another provider or facility. Please remember that participating providers may estimate the LMP on delivery claims based on the gestational age of the child at birth.

This will help ensure that your delivery claims do not go unpaid because of missing claim information.

What to Include on Claims That Require National Drug Code:

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

Instructions for National Drug Code on Paper Claims

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code – F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC, or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

Tips for Submitting Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. CareSource uses an optical/intelligent character recognition (OCR/ICR) system to capture claims information, which increases efficiency, improves accuracy and results in faster turnaround time.

To Ensure Optimal Claims Processing Timelines:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.
- When submitting paper claims, know we require the most current form version as designated by CMS, NUCC, and the ADA.
- Do not submit handwritten (including printed claims with any handwritten information) claims or SuperBills. They will not be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Ensure fonts are 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.
- NPI, GNPI (is applicable) and federal TIN or physician SSN is required for all claim submissions.

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

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

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

CareSource has chosen to establish relationships with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as critical safety net providers. CareSource will reimburse FQHCs and RHCs at no less than the reimbursement level CareSource would make to a non-FQHC or non-RHC for the same

services. The state requires CareSource to identify and report any performance incentives it offers to the FQHC or RHC in relation to the cost of providing FQHC covered or RHC covered services to its members. Given the state makes supplemental payments to FQHCs and RHCs that contract with CareSource, the payments are meant to represent the difference, if applicable, between the payment an FQHC or RHC would be entitled to under the Benefits Improvement and Protection Act of 2000 (BIPA).

CareSource will perform claim reconciliations with each of the FQHCs or RHCs it contracts with in an effort to determine billing issues and resolve discrepancies that may affect the clinic's annual reconciliation with the State of Indiana. To that end, CareSource will provide separate reports for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW) around utilization and reimbursement to the State annually. To ensure accurate documentation of encounters, we encourage our partners to properly capture the National Provider Identifier (NPI) for all practitioners rendering service on their claims. Capitated FQHCs and RHCs must also submit encounter data (i.e. shadow claims) to CareSource on a monthly basis.

Claim Submission Timely Filing

For in-network providers, claims must be submitted within 90 calendar days of the date of service or discharge. For out-of-network providers, claims must be submitted within 180 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, as the claim will be denied. If this happens a corrected claim may be submitted with corrected information, but this is still considered an initial claim and will be subject to 90 day filing limit, from original date of service or discharge.

Claim Processing Guidelines

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

- If a claim denial is due to a provider's incorrect or inaccurate claim information, the provider may resubmit the claim with corrections. For adjudication purposes, a denied claim that is resubmitted with corrected information is considered to be an initial claim and, as such, is subject to the 90-day timely filing limit. For adjudication purposes, a denied claim resubmitted without corrected information is considered to be a duplicate claim and will continue to deny for the same reasons. Resubmitted claims with no correction will be subject to the 90-day timely filing limit and will not be accepted as "reasonable and continuous attempts to resolve a claim problem" for consideration to waive or extend the timely filing limit.
- If a claim denial is not due to a provider's incorrect or inaccurate claim information, but the provider disagrees with the denial, the provider may submit a claim dispute. The dispute must be filed within 60 calendar days from the date of receipt of the claim decision notification, also referred to as the explanation of payment (EOP). If the claim dispute is not submitted in the required time frame, the claim will not be considered and the dispute will be denied.
- If a line item on a claim is denied, that line item should be resubmitted separately, unless the claim details are dependent of one another for payment. For example; all surgical services for the same member, same date and same provider must be submitted on one claim form and cannot be separately processed. To rebill a surgical procedure, a claim adjustment must be requested.
- If an initial claim is **filed timely** and is **paid**, including claims **partially paid**, or **paid at zero**, the provider has the following options:
- If a claim paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider may submit a corrected claim. The corrected claim must be filed within 60 calendar days from the date of receipt of the claim decision notification, also referred to as the explanation of payment (EOP).

- If a claim payment disagreement is not due to a provider's error, the provider may submit a dispute within 60 calendar days from the date of receipt of the claim decision notification.
- If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment within 90 calendar days of the primary carrier's EOP.
- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.
- There will be times when a member is hospitalized for longer periods of time. The provider will be able to submit interim bills, which CareSource will pay at 30 percent of the billed charges submitted. When the patient is discharged, the provider will be required to submit a final bill, which includes the entire bill from date admitted to date discharged. CareSource is not able to determine correct payment unless the full, final bill is submitted. The provider will have 90 calendar days from the date of discharge to submit the complete bill. If this information is not submitted within the timely filing guidelines, the claim will be denied, and previous payments will be recouped.

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

Claims that Require Completed Consent Forms

- Abortion – For spontaneous abortions, IHCP requires no documentation from providers billing with the appropriate treatment code. For elective abortions, the physician must specify in writing the physical condition of the patient leading to the professional judgment that the abortion was one of the following:
  - Necessary to preserve the life of the pregnant woman
  - Due to rape or incest
- The documentation must contain the name and address of the member, dates of service, physician's name, and physician's signature. Providers must attach this documentation to the paper claim form, or send it separately as an attachment to the electronic claim transaction.
- Hysterectomy procedures must comply with federal regulations.
- A hysterectomy performed solely for the purpose of rendering a woman permanently incapable of reproducing, whether performed as a primary or secondary procedure, is not reimbursable by Medicaid.
- The acknowledgement of the hysterectomy information statement must be signed by the recipient, or recipient's representative, but is not required where the recipient is already sterile or where a life-threatening emergency exists.
- Where the hysterectomy is performed on an already sterile patient, the provider who performs the hysterectomy must certify in writing that the recipient was already sterile at the time the hysterectomy was performed and state the cause of the sterility.

- Where the hysterectomy is performed under a life-threatening emergency, the provider who performed the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation and that prior acknowledgement was not possible. The provider must include a description of the nature of the life-threatening emergency.
- The individual must be informed orally and in writing that this procedure will render the individual permanently incapable of reproducing, and the individual must sign a written acknowledgement of receipt of this information.
- Hysterectomy is subject to prior authorization. Where the hysterectomy is performed under a life-threatening emergency situation, the provider shall notify the contractor within 48 hours of the procedure, not including Saturday, Sunday and legal holidays, to obtain prior authorization.
- All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement may be made.

Sterilization

This type of service requires a completed Consent for Sterilization Form - HHS-687.

For additional information please see the "Covered Services and Exclusions" section on page 66 of this manual. The forms referenced above are available on our provider website at **CareSource.com** Provider Overview > Tools & Resources > Forms.

Searching for Claims Information Online

Claim status is updated daily on our Provider Portal, and you can check claims that were submitted for the previous 36 months from the data of service (DOS). You can search by RID, member name and date of birth, claim number, check number, or patient number.

Additional Claims Enhancements on the Provider Portal

- Claim history available up to 36 months from the date of service
- Submit claim appeal and disputes
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date

Dental Claim Submissions

Contact the web portal team at DentalProviderPortal@skygenusa.com to get registered and request a demonstration.

Procedure and Diagnosis Codes

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

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10- CM) (Available) from the U.S. Government Printing Office at 202-512-1800, 202-512-2250 (fax) and from many other (vendors)
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at www.ama-assn.org
- HCFA Common Procedure Coding System (HCPCS). Available at cms.gov
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org
- National Drug Codes (NDC). Available at fda.gov

Procedures That Do Not Have a Corresponding Code

- If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
  - A full, detailed description of the service provided.
  - A report, such as an operative report or a plan of treatment.
  - Any information that would assist in determining the service rendered. For example, 84999 is an unlisted lab code that would require additional explanation.
- Drug injections that do not have specific J code (J3490 thru J3999) and any assigned HCPCS J code that is not listed on the Medicaid fee schedule require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.
- Sterilization and Hysterectomy procedures – Consent forms must be attached.
  - Acknowledgement of Receipt of Hysterectomy Information form
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report plus any other documentation that will assist in determining reimbursement.
- Coordination of Benefits (COB) claims require a copy of the Explanation of Payment (EOP) from the primary carrier or required dollar amounts billed via the HIPAA 837 claim transaction. If you have questions on how to bill COB claims electronically, please contact your EDI vendor.

Code Editing

CareSource uses clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately, and efficiently.

CareSource's code editing software finds any coding conflict or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need for additional information from the provider.

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

Corrected Claims Submissions

Accepted standards for corrected claim submissions require that the original claim number is populated on both EDI 837 transactions and paper forms. Including the original claim number allows your corrected claim to auto adjudicate, resulting in the fastest payment.

CareSource will reject both EDI and paper form corrected claims that are received without the original claim number.

Electronic Data Interchange Billing Instructions:

We strongly encourage use of electronic claim submission for all standard claim transactions, including corrected claims.

- Submit the corrected claim in the nationally recognized Electronic Data Interchange (EDI) 837 file format.
- Use an EDI 837 Loop 2300 CLM 05-3 value of “7” (Replacement).
- Carry over the Original Reference No. /Claim No. (12-character data) on the REF 02 data element with a Qualifier “F8” on Loop 2300.

Paper Form Billing Instructions:

Professional Claims:

For professional claims, the provider must include the original CareSource claim number and a frequency code of “7” per industry standards. When submitting a corrected claim, enter a ”7” in the left-hand side of Box 22 and the original claim number in the right-hand side of that box.

Institutional Claims:

For institutional claims, the provider must include the original CareSource claim number in Box 64 and a valid bill frequency code in Box 4 per industry standards.

Please Note: If a corrected claim is submitted without this information, the claim will be processed as an original claim and rejected or denied as a duplicate. Additionally, this process is for correcting denied claims only, not for resubmission of rejected claims (rejected claims are defined as EDI claims not accepted by CareSource).

Provider Coding and Reimbursement Guidelines

CareSource strives to be consistent with all Indiana Office of Medicaid Policy and Planning (OMPP), Medicare and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code or code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims.

Accordingly, we accept only HIPAA compliant code sets (HCPCS, CPT, ICD-10, and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored, as would be any aspect of a provider contract. When referenced in a contract, OMPP reimbursement rules are followed. In addition, the Center for Medicare and Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed. Finally, generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the listed links for details:

- Medicare: cms.gov
- Indiana Medicaid: https://www.in.gov/medicaid/

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

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

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

Any specific claim is subject to current CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Emergency Department Reimbursement Guidelines

CareSource would like to remind emergency department (ED) providers of coverage for emergency services. In alignment with Indiana Health Coverage Program (IHCP) reimbursement policy, hospitals are reimbursed for screenings that are necessary to determine whether the member has an emergency condition. Billing guidelines for the institutional claim (UB-04 claim form or electronic equivalent) depend on the result of the screening, as follows:

- If the screening result does not meet the definition of an emergency visit, using the prudent layperson review criteria, the hospital should bill only for the screening service, using revenue code 451 – Emergency Medical Treatment and Labor Act [EMTALA] Emergency Medical Screening Services. No emergency room treatment services are reimbursed if billed in conjunction with revenue code 451.
- If the screening determines that the member does have an emergency condition, the hospital should not bill revenue code 451 for the screening. Instead, the hospital should bill for the medically necessary emergency services provided, using the appropriate revenue code (such as 450 – Emergency Room – General) along with applicable procedure codes.

Physicians bill for their services on a professional claim (CMS-1500 claim form or electronic equivalent), and must use Current Procedural Terminology (CPT®1) codes 99281–99285 to reflect the appropriate level of emergency department screening exam performed.

CareSource follows IHCP guidance and does not reimburse hospitals for nonemergency services rendered in emergency room settings. Hospitals are reimbursed for screenings that are necessary to determine whether the member has an emergency condition. If the screening does not indicate an emergency medical condition, the hospital is reimbursed only for the screening itself, billed with revenue code 451. Physicians who provide services in an emergency department setting to patients whose screenings do not indicate an emergency medical condition should bill these nonemergency services using the applicable office visit procedure code instead of the emergency room screening procedure code.

CareSource has implemented a list of diagnosis codes established by IHCP to determine if a service meets an emergent level of care. CareSource will check the diagnosis codes in fields 67 and 67A-E on the UB04 and 21A-F on the CMS 1500 against the emergency department autopay list. If an emergent diagnosis code is not used, the claim will be pended for a prudent layperson to review the claim and make a determination on the appropriate type of visit.

If the prudent layperson review determines the service was not an emergency, CareSource will reimburse for the medical screening examination and facility fee only, and a copay will be applied. Providers can submit medical records or other supporting documentation within 120 days following the date of payment of the screening fees for re-consideration by the prudent layperson. This documentation should be submitted through the CareSource Provider Portal.

Copayment

HIP members may incur an $8 copayment for all non-emergent ED visits. The copayment is waived if the member called the CareSource24 nurse hotline prior to the ED visit.

HIP members who are exempt from cost-sharing (for example, members who are pregnant or members identified as American Indians/Alaska Natives (AIs/ANs), pursuant to *42 CFR 136.12*), and will not be required to pay copayments for nonurgent use of hospital ED services. If a copayment is collected at the time of service, the payment will need to be refunded back to the member and reimbursement for the visit will not be reduced by the amount of the copayment.

Notification

If a CareSource member presents to the emergency department for services, the provider may notify CareSource to allow for care management services, preparation for admission, or discharge planning. Calls to CareSource with the notification should be made to Provider Services at **1-844-607-2831**. If the call occurs after hours, CareSource will return the call within 24 hours. If an inpatient admission is expected, a prior authorization may be needed. Additional information along with instructions to submit a request can found at **CareSource.com**.

Explanation of Payment

Explanation of Payments (EOPs) are statements of the 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 claim submission activity. Providers who receive EFT payments will receive an Electronic Remittance Advice (ERA) and can access it 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 provider'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.

CareSource is responsible for resolving any pended claims, not the provider. 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

Coordination of Benefits

CareSource collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately, and in general we are required to comply with the federal regulations that Medicaid programs serve as the payer of last resort.

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

Search COB on the Provider Portal By:

- Member's RID
- CareSource member ID number
- Member name and date of birth

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

Claims involving COB will not be paid until an Explanation of Benefits/Payment or EDI payment information has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (zero balance) must still be submitted to CareSource for processing. This is due to regulatory requirements.

COB Overpayment

If a provider receives a payment from another carrier after receiving payment from CareSource for the same items or services, this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the provider, or the provider can issue refund checks to CareSource for any overpayments. Providers should not refund any money received from a third party to a member.

Workers' Compensation

Claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The provider will be advised to submit the charges to workers' compensation for reimbursement.

Third-Party Liability/Subrogation

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

Member Billing Policy

In order to charge the member for non-covered services, the member must be informed that he or she may be eligible for the service by a different Medicaid provider (if applicable). The provider must disclose the following in writing:

- That the service to be rendered is not covered by Medicaid.
- Whether there are procedures or treatments covered by the Department that are available to the member in lieu of the non-covered procedure or treatment. If there are covered procedures or treatments available to the member, the member must indicate on the disclosure form his or her willingness to accept the non-covered service.

The requirements and documentation must be signed prior to providing any service. Members in emergent situations cannot be billed for services. For example, a member who uses a transportation provider who is not enrolled in IHCP for an ambulance ride to an emergency room may *not* be billed.

Generally, providers enrolled in the IHCP can bill members only under the following conditions:

- The service is not covered under the IHCP (for example, cosmetic procedures).
- The member has exceeded the program limitation for a particular service.
- The member understands that the IHCP does not cover the service and accepts financial responsibility before receiving a service that is not covered by the program.
- The services provided are covered or non-covered embellishments or enhancements to covered services. These services can be considered and billed separately from the basic service only if a separate procedure, revenue or National Drug Code (NDC) exists for the enhancement. Otherwise, a service in its entirety is considered covered or non-covered.
    - The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service.The provider has taken appropriate action to identify a responsible payer, and the enrollee has failed to inform the provider of IHCP eligibility before the one-year claim-filing limitation.
- The provider has taken appropriate action to identify a responsible payer, and the enrollee has failed to inform the provider of IHCP eligibility before the one-year claim-filing limitation.

It is never appropriate to balance bill a Medicaid member for a Medicaid covered service. A member must be given an option, with the ability, to leave and find an alternative option prior to rendering consent for direct billing.

POWER Account

Indiana offers HIP members a comprehensive benefit package through a $2,500 deductible health plan paired with a personal health care account. The state will contribute most of the required amount, but members will also be responsible for making a small contribution to their account each month. The amount of a member's contribution amount is based on income, two percent of their income or at minimum of $1 for those without incomes.

Frequently Asked Questions

What is the deductible?

HIP members use the funds in their POWER Accounts to meet their $2,500 deductible.

Who contributes?

HIP Plus members, the state and (in some cases) nonprofits and employers may contribute to the POWER Account to meet their deductible. HIP Basic members are required to make copayments for most services, per the benefits grid. Providers are expected to collect the copayment at the time of service.

How can members contribute?

HIP Plus members make payments in equal monthly installments. There is no penalty or fee for making payments or paying the annual account contribution in full. Families may make combined POWER Account payments to CareSource on behalf of each family enrolled in the CareSource plan. CareSource will offer members the capacity to pay their premiums through national outlets.

HIP Basic members do not make POWER Account contributions, but rather incur copayments for most services they receive, except for a select list of preventive services.

Can accounts be rolled over?

At the end of a benefit period of 12 months, members have an opportunity to renew their eligibility in HIP by completing the redetermination process. If the member is redetermined eligible for HIP, any funds remaining in the member's POWER Account may be rolled over and applied as a credit towards the member's required contribution in the subsequent benefit period. The amount rolled over or discounted, as applicable, depends on whether the member received his or her recommended preventive care services. It also depends on what program (Plus or Basic) the member is enrolled in on the last day of their benefit period; prior to the current benefit period to which the rollover is being calculated for and applied. To allow a claims run-out period, rollover is processed 120 calendar days following the end of the member's prior benefit period. HIP Basic members get an opportunity to opt into HIP Plus when they have rollover dollars in addition to when they go through the redetermination process.

What can the member use the POWER Account funds for?

Each member is responsible for the use of funds in his or her POWER Account until the deductible is met. However, POWER Account funds can be used by the member only to pay for HIP covered services.

In spending POWER Account funds, members must be permitted to receive the following covered services, even if obtained through out-of-network providers:

- Family planning services, if obtained from an IHCP provider – *no authorization required.*
- Emergency medical services – *no authorization required.*
- Other self-referral services, if obtained from an IHCP provider – *no authorization required.*
- Medically necessary covered services – authorization required. This is only applicable out of network if CareSource's network is unable to provide the service within a 60-mile radius of the member's residence, as specified in 42 CFR 438.206(b)(4) and Section 5.14.
- Nurse practitioner services, if provided by an IHCP provider.

Members cannot use POWER Account funds to pay for copayments, as they are an out-of-pocket expense. Providers will collect the copayment from the member.

How do I charge the member's POWER Account?

Providers should submit a claim for every service. CareSource will deduct the member's cost sharing responsibility from the member's POWER Account at the time of claim processing. CareSource will then reimburse the provider for the remainder amount of the claim.

Covered services provided by out-of-network providers must be billed to CareSource. CareSource will reimburse the provider with available funds in the member's POWER Account.

If a member has exhausted the balance of the POWER Account, participating providers should submit a claim to CareSource and be reimbursed via the normal claim process. It is never appropriate to balance bill a Medicaid member for a Medicaid covered service.

Copayments/Cost Sharing

Certain services such as transportation, office visits, inpatient stays, non-emergency use of emergency room and pharmacy may be subject to member copayments in Healthy Indiana Plan. Pregnant women and children are not subject to copayment requirements and cannot be charged any copayments or other cost-sharing fees. Providers cannot refuse to see members based on the members' inability to pay the copayment and must accept IHCP reimbursement as payment in full for the services rendered.

Cost-sharing, including contributions and coinsurance, is prohibited in HIP with the exception of member POWER Account contributions and copayments. IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered IHCP service.

Pursuant to federal law, the POWER Account contributions, or any other cost-sharing, including copayments for non-urgent use of hospital emergency departments, may not be collected from members identified as an American Indian/Alaska Native (AI/AN), pursuant to 42 CFR 136.12. The state will identify all AI/AN members through the eligibility determination process.

For all HIP members, the total annual aggregate cost-sharing may not exceed five percent of the household income. This is determined on a quarterly basis. The state, CareSource and the member are responsible for monitoring total aggregate cost sharing. Once the member's total aggregate cost sharing reaches five percent of income for a quarter, the member will receive a notice in the mail and the following will take effect:

- Member monthly contributions are reduced to $1.00, or $1.50 for those with tobacco surcharge, for the remainder of the quarter that the five percent is reached.
- CareSource will notify the State that the member's five percent cost-sharing threshold has been met. This will be visible to providers via the CareSource Provider Portal and the Web Interchange.
- Providers must refund any copays collected after cost-sharing was turned off.
- Members enrolled in HIP Basic or HIP State Plan Basic are not required to make monthly contributions to their POWER Account, but are required to pay the following copayments at the time services are rendered:
    - $8 copayment for non-emergent emergency room (ER) visit
    - $4 copayment for outpatient services
    - $4 copayment for preferred drugs
    - $8 copayment for non-preferred drugs
    - $75 copayment for inpatient services
        - However, no copayment is required for preventive care, including early periodic screening, diagnostic and testing services or family planning services. When cost-sharing is turned off, HIP Basic members will not incur copayments. For all individuals who call CareSource24®, the 24-hour nurse hotline, before using the ER, the copay will be waived.

Hoosier Healthwise Copayments

Members enrolled in HHW Package C will have copays for some services in order to receive those services. The following copayments are applicable:

- $10 copayment for emergency transportation
- $3 copayment, per prescription, for pharmacy (generic)
- $10 copayment, per prescription, for pharmacy (brand name)

No copayment is required for non-emergency usage of ER.

REFERRALS AND PRIOR AUTHORIZATIONS

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

Referral Information

If you have questions about referrals and prior authorizations, please call our Utilization Management Department at **1-844-607-2831.**

Referral Procedures

Any treating provider can refer CareSource members to specialists. Please refer to our website for more information on services that require a referral. Simply put a note about the referral in the patient's chart. Please remember, nonparticipating specialists must request prior authorization for any services rendered to CareSource patients and must be enrolled as an IHCP provider.

Or, you can submit a request on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal. Or, you can request a prior authorization by calling our Utilization Management Department at **1-844-607-2831**, and select the option to request a prior authorization.

If you have difficulty finding a specialist for your CareSource member, please use our online Find a Doctor/ Provider tool at **CareSource.com** > Members > Tools & Resources > Find a Doctor or call Provider Services at: **1-844-607-2831**.

Services That Do Not Require a Referral

Some health care services provided by specialists do not require a referral from a primary medical provider (PMP) or dental provider. Members may schedule self-referred services from participating providers themselves, provided the service is covered under their specific plan. Note that although CareSource does not require members obtain referrals for the providers below, the specific services rendered may still require prior authorization from CareSource. In addition, all services rendered are still subject to benefit limits. PMPs or dental providers do not need to arrange or approve these services for members as long as any applicable benefit limits have not been exhausted. These include the following:

- Certified Nurse Practitioner (CNP) services
- Chiropractic care
- Some dental services (excluding oral surgery and orthodontics)
- Services to treat an emergency
- Family planning services
- Laboratory services (must be ordered by a participating provider)
- Podiatric care
- Psychiatric care, including mental health and SUD as applicable
- Psychological care (from private practitioners or at Community Mental Health Centers)
- Care at public health clinics
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Most radiology services (must be ordered by a participating provider)
- Routine eye exams (at participating vision centers)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours
- Services for children with medical handicaps
- Behavioral health providers. Members may also self-refer to any IHCP-enrolled psychiatrist. The mental health providers to which the member may self-refer within network include:
    - Outpatient mental health clinics
    - Community Mental Health Centers
    - Psychologists
    - Certified psychologists
    - Health services providers in psychology (HSPPs)
    - Certified social workers
    - Psychiatric nurses
    - Independent practice school psychologists
    - Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
    - Persons holding a master's degree in social work, marital and family therapy or mental health counseling

Members May Go to Nonparticipating Providers for:

- Emergency care
- Care at Community Mental Health Centers
- Psychiatric care
- Family planning services provided at qualified family planning providers
- Care at FQHCs and RHCs
- Necessary covered medical services if CareSource does not have in-network providers within 60 miles of the member's residence

Please Note: Non-participating providers must be IHCP-enrolled to receive reimbursement and claims must be submitted within the filing limit for non-participating providers.

How to Make a Referral to a Specialist

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 PMP. 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. CareSource expects specialists to collaborate on the member's care and inform the member of treatment plan updates.

Standing Referrals – A PMP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PMP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral. Treating providers must get prior authorization from our health plan before sending a member to an out-of-network provider.

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. In accordance with 42 CFR 438.206(b)(3), CareSource complies with all member requests for a second opinion from a qualified professional. If our network does not include a provider who is qualified to give a second opinion, CareSource shall arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

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

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

Prior Authorization Information

Services that Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. Prior authorization requirements by service type may be found at **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization or on the searchable authorization lookup tool.

Ordering physicians must obtain a prior authorization for the following outpatient, non-emergent diagnostic imaging procedures:

- MRI/MRAs
- CT/CTA scans
- PET scans

Providers can obtain prior authorization from NIA Magellan for an imaging procedure in the following ways:

- Online – www.radmd.com
- By phone – **1-800-424-4883** (follow the options to obtain a prior authorization and select the option for advanced radiology prior authorization), Monday through Friday, from 8 a.m. to 8 p.m. EST.

Please Note: Imaging procedures performed during an inpatient admission, hospital observation stay or emergency room visit are not included in this program.

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

CareSource as Secondary Payor

If CareSource requires PA for a service, and the member has additional insurance coverage that is primary, the provider must follow the primary insurance requirements for obtaining PA and must also obtain PA from CareSource.

Synagis Prior Authorization

CareSource's Medical Policy for administration of Synagis follows the American Academy of Pediatrics (AAP) guidelines for Respiratory Syncytial Virus (RSV), which may be found at www.aappublications.org. CareSource will review according to the guidelines in determining payment authorization for Synagis immunization. Consistent with epidemiologic findings, CareSource considers "RSV season" to be November 1 through March 31.

Coverage for the RSV season ends on March 31 with an extension possible if RSV is still in the community. Requests for Synagis injections can be submitted on our secure Provider Portal.

In addition, any provider who is not a participating provider with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource member.

CareSource does not require prior authorization for unlisted procedure CPT codes. However, it requires a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code.

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. Denials will be reconsidered through the appeal process with pertinent clinical records. Unlisted CPT codes must also be covered as indicated on the Indiana Medicaid fee schedule.

Prior Authorization Procedures

The Provider Portal is the preferred method to request prior authorization for health care services. You can get immediate approval or pend status, and can check pending claim status. Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone, fax or mail. If submitted by mail or fax, the prior authorization form used should be the IHCP prior authorization request form.

Online

Visit **CareSource.com** > Login > Provider. Alternate methods include phone, fax or mail.

Phone

Please call **1-844-607-2831**, then tell our IVR that you need to submit an authorization request.

Fax

Please fax the prior authorization form to **844-432-8924**. The prior authorization form can be found on **CareSource.com** > Providers > Tools & Resources > Forms.

Mail

Send prior authorization requests to:
CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Behavioral Health Prior Authorization Submission Address

CareSource
Attn: Indiana Behavioral Health Utilization Management Department
P.O. Box 1307
Dayton, OH 45401

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource member ID (RID) number
- Provider name, TIN 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-network provider, if applicable
- Clinical information to support the medical necessity for the service

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.

CareSource requires timely submissions of prior authorization requests for **inpatient** admissions. If the service is an acute **inpatient** emergent admission CareSource expects the facility to submit the authorization request within 48 hours of admission, not including Saturdays, Sundays, or legal holidays. However, if it is a planned admission, CareSource expects that the physician submits a prior authorization request prior to admission.

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

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

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness, and 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. Providers must verify eligibility on the date of the service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the provider.

CareSource will notify you of prior authorization determinations by a letter mailed to the provider's address on file.

For standard prior authorization decisions, CareSource provides notice to the provider and member as expeditiously as the member's health condition requires, but no later than five business days following receipt of the request for service.

Urgent prior authorization decisions are made within 48 hours of receipt of request for service. Please specify if you believe the request is urgent.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits, and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. If an authorization is being appealed for medical necessity, a member consent form must also be submitted.

Authorization Type	Decision	Extension
Concurrent	48 hours from receipt of request	May extend the timeframe once, by up to 14 calendar days, under the following conditions: • The member requests an extension, or • CareSource needs additional information, provided it documents at least one attempt to obtain the necessary information.
Urgent Preservice	48 hours from receipt of the request	If an urgent pre-service request is incomplete and requires additional information, CareSource must request the additional information within forty-eight (48) hours. Healthcare providers then have forty-eight (48) hours to respond to the request.
Standard Preservice	5 business days	CareSource may extend the time frame once, by up to 14 calendar days if a member requests the extension or CareSource needs additional information, provided it documents at least one attempt to obtain the necessary information.
Retro (Post service)	30 calendar days	None

Dental Authorizations

Dental authorization requests may be submitted via paper or online at: www.SKYGENUSA.com. Clinical appeals for dental authorizations follow the same appeal process as medical services.

Online

Contact the web portal team at dentalproviderportal@skygenusa.com to get registered for the Skygen Provider Web Portal and request a demonstration. Some of the time-saving features of the dental Provider Web Portal include:

- View member service history covered benefits and fee schedules.
- Create a member eligibility calendar and view real-time eligibility for multiple members.
- View authorization guidelines and required documentation prior to submitting authorizations.
- Submit authorizations with attachments for faster determinations.

Paper

Paper dental authorization requests may be sent to:
CareSource IN: Authorizations
P.O. Box 745
Milwaukee, WI, 53201

Billing for Services Denied Prior Authorization

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

- The provider must establish that authorization has been requested and denied before rendering the service.
- The provider can request CareSource review of the authorization decision. CareSource must inform providers of the contact person, the means for contact, the information required to complete the review and procedures for expedited review, if necessary.
- If CareSource maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that the authorization has been denied.
- The member must be informed of the right to contact CareSource to file an appeal if the member disagrees with the decision to deny authorization.
- The provider must inform members of member responsibility for payment if the member chooses to or insists on receiving the service without authorization.

If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:

- The waiver is signed only after the member receives the appropriate notification stated in requirements three and four.
- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
- Providers must not use nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.
- The waiver must identify the specific procedure to be performed, and the member must sign the consent before receiving the service.
- Please add a bullet point that states “The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that CareSource did not authorize the service.

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

Healthy Indiana Plan Members

This policy should not be interpreted as interfering with a provider’s ability to hold HIP members liable for the emergency services copayment or HIP Basic or HIP State Plan Basic member liability for allowable copayment amounts.

Further, this policy should not be interpreted as preventing payment of covered services with POWER Account funds before the member’s deductible has been met. However, if CareSource permits providers to bill members for services that require authorization, but for which authorization is denied, as outlined above, POWER Account funds shall not be used to reimburse the provider for the non-covered service.

UTILIZATION MANAGEMENT

Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The UM 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 care management team are made, if needed. CareSource makes its UM criteria available in writing by mail, fax, and online.

Mail

CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Fax

844-432-8924

Criteria

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

CareSource also has medical policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource Clinical Peer Reviewer for further review and determination. Clinical Peer Reviewers from CareSource are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request.

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

Our members' health is always our number one priority. Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations when an adverse decision has been rendered. You may request the information by calling or faxing the CareSource Utilization Management Department. If you would like to discuss an adverse decision with a CareSource Clinical Peer Reviewer, please call the Utilization Management Department at **1-844-607-2831** then state "extension" once the automated phone system completes the introduction. Please then ask for extension 1283. This request for the discussion with the Clinical Peer Reviewer needs to occur within seven business days of the determination.

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

Post Stabilization Services

Please call **1-844-607-2831** 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 provider. To request prior authorization for observation services as a nonparticipating provider or to request authorization for an inpatient admission please call **1-844-607-2831**.

When calling, follow the prompt for post-stabilization. During regular business hours, your call will be answered by our Utilization Management Department. If calling after regular business hours, the call will be answered by CareSource24, our nurse advice line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

Access to Staff

Providers may call our Utilization Department at **1-844-607-2831** with any questions.

Staff Availability

- Staff members are available from 8 a.m. to 5 p.m. Eastern Time (ET) during normal business hours for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

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

PHARMACY

CareSource covers all medically necessary Medicaid-covered prescription drugs and medical supplies. This applies to all CareSource members who get health care through an Indiana Medicaid managed care plan, including HHW and HIP.

CareSource works with Express Scripts, our delegated pharmacy innovation partner, to manage our prescription drug costs and develop and implement plan-specific preferred drug lists (PDLs).

Prescription Drug Coverage

- **Copayment requirements** – Depending on the plan chosen and whether the drug is preferred or not preferred, an individual may have a required copay. Some medical supplies are covered under the pharmacy benefit, including diabetes supplies, spacers, peak flow meters and condoms.
- **Other medical supplies and durable medical equipment (DME)** – To support member access and convenience, other select medical supplies, such as wound care supplies and enteral feeds, may be filled through the retail pharmacy for a limited period of time (up to 30 days) until you coordinate delivery with a DME provider.
- **Medications administered in the provider setting** – Physician administered drugs/medications that are administered in a provider setting (such as a physician office, hospital, outpatient department, clinic, dialysis center, or infusion center) will be billed to CareSource with the exception of drugs carved out and covered by Indiana's Fee for Service Medicaid program.
  Please Note: prior authorization requirements exist for many injectable medications.
- **Transition period** – A 90-day transition period applies for members new to the plan who are on pre-existing drug regimens. Some medications are excluded from the transition period. After the 90-day transition period has ended, prior authorization may be applicable, depending on the member's medication. Check **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization to find out medications require prior authorization.

Preferred Drug List

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

CareSource follows Indiana's Statewide Uniform Preferred Drug List (SUPDL). Drugs and drug categories not on the SUPDL are termed neutral and are managed by CareSource. Both preferred SUPDL and preferred neutral products are found within CareSource's posted Preferred Drug Lists (PDLs). CareSource also maintains an online drug formulary search tool. These and additional resources can be found online at **CareSource.com** > Providers > Drug Formulary.

CareSource provides advance notification for PDL changes here **CareSource.com** > Providers > Tools & Resources > Drug Formulary > Drug Formulary Changes.

Step Therapy and Quantity Limits

Certain medications on and off of the PDL require utilization criteria to be met. Step therapy is a utilization technique that requires use of preferred medication(s) before a non-preferred, or higher cost 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 PDL, boldface type indicates generic availability. However, not all strengths or dosage forms of the generic name in **boldface type** may be generically available. In most instances, a brand-name drug for which a generic product becomes available will not be available in the PDL, with the generic product covered in its place, upon release of the generic product onto the market.

However, the PDL 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).

A list of preferred drugs is available at **CareSource.com** > Provider Overview > Tools & Resources > Drug Formulary. This site also includes other information about the CareSource pharmacy program.

Prior Authorization

CareSource will process prior authorization requests in accordance with Indiana Medicaid regulations. Prior authorization requires that a drug be pre-approved in order for it to be covered under a health benefit.

The prior authorization staff will adhere to the OMPP regulations and determine medical necessity for PDL exception requests that will be reviewed based on drug-specific prior authorization criteria or standard non-PDL prescription request criteria.

The Provider Portal is the preferred method to request prior authorization for pharmacy services under the medical benefit. Providers can also submit prior authorization requests by fax, or urgent prior authorizations requests by phone. Providers will be required to submit pertinent medical/drug history, prior treatment history and any other necessary supporting clinical information with the request.

Online

Visit **CareSource.com** > Login > Provider. Alternate methods include phone, fax, or mail.

Fax

1-866-930-0019

Phone

1-844-607-2831

Specialty Pharmacy Program

In order to improve medication compliance, disease state and side effect management, our preferred specialty provider is Accredo or Amber Specialty Pharmacy. Accredo or Amber Specialty Pharmacy will provide specialty medications directly to the member or the prescribing physician and coordinates nursing care if required. Please visit our Pharmacy webpage at **CareSource.com** > Providers > Education > Pharmacy, selecting Indiana Medicaid from the dropdown menu, to see more details about the Specialty Pharmacy program.

Medication Therapy Management Program

CareSource offers a medication therapy management (MTM) program for all members. MTM services allow local pharmacists to work collaboratively with other physicians and 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, as we want to make sure they are getting the best results from the medications they are taking.

BEHAVIORAL HEALTH

Behavioral health is critical to each member's overall health. CareSource ensures that all members have access to behavioral health resources and that behavioral health is integrated across all interventions. Behavioral health providers (BHPs) are expected to assist members in accessing emergent, urgent, and routine behavioral services as expeditiously as the member's condition requires.

CareSource provides behavioral health benefits to our Medicaid members. Members may self-refer to behavioral health services within our provider network without a referral from their primary medical provider (PMP). Members may also self-refer to any Indiana Health Coverage Programs (IHCP) psychiatrist outside of our network. Note that although CareSource does not require members to obtain referrals for the providers below, the specific services rendered may still require prior authorization from CareSource. In addition, all services rendered are still subject to benefit limits.

Physical Health and Behavioral Health Coordination

CareSource encourages communication and care coordination between PMPs, specialists and behavioral health providers to achieve optimal health for our members. Communication between PMPs, specialists and BHPs is necessary to ensure continuity of care and member safety. CareSource requires every provider to ask and encourage members to sign a consent permitting release of substance use disorder information to CareSource and to the PMP or BHP. The consent form can be found on **CareSource.com** > Members > Tools & Resources > Forms.

42 CFR Part 2, better known as Part 2, requires Part 2 providers to obtain written consent from the member before releasing information related to substance use disorder services. This type of release of information also requires the provider to include a "Prohibition on Redisclosure" statement. CareSource contractually requires that physical and behavioral health providers document and reciprocally share the following information for each member:

- Primary and secondary diagnoses
- Findings from assessments
- Medication prescribed
- Psychotherapy prescribed
- Any other relevant information

CareSource ensures members' Behavioral Health Profiles are sent to their respective PMP on file each quarter (or more frequently if clinically indicated). The Behavioral Health Profile is a summary report of a member's physical and behavioral health treatment received during the previous reporting period. Information about substance use disorder treatment and HIV/AIDS is only released when the member's consent has been obtained.

The intent of the Member Profile is for coordination of care between physical and behavioral health to better serve members. Thorough and timely sharing of patient information is essential to addressing patients' care plan needs to support positive health outcomes.

CareSource requires that all members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. If a member misses an outpatient follow-up appointment or continuing treatment, CareSource requires the behavioral health provider to notify CareSource through the Provider Portal and the care manager contact the member within three business days of notification of the missed appointment to reschedule.

CareSource is required to notify both the BHP and PMP when a member has an inpatient behavioral health admission or receives emergency treatment within five (5) days for all behavioral health conditions. However, if the member has a substance use disorder (SUD) diagnosis, we must have their consent to notify the PMP and BHP.

In addition, Behavioral Health network providers are required to notify CareSource within five (5) calendar days of the member's inpatient visit and within five (5) days of a member's initial referral visit, and submit information about the treatment plan, the member's diagnosis, medications, and other pertinent information. Disclosure of mental health records by the provider to CareSource and to the member's physician is permissible under the Health Insurance Portability and Accountability Act (HIPAA) and state law (IC 16-39-2-6(a)) without consent of the member because it is for treatment. However, consent from the member is necessary for substance use disorder records.

CareSource facilitates coordination of care between BHPs and PMPs. CareSource requires that BHPs refer members with known or suspected and untreated physical health problems or disorders to their PMP for examination and treatment, with the member's or the member's legal guardian's consent. CareSource requires that PMPs and specialists have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

CareSource assures that behavioral health services are integrated with physical health care services and that behavioral health services are part of the treatment continuum of care. CareSource has developed protocols:

- To address the needs of members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health,
- For providers to provide a written plan and evidence of ongoing increased communication between the PMP, the managed care plan (MCP) and the BHP, and
- To coordinate management of utilization of behavioral health care services with Medicaid Rehabilitation Option (MRO) and 1915(i) services and services for physical health.

Behavioral Health Initiatives

In addition to behavioral health care coordination, CareSource partners with providers to offer innovative behavioral health services and supports for members. These enhanced services and supports are designed to help members with behavioral health needs to receive the care they need at the time they need it while rewarding them for taking the necessary steps to improve their health and well-being.

CareSource MyHealth Journey Rewards Program

CareSource rewards members on the road to recovery by offering incentives for taking steps to improve their health. HIP and adult HHW members being treated for Substance Use Disorder (SUD) can attend an in-network Intensive Outpatient Program (IOP) groups and earn rewards for completing sessions. CareSource has developed a pathway to rewards for HIP and adult HHW members to earn up to $100 for attending IOP groups, which goes towards their $300 total rewards that can be earned across all incentive programs in the MyHealth Journey Program. Members receive behavioral health rewards for each in-network IOP group session they attend ($10 for each session, up to $100). Members can track their rewards in the free CareSource mobile app or on their MyHealth account, and then use their rewards to shop for food or technology. For questions about the SUD IOP reward, please call Provider Services at **1-844-607-2831**.

Providers can access educational toolkits related to SUD, opioid use, suicide prevention and depression at **CareSource.com** > Providers > Behavioral Health.

Prior Member Consent

Prior member consent is required to disclose sensitive health information, a subset of protected health information. Impacted conditions includes SUD. Consent requirements are based on federal and state requirements.

For SUD, federal rule 42 CFR PART 2 exists to encourage people to engage in substance use treatment without fear of legal prosecution. This rule:

- Is commonly called “Part 2”;
- Is part of the Code of Federal Regulations;
- Pertains only to drug and alcohol treatment;
- Restricts disclosure of records by a Part 2 provider (any entity that “provides alcohol or drug abuse diagnosis, treatment or referral for treatment”) and redisclosure of records received from a Part 2 provide; and
- Is more stringent than HIPAA privacy rules

To secure appropriate consent, members are encouraged to complete the Member Consent/HIPAA Authorization Form, which allows their providers to effectively communicate and coordinate care. Find this form at **CareSource.com** > Member Overview > Tools & Resources > Forms.

Your CareSource members' current consent status can be found on the Provider Portal. Search for the patient using the "Member Eligibility" option.

If you have questions, contact Provider Services at **1-844-607-2831**.

Access and Availability Standards

Behavioral Health Providers

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Non-life threatening emergency	Not to exceed six hours
Urgent care*	Not to exceed 48 hours
Initial visit for routine care	Not to exceed 10 business days
Follow-up routine care	Not to exceed 30 calendar days based off the condition
Follow-up after discharge	Within seven days from the date of discharge

Scope of Practice

BHPs may provide physical health care services within their scope of practice. PMPs and specialists may provide clinically appropriate behavioral health services within the scope of their practice. Behavioral health providers are required to use DSM-5 when assessing the member for behavioral health services. Behavioral health providers are required to document the DSM-5 diagnosis and outcome of assessment information in the member's medical record.

MEMBER ENROLLMENT AND ELIGIBILITY

The Division of Family Resources (DFR) is responsible for determining eligibility in Indiana Health Coverage Programs (IHCP), which includes Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP). Hoosier Healthwise Eligibility

Hoosier Healthwise is a risk-based managed care program that covers children up to age 19, pregnant women and low-income parent/caretakers of children under the age of 18.

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HHW Enrollment Categories

Enrollment in a HHW managed care plan is mandatory for members in the following groups:

- **Pregnancy Medicaid:** Includes pregnant women who do not receive Temporary Assistance for Needy Families (TANF). The full scope of benefits is available to women who meet strict income and resource criteria. Pregnancy-related coverage is provided to women who meet eligibility requirements without regard to resources.
- **Children's Medicaid:** Includes children whose families do not receive TANF, but who are younger than 21 years old and meet the eligibility requirements.
- **Children's Health Insurance Program (Phase I expansion):** Effective July 1, 1998, includes children from 1 to 19 years old who are uninsured and otherwise ineligible for IHCP benefits, and whose family meets the eligibility requirements.
- **Children's Health Insurance Program (CHIP) (Phase 2 expansion – Package C):** As of Jan. 1, 2000, includes children from birth to 19 years old who are uninsured and otherwise ineligible for IHCP benefits, and whose families meet eligibility requirements. Unlike other categories of eligibility in Hoosier Healthwise, continued eligibility in Package C depends on payment of monthly premiums. Enrollees remain conditionally eligible until they have made their first CHIP premium payment.

HHW Packages

The aid categories above determine an eligible enrollee's benefit package. HHW enrollees are eligible for one of the following packages:

- **Package A (Standard plan):** Provides full coverage for children and pregnant women
- **Package C (Children's plan):** Preventive, primary and acute care services for children under 19 years old in families with incomes greater than 208 percent but less than 158 percent of the federal poverty level (FPL)

Members do not receive HHW identification cards until determination of the member's HHW eligibility.

Healthy Indiana Plan Eligibility

HIP provides health care coverage to adults ages 19-64 who meet specific income levels.

HIP Eligibility Requirements

- Between ages 19 and 64 (If over 64 but considered a Low-Income Parent/Caretaker that is not receiving Medicare, may continue to be enrolled in HIP. Providers must report any Medicare enrollees who are receiving HIP)
- U.S. citizenship
- Household income at or below 138 percent FPL for enrollment in HIP Plus
- Household income at or below 100 percent FPL for enrollment in HIP Basic (but members default into Plus and if they stop paying, they drop to Basic)

Indiana offers HIP members a comprehensive benefit package through a deductible health plan paired with a personal health care account. The State will contribute most of the required amount, but members will also be responsible for making a small contribution to their account each month. The amount of a member's monthly contribution amount is based on two percent of an individual's annual income.

HIP Enrollment Categories

- **HIP Plus:** HIP Plus is the preferred plan for all HIP members. HIP Plus provides the best value coverage and includes vision and dental services. In HIP Plus, members pay an affordable monthly contribution of approximately two percent of income and do not pay any other costs or copayments unless they visit the emergency room when they don't have an emergency health condition. HIP Plus Members with incomes over 100 percent of the FPL who don't pay or miss their monthly POWER contribution will lose their HIP coverage.
- **HIP Basic:** HIP Plus members who do not pay their monthly POWER Account contributions are disenrolled from HIP Plus and fall to Basic if they are below 100 percent of the FPL. HIP Basic benefits provide coverage for all required services but are more limited and do not provide vision or dental coverage, along with some other benefits. In HIP Basic, members have to make a copayment for most services other than preventive services. These copayments may range from $4 to $8 per doctor visit or prescription filled and may be as high as $75 per hospital stay. HIP Basic can be much more expensive than HIP Plus overall. HIP Basic members that are Basic at the end of their benefit period and qualify for rollover can buy up to HIP Plus. This is also an option when a member redetermines after 12 months.

- **HIP State Plan:** Available to individuals who qualify as low-income parents and caretakers, low-income 19- and 20-year-olds and individuals with serious and complex medical conditions who are deemed "medically frail." The HIP State Plan provides access to comprehensive Indiana Medicaid State Plan services and includes cost-sharing responsibilities through POWER Account contributions (HIP State Plan Plus) or copayments (HIP State Plan Basic), as determined by a member's eligibility category and income level.
  - **HIP State Plan Plus:** Individuals enrolled in State Plan benefits have access to the greater benefit package available under the state plan. Those in *State Plan Plus* have the same cost-sharing requirements as *HIP Plus*; they must make a POWER Account contribution, and they do not have copayments for services.
  - **HIP State Plan Basic:** Individuals enrolled in State Plan benefits have access to the greater benefit package available under the state plan. Those in *State Plan Basic* have the same cost sharing requirements as *HIP Basic* and they have the same copayments for services.
- **HIP Maternity:** HIP members who are pregnant may keep their HIP coverage for the duration of their pregnancy. Pregnant members will have all cost sharing eliminated and will receive additional benefits during their pregnancy including non-emergency transportation. A pregnant HIP member must promptly report her pregnancy. After reporting a pregnancy, pregnant mothers will continue to have a POWER account but will not be required to make payments. Pregnant members are eligible to receive incentives for completing preventive care like all other HIP members. HIP Maternity members will receive vision, dental, chiropractic coverage, non-emergency transportation and access to additional smoking cessation services designed specifically for pregnant women. At the end of the pregnancy, additional pregnancy benefits will continue for another 12-month post-partum period. Pregnant members will continue to not have any cost sharing responsibilities during this period. If, at the end of the 12-month postpartum coverage period, the member is no longer eligible in their previous category of coverage, the Division of Family Resources (DFR) will review eligibility in any other Indiana Health Coverage Programs (IHCP) benefit plan before disenrolling. Members who are eligible for HIP coverage when their postpartum period ends will start out in HIP Basic Potential Plus and be given an opportunity to pay their first Personal Wellness and Responsibility (POWER) Account contribution and move to HIP Plus.

Member Eligibility Verification

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

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

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

Providers may also check enrollee eligibility through the Eligibility Verification System (EVS) Web Interchange, which is managed by the State's fiscal agent. ICES eligibility is updated in Web Interchange daily.

The EVS consists of interactive, real-time options:

- The Automated Voice Response (AVR) System,
- Web Interchange

After the user enters the provider identification number, applicable provider identification requirements, the member's name and date of birth or SSN, and the "from" and "through" dates of service, eligibility information is transmitted online. The eligibility information includes the current member ID (RID), and the name and telephone number of the member's PMP, along with the MCE's name, telephone number, network (if applicable), and network telephone number (if applicable). If the member is not linked to a PMP, the EVS indicates the PMP is not assigned.

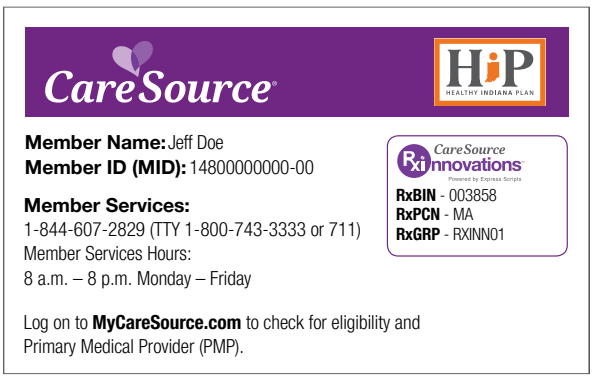
Member ID Cards

The member ID card is used to identify a CareSource member. However, having a member ID card does not guarantee eligibility or benefits coverage. Please verify member's eligibility prior to each service rendered.

You can use our secure Provider Portal or call Provider Services at **1-844-607-2831** and follow the prompt to check member eligibility.

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.

Healthy Indiana Plan


CareSource
HIP HEALTHY INDIANA PLAN

Member Name: Jeff Doe
Member ID (MID): 14800000000-00

Member Services:
1-844-607-2829 (TTY 1-800-743-3333 or 711)
Member Services Hours:
8 a.m. – 8 p.m. Monday – Friday

CareSource Rx Innovations
Powered by Express Scripts
RxBIN - 003858
RxPCN - MA
RxGRP - RXINN01

Log on to **MyCareSource.com** to check for eligibility and Primary Medical Provider (PMP).

EMERGENCIES:

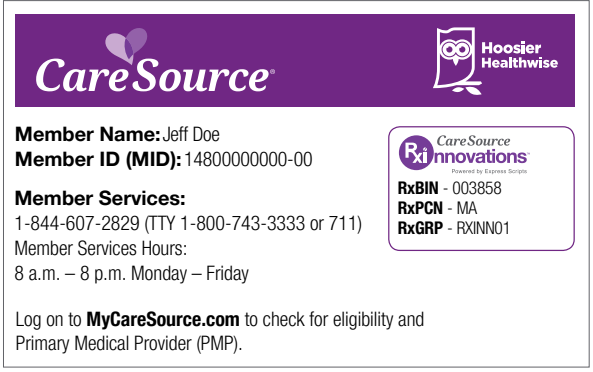
FOR EMERGENCIES CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM (ER)
For non-emergency visits to the ER, an $8 copay may apply. If your health event is not life-threatening and you are not sure about going to the ER, call the RNs at **CareSource24®, Nurse Advice Line for help** at 1-844-206-5947 (TTY: 1-800-743-3333 or 711).

BEHAVIORAL HEALTH CRISIS LINE: 1-833-227-3464
ESI PHARMACY HELP DESK: 1-800-416-3632
PROVIDER SERVICES: 1-844-607-2831

Other co-payments may apply. Review member handbook or contact Member Services for specific amounts.

IN-MED-M-908350

Hoosier Healthwise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IN-MED-M-908313

New Member Welcome Kits

Each household receives a new member kit, a welcome letter and an ID card for each person in the family who has joined CareSource.

New Member Kit Elements

- A Member Handbook, which explains plan services and benefits and how to access them
- A quick start guide for how to get started with CareSource
- Information on how to access or request a health assessment survey
- CareSource's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA)
- Other preventive health education materials and information, including how to select a PMP and how to complete an initial health screening

Please Note: Members will receive a Provider Directory only if they requested one at the time of enrollment or if they return a request postcard included in new member kits that indicates they would like a printed copy. The Provider Directory lists participating CareSource providers and facilities within a certain radius of the member's residence. As the contents of the printed directory are subject to change, we encourage members to call CareSource or the provider directly to confirm they are in network.

Members are referred to the Provider Directory, which lists providers and facilities participating with CareSource. A current list of providers can be found at any time on CareSource's website, **CareSource.com** > Members > Tools & Resources > Find a Doctor.

Medically Frail Members

Within the HIP-eligible population, a member's MCE identifies those members who may be medically frail and provides enhanced coverage for those individuals who meet the medically frail criteria. Federal regulations define the medically frail as individuals with one or more of the following:

- Disabling mental disorder
- Chronic substance abuse disorder
- Serious and complex medical condition
- Physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living
- Disability determination from the Social Security Administration (SSA)

HIP-eligible medically frail individuals will be enrolled in HIP State Plan Plus or HIP State Plan Basic and will receive coverage for comprehensive State Plan benefits equivalent to Package A benefits, including non-emergency transportation to medical appointments.

Like all HIP Plus eligible individuals, CareSource medically frail HIP members will be required to contribute to POWER Accounts. Members will be enrolled in HIP State Plan Plus if they make their monthly POWER Account contributions. Members who do not make their monthly contributions will be enrolled in HIP Basic, unless their income is over 100 percent of the FPL, in which case they will start paying copays but will not change benefit packages. CareSource cannot bill for past-due payments once the member had dropped from Plus or had benefits terminated, and CareSource cannot prevent a member from coming back into the plan if the member still has debt.

Individuals with one of the following will automatically be deemed medically frail:

- A disability determination from the SSA
- A verified impairment with an activity of daily living

CareSource applies claims data through Milliman medical underwriting guidelines (MUGs) to determine whether members qualify as medically frail. Individuals with a qualifying condition will be assessed by CareSource to verify that the condition is active and to determine how well the condition is controlled, as well as to identify any complicating comorbidities. Those members designated medically frail as a result of the Milliman MUGs tool and CareSource's assessment will be enrolled in the HIP State Plan Plus option.

Newborn Enrollment

The mother will have the choice up to 90 days from the baby's date of birth to make a one-time change. If no change is made, the baby will stay on the mother's health plan until the next year.

Member Disenrollment

Hoosier Healthwise or HIP members can be disenrolled from the IHCP Hoosier Healthwise and HIP programs.

Reasons for Member Disenrollment

Members may be disenrolled from HHW or HIP due to the following reasons:

- The member was enrolled in error or because of a data-entry error.
- The member loses eligibility in the IHCP.
- The member moves out of state.
- The member becomes eligible in another Medicaid aid category.
- The member passes away.
- The member voluntarily withdraws from the program.

HIP members may also be disenrolled due to the following reasons:

- The member was enrolled in error or because of a data entry error.
- The member loses eligibility in HIP because of the discovery of noncomplying third-party liability or gaining alternative health care coverage.
- The member loses eligibility for nonpayment of POWER Account.
- The member becomes eligible for another Medicaid aid category or Medicare.
- The member moves out of state.
- The member passes away.
- The member voluntarily withdraws from the program.
- The member fails to make his or her POWER Account contribution timely.

A HIP member may disenroll from an MCE while retaining eligibility in the HIP program. Circumstances where this occurs include the following:

- The member selects another MCE before making his or her initial contribution.
- The member selects another MCE at the beginning of a new coverage period.
- The member's MCE disenrolls from the HIP program.
- The member is granted a change request due to a just cause determined by the State.

Provider-Initiated Requests for Member Reassignment

The Hoosier Healthwise and HIP programs encourage positive and continuous relationships between members and PMPs. In rare instances, a PMP may request reassignment of a member to another PMP within CareSource. CareSource must approve and document these situations. The reasons for these situations include the following:

- Missed appointments (with appropriate documentation and criteria).
- Member fraud (upper-level review required).
- Uncooperative or disruptive behavior on the part of the member or member's family (upper-level review required).
- Medical needs that could be better met by a different PMP (upper-level review required).
- Breakdown in physician and patient relationship (upper-level review required).
- The member accesses care from providers other than the selected or assigned PMP (upper-level review required).
- Previously approved termination.
- Member insists on medically unnecessary medication.

CareSource's medical director or a committee appointed by the medical director performs an *upper-level review* – a thorough review of the individual case – to determine whether the cause and documentation are sufficient to approve a reassignment. The upper-level review includes monitoring to improve the overall quality of the program and to ensure that CareSource's guidelines and policies are consistent with those of the program.

The following, developed and finalized by the Hoosier Healthwise Quality Improvement Committee (QIC), provides guidelines for situations outlined previously:

- **Missed appointments** – A member may miss at least three scheduled appointments without defensible reasons before a PMP may request member reassignment. The PMP or staff is responsible for educating the member, on the first occurrence, about the problems and consequences associated with missed appointments. Hoosier Healthwise members are not penalized for an inability to leave work, for lack of transportation, or for other defensible reasons. Missed appointments must be documented in the member's chart that is accessible to the PMP and staff. On documentation of the third missed appointment for non-defensible reasons, CareSource may approve the PMP's request for the member's reassignment within CareSource. CareSource has procedures in place to assist members and PMPs with missed appointments and may intervene to resolve issues, while supporting the overall goals of the Hoosier Healthwise program.
- **Member fraud** – This reason for member reassignment must be restricted to cases referred to the Indiana Bureau of Investigation or the Office of the Inspector General (OIG).

- **Threatening, abusive or hostile actions by members** – The PMP can request a member's reassignment when the member or the member's family becomes threatening, abusive or hostile to the PMP or to the office staff after attempts at conflict resolution have failed. The request must be consistent with the PMP's office policies and with criteria used to request reassignment of commercial patients.
- **Member's medical needs may be better met by another PMP** – A PMP may request member reassignment because the PMP believes a member's medical needs would be better met by a different PMP. This request must be documented as to the severity of the condition and must be reviewed by the CareSource's medical director. CareSource's medical director must review the request based on the specific condition or severity of the condition as a PMP scope-of-practice matter, not based on a bias against an individual member.
- **Breakdown of physician and patient relationship** – CareSource must conduct an upper-level review, as defined previously, to ensure that the breakdown in the relationship between the PMP and the member is mutual.
- **Member accessing care from other than the selected or assigned PMP** – CareSource must conduct member education about the health plan and the PMP selection process. If the member does not initiate a PMP change and continues to access primary care services from a provider other than the PMP, the PMP may request the member's reassignment. Misuse of the emergency room is not a valid reason for requesting a member's reassignment.

Most of these situations can be resolved by facilitating the member's selection of another PMP within the health plan. Members who require services of providers not available within the health plan generally are not disenrolled but remain in CareSource, with CareSource managing and reimbursing for out-of-network services.

Unacceptable reasons for PMP-initiated member reassignment requests:

- **For good cause** – This term is used for member-initiated PMP change requests.
- **Noncompliance with mutually agreed-to treatment** – Members are not reassigned for being noncompliant or refusing treatment. A patient has the right to refuse treatment.
- **Demand for unnecessary care** – A PMP-initiated request for member reassignment is not approved for this reason unless there is documentation of threatening, abusive or hostile behavior, as described.
- **Language and cultural barriers** – PMPs who have difficulty with a member's language or other cultural barriers must request assistance from CareSource to address the problem.
- **Unpaid bills incurred before Hoosier Healthwise enrollment** – PMPs may not initiate member transfer requests because of unpaid medical bills incurred before Hoosier Healthwise enrollment. PMPs can pursue charges outstanding before Hoosier Healthwise enrollment through the normal collection process.

COVERED SERVICES AND EXCLUSIONS

Please visit **CareSource.com** for information on services, including dental services, the member's coverage status and other information about obtaining services for Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP). Please refer to our website and the "Referrals and Prior Authorizations" section on page 41 for more information about referral and prior authorization procedures.

For the most comprehensive and up-to-date list of CareSource Indiana's HHW covered benefits, please see the CareSource Covered Benefits grid at **CareSource.com** > Indiana > Plans > Medicaid > Benefits and Services > Hoosier Healthwise (HHW) Benefits & Services.

HHW Benefit Summary

Below is a list of common services under each HHW Package. Services provided by out-of-network health care providers need prior authorization.

Type of Service	Office Visits / Hospital		Prior Authorization Needed?
	Package A	Package C	
Doctor Visits	Yes	Yes	No
Checkups	Yes	Yes	No
Chiropractors	Yes	Yes	Yes, after initial benefit is met.
Family Planning Services	Yes	Yes	No
Clinic Services	Yes	Yes	No

Office Visits / Hospital			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Nurse Practitioner Services	Yes	Yes	No
Urgent Care Services	Yes. Urgent Care services are covered if they are medically necessary. Urgent care is needed for non-life-threatening emergencies that cannot wait for a normal scheduled office visit.	Yes. Urgent Care services are covered if they are medically necessary. Urgent care is care needed for non-life-threatening emergencies that cannot wait for a normal scheduled office visit.	No
Hospital Care (Non-Emergency)	Yes	Yes	Yes

Pharmacy and Medicine			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Preferred Drug List Drugs	Yes	$3 copay generic, compound and sole source drugs. $10 copay brand-name drugs.	Prior authorization is needed for some drugs that require step therapy, quantity, or medical necessity.

Emergencies, Tests and Transportation			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Emergency Services	Yes	Yes	No
Lab and X-ray Services	Yes	Yes	No
Emergency Transportation	Yes	$10 copay for ambulance transportation	No Prior authorization needed for airline or air ambulance (can get after services are rendered). Please see Indiana Health Coverage Programs (IHCP) rules for medical necessity, special circumstances and hospital-to-hospital transfers.

Dental Benefits			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Oral Exams and X-Rays	Yes	Yes	No
Dental Cleanings	Yes	Yes	No
Other Preventive Services	Yes	Yes	No
Minor Restorative Services (ex: Fillings)	Yes	Yes	Some services require a prior authorization.
Major Restorative Services (ex: Dentures)	Yes	Yes	Some services require a prior authorization.
Periodontal Services	Yes	Yes	Some services require a prior authorization.
Extractions and Oral Surgery	Yes	Yes	Yes
Orthodontics	Yes	Yes	Yes
If dental services are to be performed in hospital or ambulatory surgical center, a prior authorization is required.			

Special Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Anesthesia (including dental)	Yes	Yes	Yes
Nursing Facility Services (Long Term)	Transition of Care up to 60 days	No	N/A
Skilled Nursing Facility Services (Short Term)	Yes, less than 30 days	No	Yes
Hospice Care	No*	No	No
Nurse Midwife Services	Yes	Yes	No
Foot Care	Laboratory services, x ray services, hospital stays and surgical procedures involving the foot are covered when medically necessary. No more than six routine foot care visits per year are covered. Exceptions may apply.	Laboratory services, x ray services, hospital stays and surgical procedures involving the foot are covered when medically necessary. Routine foot care services are not covered. Exceptions may apply.	Yes

Special Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
CareSource Life Services® and CareSource JobConnect™, support programs for non-medical barriers	Yes	Yes	No
Home Health Services	Yes	Yes	Yes
Non-Emergency Transportation	Yes	No	No
DME/Orthotics/ Prosthetics	Yes	Yes	Yes
Stop Tobacco Use *Quit Now Indiana* ***1-800-784-8669***	Yes	Yes	No
Education/Training Services	Yes	Yes	No
***Members requiring long-term care may qualify for Hospice benefits under Traditional Medicaid. For more information, please call Member Services at 1-844-607-2829.**			

Mental Health and Addiction Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Assessments, Screenings, & Evaluations	Yes	Yes	No Assessments and screenings do not require prior authorization. Diagnostic evaluations prior authorization is needed after one per benefit year.
Counseling	Yes	Yes	Yes, prior authorization is needed after 20 sessions (individual, family and group) per provider per 12 month period.
Psychiatry	Yes	Yes	No
Intensive Outpatient Treatment (IOT)	Yes	Yes	Yes

Mental Health and Addiction Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Partial Hospitalization Program (PHP)	Yes	Yes	Yes
Medication Assisted Treatment (MAT)	Yes	Yes	Prior authorization is not needed for preferred drug. Yes, prior authorization is needed for non-preferred drug.
Withdrawal Management	Yes	Yes	Yes
Substance Use Disorder Residential Treatment	Yes	Yes	Yes
Inpatient Mental Health and Substance Use Disorder Treatment	Yes	Yes	Yes

Therapies/Habilitative Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Applied Behavioral Analysis (for Autism Spectrum Disorder)	Yes	Yes	Yes
Speech Therapy	Yes	Yes	Yes
Respiratory Therapy	Yes	Yes	Yes
Occupational Therapy	Yes	Yes	Yes
Physical Therapy	Yes	Yes	Yes

For the most comprehensive and up-to-date list of CareSource Indiana's HIP covered benefits, please see the CareSource Covered Benefits grid at **CareSource.com** > Indiana > Plans > Medicaid > Benefits and Services > Healthy Indiana Plan (HIP) Benefits & Services.

HIP Benefit Summary

Below is a list of common services under each HIP Package. Please call Member Services if you do not see the service you need. Services provided by out-of-network health care providers need prior authorization.

Office Visits/Hospital Visits	HIP Plus	HIP Basic *Copays may apply*	HIP Maternity	HIP State Plus	HIP State Basic *Copays may apply*	Prior Authorization Needed?
Doctor Visits	Yes	Yes	Yes	Yes	Yes	No
Checkups	Yes	Yes	Yes	Yes	Yes	No
Chiropractic Manipulation	Yes, Limit 6 per year	No	Yes, Limit 6 per year	Yes, Limit 6 per year	Yes, Limit 6 per year	No
Family Planning Services	Yes	Yes	Yes	Yes	Yes	No
Clinic Services	Yes	Yes	Yes	Yes	Yes	No
Nurse Practitioner Services	Yes	Yes	Yes	Yes	Yes	No
Hospital Care (Non-Emergency)	Yes	Yes	Yes	Yes	Yes	Inpatient: Yes Outpatient: Yes

Pharmacy and Medicine	HIP Plus	HIP Basic *Copays may apply*	HIP Maternity	HIP State Plus	HIP State Basic *Copays may apply*	Prior Authorization Needed?
Preferred Drug List (PDL) Drugs	Yes	Yes	Yes	Yes	Yes	Prior authorization needed for some drugs for step therapy, quantity, or medical necessity.

Emergencies, Tests, and Transportation						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Emergency Services	Yes. If the service is not for an emergency the copay will be $8.	Yes. If the service is not for an emergency the copay will be $8.	Yes	Yes If the service is not for an emergency the copay will be $8.	Yes If the service is not for an emergency the copay will be $8.	No
Lab and X-ray Services	Yes	Yes	Yes	Yes	Yes	No
Emergency Transportation	Yes	Yes	Yes	Yes	Yes	No Prior authorization needed for airline or air ambulance (can get after services are rendered). Please see Indiana Health Coverage Programs (IHCP) rules for medical necessity, special circumstances and hospital-to-hospital transfers.

Mental Health and Addiction Services Treatment						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Assessments, Screenings, & Evaluations	Yes	Yes	Yes	Yes	Yes	No Diagnostic evaluations prior authorization is needed after one per benefit year.
Counseling	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization is needed after 20 sessions (individual, family and group) per provider per 12 month period.
Psychiatry	Yes	Yes	Yes	Yes	Yes	No
Intensive Outpatient Treatment (IOT)	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization needed for all visits.
Partial Hospitalization Program (PHP)	Yes	Yes	Yes	Yes	Yes	Yes
Medication Assisted Treatment (MAT)	Yes	Yes	Yes	Yes	Yes	No. Prior authorization is not needed for preferred drug. Yes. Prior authorization is needed for non-preferred drug.
Withdrawal Management	Yes	Yes	Yes	Yes	Yes	Yes
Substance Use Disorder Residential Treatment	Yes	Yes	Yes	Yes	Yes	Yes
Inpatient Mental Health and Substance Use Disorder Treatment	Yes	Yes	Yes	Yes	Yes	Yes

Dental Benefits						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Oral Exams and X-Rays	Yes	No. HIP Basic members age 19-20 are eligible for (EPSDT) services and some limited enhanced preventive and diagnostic dental services.	Yes	Yes	Yes	No
Dental Cleanings	Yes		Yes	Yes	Yes	No
Other Preventive Services	Yes		Yes	Yes	Yes	No
Minor Restorative Services (ex: Fillings)	Yes		Yes	Yes	Yes	Some services require a prior authorization.
Major Restorative Services (ex: Dentures)	Yes		Yes	Yes	Yes	Some services require a prior authorization.
Periodontal Services	Yes		Yes	Yes	Yes	Some services require a prior authorization.
Extractions and Oral Surgery	Yes		Yes	Yes	Yes	Yes
If dental services are to be performed in hospital or ambulatory surgical center, a prior authorization is required.						

Specialty Services						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Foot Care	Only if deemed medically necessary	Only if deemed medically necessary	Yes, 6 visits per year	Yes, 6 visits per year	Yes, 6 visits per year	No
Vision Care	Yes. One routine exam per 12-month period for members under 21 years of age. One pair of eyeglasses per 12-month period for members under 21 years of age.	No. Vision benefit available only for members under 21 years of age.	Yes. One routine exam every 2 years for members 21 years of age and older. One pair of eyeglasses every 5 years for members 21 years of age or older.			No
Skilled Nursing Facility Services	Yes, 100-day limit per benefit period	Yes, 100-day limit per benefit period	Yes, 100-day limit per benefit period	Yes, 100-day limit per benefit period	Yes, 100-day limit per benefit period	Yes
DME/Orthotics/ Prosthetics	Yes	Yes	Yes	Yes	Yes	Yes
Home Health Services	Yes, 100 Visits	Yes, 100 Visits	Yes, 100 Visits	Yes, 100 Visits	Yes, 100 Visits	Yes
Hospice Care	Yes	Yes	Yes	Yes	Yes	Yes
Medical Supplies and Equipment (e.g. hearing aids, prosthetic devices, etc.)	Yes	Yes	Yes	Yes	Yes	Yes
Education and Training Services	Yes	Yes	Yes	Yes	Yes	No

Specialty Services	HIP Plus	HIP Basic *Copays may apply*	HIP Maternity	HIP State Plus	HIP State Basic *Copays may apply*	Prior Authorization Needed?
Non-Emergency Transportation	Yes *Added CareSource Benefit CareSource Benefit	Yes *Added CareSource Benefit CareSource Benefit	Yes *Added CareSource Benefit CareSource Benefit	Yes	Yes	No

Therapies/Habilitative Services 60 (Basic Plan)/75 (Plus Plan) combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac and pulmonary rehabilitation	HIP Plus	HIP Basic *Copays may apply*	HIP Maternity	HIP State Plus	HIP State Basic *Copays may apply*	Prior Authorization Needed?
Rehabilitation Services	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization needed for some visits.
Speech Therapy	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization needed for some visits.
Occupational Therapy	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization needed for some visits.
Physical Therapy	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization needed for some visits.

Opioid Treatment Program (OTP) Coverage

CareSource provides coverage for the daily Opioid Treatment Program (OTP). A daily opioid treatment program includes administration and coverage of methadone, routine drug testing, group therapy, individual therapy, pharmacological management, HIV testing, Hepatitis A, B, and C testing, pregnancy tests, Tuberculosis testing, Syphilis testing, follow-up examinations, case management and one evaluation and management office visit every 90 days for the management of patient activities identified in the individualized treatment plan that assist in patient goal attainment, including referrals to other service providers and linking patients to recovery support groups.

Providers rendering OTP treatment must be enrolled with Indiana Health Coverage Programs (IHCP) with the provider specialty of OTP as defined in the IHCP Provider Enrollment Type and Specialty Matrix.

Eligible members include:

- Members 18 years and older who have become addicted at least one year prior to admission and are placed in the Opioid Treatment Services (OTS) Level of Care according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.
- Members under 18 years of age and have had two documented unsuccessful attempts at short-term withdrawal management or drug free treatment within a 12-month period.
- All members released from penal institution (within six months of release).
- Pregnant members.
- Previously treated members (up to two years after discharge).

Prior authorization is not required for OTP services. Providers must maintain documentation demonstrating medical necessity and that the coverage criteria are met, as well as the individual's length of treatment, in the member's records.

Residential Substance Use Disorder (SUD) Services

CareSource providers coverage for short-term low-intensity and high-intensity residential treatment for opioid use disorder (OUD) and other substance use disorder (SUD) in settings of all sizes, including facilities that qualify as institutes of mental disease (IMDs).

Prior authorization (PA) is required for all residential SUD stays. When residential services are determined medically necessary for a member, the Contractor will approve a minimum of 14 days for residential treatment, unless the facility requests fewer than 14 days. If a facility determines that a member requires more time than the initial 14 days, the facility should submit a PA update request showing that the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria:

- ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services
- ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

Facilities need to include all necessary documentation to demonstrate medical necessity for the SUD level of care being requested. This documentation should include diagnoses, clinical presentation, treatment history, treatment goals, prescriber contact following admission and weekly thereafter, and other relevant information to provide a complete picture of an individual's needs. Providers should incorporate documentation supporting the ASAM six dimensions of multidimensional assessment. When submitting an initial PA request, it is helpful to include documentation of the psychosocial assessment.

Facilities must be appropriately enrolled with Indiana Health Coverage Programs (IHCP) as an SUD Residential Additional Treatment Facility in addition to being certified by the Division of Mental Health and Addiction (DMHA). Residential substance use disorder treatment facilities are not eligible for hospital assessment fee (HAF) adjustments. The service must be billed appropriately on a CMS-1500/professional claim and codes must match the authorization in order to be eligible for reimbursement.

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 that the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Provider Services at **1-844-607-2831**.

Covered services may require prior authorization. Please visit **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization for the most up-to-date list of services that require prior authorization. Prior authorization requirements for members enrolled with CareSource are determined and enforced by CareSource.

Medical Necessity Standards and Practice Guidelines

"Medically reasonable and necessary service" is a covered service that is required for the care or well-being of the member and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable, it must:

- Be medically reasonable and necessary, as determined by CareSource, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
- Not be listed as a non-covered service, or otherwise excluded from coverage.

Some services require prior authorization. CareSource reviews all service requests for Medicaid members under the age of 21 (through the month of the member's 21st birthday) for medical necessity. If a request for authorization is submitted, CareSource will notify the provider and member in writing of the determination. Authorizations can also be requested retroactively in emergencies. For more information about our authorization procedures, see the "Referrals and Prior Authorizations" section on page 41 of this manual.

If a service cannot be covered, providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Grievances and Appeals" section on page 116 for information on how to file an appeal.

Covered Services Excluded from Hoosier Healthwise and HIP

Broad categories of service, covered by the Indiana Health Coverage Programs (IHCP) but excluded from managed care, are payable as fee-for-service (FFS) claims by the State fiscal agent. If a CareSource member becomes eligible for any of these services, the member is disenrolled from Hoosier Healthwise managed care. Excluded services include the following:

- **Long-term institutional care:** Package A members and HIP members requiring long-term care in a nursing facility or intermediate care facility (ICF) for members with intellectual and developmental disabilities must be disenrolled from the Hoosier Healthwise or HIP programs and converted to fee-for-service eligibility in the IHCP. Before the nursing facility can be reimbursed by the IHCP for the care provided, the nursing facility must request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State must then approve the PASRR request, designate the appropriate level of care in CoreMMIS, and disenroll the member from Hoosier Healthwise or HIP.

CareSource coordinates care for its members who are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR. CareSource is responsible for payment for up to 60 calendar days for its members placed in long-term care facilities while the level of care determinations are pending. However, CareSource may obtain services for its members in a nursing-facility setting on a short-term basis, such as for fewer than 30 calendar days. This may occur if this setting is more cost-effective than other options, and the member can obtain the care and services needed in the nursing facility. CareSource may negotiate rates for reimbursing the nursing facilities for these short-term stays. Providers are encouraged to immediately contact CareSource for case management and to arrange care for a member needing services outside of their covered benefits.

- **Hospice care:** Hoosier Healthwise members must be disenrolled from managed care in order to receive hospice care. HIP members do not need to be disenrolled from managed care in order to receive hospice care.
- **Home and community-based waiver services:** Home and community-based waiver services are also excluded from the Hoosier Healthwise and HIP programs. Similar to the situations described previously, members who have been approved for these waiver services must be disenrolled from managed care, and CareSource will coordinate care for its members who are transitioning into a HCBS waiver program until the disenrollment from Hoosier Healthwise or HIP is effective.
- **Psychiatric treatment in a State hospital:** Hoosier Healthwise members receiving psychiatric treatment in a State hospital are disenrolled from Hoosier Healthwise. HIP members receiving psychiatric treatment in a State hospital are not disenrolled from HIP, but must be directed to an alternative inpatient facility.
- **Psychiatric Residential Treatment Facility (PRTF) Services:** Members receiving treatment in a PRTF are not CareSource's responsibility and will be disenrolled from Hoosier Healthwise. When the prior authorization vendor enters a PRTF level of care for a Hoosier Healthwise member, the managed care assignment is automatically end-dated as of the date the PRTF level of care is entered in CoreMMIS. Once the member is discharged from the PRTF and the LOC is end-dated, the auto-assignment process immediately reassigns the member to his or her previous managed care entity (MCE) with an effective date of the 15th of the month for discharges occurring on day one through day 14 of the month; or effective the first day of the following month for discharges that occur on day 15 through the last day of the month.

CareSource members who qualify for long-term institutional care, hospice care or waiver services are disenrolled from their Hoosier Healthwise managed care plans. CareSource must note that it is possible for a member's IPAS/PASRR process to be under way (but not complete) when the member is linked to an MCE. In this situation, the financial responsibility lies with CareSource for no more than 60 days. Case management at CareSource will facilitate coverage and treatment for the member until the change is made to ensure continuity of coverage.

Emergency Room Copayments for Healthy Indiana Plan

A copayment applies when a HIP member uses the emergency room (ER) for a non-emergency, as specifically described in 405 IAC 9-7-9. For all individuals who call their PMP or CareSource24®, the 24-hour nurse hotline, and are referred to the ED, the copay will be waived. This copayment will be assessed at $8 for the member's inappropriate service. Providers will collect the copayment from the member at the time of service, and POWER Account funds cannot be used by the member to pay the non-emergency copayment. CareSource includes the member's copayment information on the member's ID card.

The copayment must be waived or returned if the member is found to have an emergency condition, as defined in section 1867(e)(1)(A) of the Emergency Medical Treatment and Active Labor Act (EMTALA), if the person is admitted to the hospital on the same day as the visit, or the member is diagnosed with a condition found on the ER Auto-Pay List. According to 405 IAC 9-2-12: "Emergency medical condition" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- Place an individual's health in serious jeopardy;
- Result in serious:
  - Impairment to the individual's bodily functions; or
  - Dysfunction of a bodily organ or part of the individual.

CareSource has two options in refunding the member's copayment:

- Provide the copayment refund to the member.
- Apply the copayment refund to the member's POWER Account.

The member must receive an appropriate medical screening examination under section 1867 of the EMTALA.

Assuming a member has an available and accessible alternate non-emergency services provider, and it has been determined that the individual does not have an emergency medical condition and did not receive a waiver from CareSource24, in accordance with 42 C.F.R. § 447.54(d), the hospital shall inform the member before providing non-emergency services that:

- The hospital may require payment of the copayment before the service is provided.
- The hospital can provide the name and location of an alternate non-emergency services provider that is available and accessible.
- An alternate provider can provide the services without a copayment.
- The hospital can provide a referral to coordinate scheduling this treatment.
- The member cannot use their POWER Account to pay emergency room copayments.

Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. Those services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require the use of the most accessible hospital available and equipped to furnish those services.

Urgent care services are covered when medical care is necessary for a condition that is not life threatening, but that requires treatment that cannot wait for routine care by a regularly scheduled clinical appointment. This would be in the case that the condition would worsen without timely medical intervention.

Abortion and Sterilization

CareSource covers abortions, hysterectomy, and sterilizations in very limited circumstances. Please review the information below for specific information.

Abortion

The IHCP uses the word abortion to describe the early termination of pregnancy. The IHCP does not consider termination of an ectopic pregnancy to be an abortion. Abortions and abortifacients are not covered services except as allowable under the federal Hyde Amendment. Abortions are covered only if the pregnancy is the result of an act of rape or incest or a case where a woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the individual in danger of death unless an abortion is performed and in compliance with 42 CFR 441.202.

For spontaneous abortions, the IHCP requires no documentation from providers billing with the appropriate treatment code For elective abortions, the physician must specify in writing the physical condition of the patient leading to the professional judgment that the abortion was one of the following:

- Necessary to preserve the life of the pregnant woman
- Due to rape or incest

The documentation must contain the name and address of the member, dates of service, physician's name, and physician's signature. Providers must attach this documentation to the paper claim form, or send it separately as an attachment to the electronic claim transaction.

Sterilization

Sterilization procedures are covered if the following requirements are met:

- The member is at least 21 years of age at the time of the informed consent.
- The member is mentally competent and not institutionalized in a correctional facility, mental hospital, or other rehabilitative facility.
- Sterilization is the result of a voluntary request for services by a member legally capable of consenting to such a procedure.
- For a female member, a hysterectomy is only rendered for medical necessity and not for the purpose of family planning, sterilization, hygiene, or mental retardation; the individual must be informed prior to the hysterectomy that she will be permanently incapable of reproducing.
- The member is given a thorough explanation of the procedure. In instances where the individual is blind, deaf, or otherwise handicapped or unable to understand the language of the consent, an interpreter must be provided for interpretation.
- Informed consent is obtained on the Consent to Sterilization Form [HHS-687 (5/2010)], which is located on our website, with legible signature(s) and submitted to our health plan with the claim.
- Informed consent is not obtained while the individual to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness.

- The procedure is scheduled at least 30 calendar days before, but not more than 180 calendar days, after the consent is signed, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form).

These requirements are applicable to all sterilizations when the primary intent of the sterilizing procedure is fertility control.

Immunizations

All members less than 21 years of age shall be provided with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

CareSource pays for the administration of the vaccine only when billed with an appropriate immunization and administration CPT code. Immunizations, flu vaccines and pneumococcal vaccines can be obtained at the retail pharmacy for those members ages 19 and older.

Please see the “Member Support Services and Benefits” section on page 83 for more details on immunizations. CareSource will not reimburse costs for vaccines obtained outside the Vaccines for Children (VFC) program when provided to children under age 19.

Annual Wellness Exams for Adults

All adults are eligible to receive a wellness exam from a PMP at the earliest opportunity upon enrollment with CareSource. Members may receive an annual wellness exam consisting of the following:

- Routine physical exam by the PMP or OB/GYN.
- Screening which consists of the following, as appropriate:
  - Abdominal aortic aneurysm ultrasound (AAA)
  - Alcohol misuse
  - Blood pressure for adults
  - Bone mass measurements
  - Cardiovascular disease
  - Cholesterol for adults
  - Depression for adults
  - Diabetes
  - Hepatitis B
  - Human immunodeficiency virus (HIV)
  - Obesity
  - Colorectal
  - Electrocardiogram (ECG or EKG)
  - Lung
  - Mammogram
  - Pap smear
  - Prostate
  - Sexually transmitted infections (STIs)
  - Tobacco/smoking
  - Vision exam for members age 21 and over

Please visit the Provider Portal on our website for up-to-date clinical and preventive care guidelines.

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 Member Services

Representatives are available by telephone Monday through Friday, except on certain holidays. Please check the website for holiday hours.

Members access Member Services by calling our toll-free number at **1-844-607-2829**, 8 a.m. to 8 p.m. Eastern Time (ET), and telling our interactive voice response system (IVR) what their question is regarding.

CareSource24® Nurse Advice Line

For Physical and Behavioral Health Services

Members can call our nurse advice 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 medical provider (PMP) by explaining the importance of their role in coordinating the member's care. For improved care coordination with PMPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse gave.

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 PMP-member relationship

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

988 Suicide & Crisis Lifeline

988 Suicide & Crisis Lifeline will offer a direct connection to compassionate, accessible care and support for anyone experiencing mental health-related distress – whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress.

Care Management/Outreach

CareSource provides the services of care management medical and behavioral health nurses, social workers, and community health workers to provide one-on-one, personal interaction with patients. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team. Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging treatment adherence, reinforcing medical instructions, and assessing social and safety needs, as well as educating pregnant women on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many conditions.

Direct Access for Medicaid

"Direct Access" for Care Management referrals and assistance with member needs is available at **1-844-607-2831**. Providers can also make electronic care management referrals on the Provider Portal.

Population Health and Care Management Services

At CareSource, we believe it is vital to deliver targeted and integrated care coordination services that are member-centric, collaborative, and supported by evidence-based care to facilitate improved member outcomes, enhanced member satisfaction and optimal resource utilization.

The focus of the CareSource Integrated Care Management (ICM) program is to provide a dynamic, community based, member-centric model of service delivery. The model, designed as a population health management approach with care coordination for members, is implemented by regional, multi-disciplinary teams responsible for a defined population and sub-populations within a region.

As a population health management model, the ultimate goals are to:

- Improve the member experience of care (including clinical quality and satisfaction);
- Improve the health of populations;
- Advancing health equity;
- Improved Clinician Experience; and
- Reduce the per capita cost of health care.

The program is designed to support the care and treatment you provide and recommend to your patient. We stress the importance of establishment of the medical home, identification of barriers and keeping appointments, and we can assist in arranging transportation to the provider's office. This one-on-one personal interaction with community health workers and licensed, professional case managers helps provide 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 needed community resources, such as assistance with housing and food.

CareSource encourages you to take an active role in your patient's care management program through the Patient Profile feature on the Provider Portal. This profile provides member-specific information on pharmacy, inpatient and Emergency Department (ED) utilization, scheduled, or planned services. This information provides you with critical information necessary to make informed decisions pertaining to your patient. In addition, we invite and encourage you to direct and provide input into patient assessment activity and participate in the development and monitoring of a care plan individualized to the needs of your patient. We believe communication, coordination, and collaboration are integral to ensure the best care for your patients.

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

- High risk pregnancy and complex newborns
- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Chronic kidney disease
- Hypertension
- Depression
- Members with special health care needs
- Members with serious and persistent mental illness (SPMI)
- Attention-deficit/hyperactivity disorder (ADHD)
- Autism spectrum disorders
- HIV
- Hepatitis C
- Sickle Cell Disease
- Substance Use Disorder (SUD)

Care Management of High-Risk Members

CareSource applies a particular community-based management model for our high-risk members. Utilizing nurses, behavioral health professionals and community health workers, this multi-disciplinary approach integrates the Case Management Society of America (CMSA) Standards of Practice into key processes to help ensure implementation of a best-practice program. Community health workers help patients overcome health care access barriers and strengthen our provider and community resource partnerships through collaboration.

Our services include face-to-face meetings with our most at-risk members. Ideally, these are conducted at the point of care to ensure development of a treatment plan that is comprehensive and collaborative. Typical high-risk members served by this model may have multiple medical issues, socioeconomic challenges, and behavioral health care needs. Care coordination efforts may include:

- Care transition planning
- Identifying gaps in care and collaborating with the care team to close gaps
- Facilitating member access to appropriate care and services
- Providing referrals to appropriate medical, behavioral, social, and community resources to address identified member needs
- Coordinating planned interventions, driven by a care coordination plan, consistent with evidence-based clinical guidelines

CareSource encourages you to take an active role in your patients' care management programs and participate in assessment activities and development of individualized care plans to help meet their needs. A new level of Care Management for complex members is Complex Provider Focus, in which CareSource will work with providers specifically for members that are unable to activity actively participate in the development of their individualized care plan (ICP). Our care management staff will call you to coordinate and develop the ICP that addresses the member's current needs. Together, we can make a difference.

Transitions of Care (TOC) Planning

When care transitions occur, CareSource identifies members who require assistance as they transition from an inpatient stay. Our team works with members and their families to coordinate care needs and make the transition to home or a lower level of care as successful as possible.

Our Transitions of Care (TOC) program has focused outreach and discharge planning activities based on the Coleman Model, utilizing a team approach to coordinate post-discharge care needs for members at risk for readmission. Through these efforts, we strive to empower and educate members to help ensure all components of the member's discharge plan are in place.

When an at-risk member is discharged from an inpatient stay, our TOC team reaches out to ensure the member has a clear path to recovery, free from barriers to care. We can coordinate home care and medical equipment needs, assist with obtaining prescribed medications and coordinate other medical care and services as needed.

We believe in the importance of partnership. That is why we collaborate with PMPs to provide our members with the services they need along the continuum of care.

Perinatal and Neonatal Care Management

CareSource's perinatal and neonatal care management program utilizes a multi-disciplinary team with extensive obstetrics and neonatal intensive care unit (OB/NICU) clinical experience. Specialized nurses are available to help manage high-risk pregnancies and medically complex newborns by working in conjunction with providers and members. The expertise offered by the staff includes a focus on patient education and care coordination and involves direct telephone contact with members and providers. All pregnant members receive educational packets throughout their pregnancy and in the immediate postpartum period. Pregnant members in care management will receive one-to-one perinatal education throughout her pregnancy.

Babies First® Program

Babies First is a free program offered to pregnant members and parents or guardians of babies less than 15 months of age. Through this program, members can earn up to $200 on a My CareSource Rewards® card. The program focuses on encouraging pregnant members to visit their doctor for prenatal care early in their pregnancies, and then as often as their doctor recommends, including a postpartum visit. Additionally, the program encourages well-baby visits as recommended to help ensure mom and baby will be as healthy as possible. Through this program, members can earn rewards and incentives for completing specific activities related to prenatal, postpartum, and well-baby care.

Upon completion and verification, the member will be able to purchase items (baby car seat, healthy items, baby toys, etc.) from a selection of merchants, such as Walmart, Dollar General and more. The rewards card blocks the purchase of items such as alcohol and/or tobacco, and cannot be converted to cash.

Members can enroll in Babies First by completing the form at **CareSource.com** > Benefits and Services > Additional Services > Rewards > Babies First or call Member Services at **1-844-607-2829**. Members must re-enroll in the program with each pregnancy.

Notification of Pregnancy

We encourage our prenatal care providers to notify our Care Management department at **1-844-607-2831** when a member with a high-risk pregnancy has been identified. Prenatal care providers are encouraged to electronically complete the Notification of Pregnancy (NOP) risk assessment. The submitted information will be used by CareSource to determine the member's health risk during her pregnancy and the level of care coordination needed. Prenatal care providers that electronically complete the NOP in adherence to IHCP guidelines through the Core MMIS may be eligible for a $60 incentive payment. To receive the incentive payment, the woman's pregnancy must be less than 30 weeks gestation at the time of the office visit on which the NOP is based, and the NOP must be submitted within five calendar days from the date of service. Providers must bill for the NOP incentive payment using Current Procedural Terminology (CPT®1) code G9997 with modifier TH. The date of service (DOS) on the NOP claim should be the date of the office visit on which the information on the NOP is based. CareSource will disburse an additional $10 to the provider if the NOP is completed within the first trimester of the member's pregnancy. No additional action is required by the provider to receive this incentive.

Disease Management Program

Our free Disease Management Program helps our members find a path to better health through information, resources, and support.

We help our members through:

- The MyHealth online program for members 18+ to participate in a journey to improve their health
- Newsletters with helpful tips and information to manage their disease, promote self-management skills, and provide additional resources.
- Coordination with outreach teams such as wellness advocates and health coaches
- One-to-one care management (if they qualify)

Members with specific disease conditions such as attention deficit hyperactivity disorder (ADHD), asthma, autism spectrum disorders, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, depression, diabetes, hepatitis C, human immunodeficiency virus (HIV), and hypertension are identified by criteria or triggers such as emergency room visits, hospital admissions, and the health assessment. All ages (children, teens, and adults) are eligible. These members are automatically mailed quarterly condition-specific newsletters. The materials are available in English and Spanish. Any member may self-refer or be referred into the disease management program to receive condition-specific information or outreach. If a member does not wish to receive newsletters or outreach, they can call **1-844-438-9498**.

Benefits to Members and Providers

Members identified in the Disease Management Program receive help finding the appropriate level of care for their condition, and they are encouraged to actively participate in the patient-provider relationship. The program improves the percentage of CareSource members who receive their recommended screenings.

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

Emergency Department Diversion

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

We instruct members to call their PMP or the CareSource24 Nurse Advice Line if they are unsure if they need to go to an ED. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access.

Member ED utilization is tracked closely. If there is frequent ED utilization, members are referred to our Care Management department for analysis or intervention. Members are contacted via phone or mail. 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.

Tobacco Cessation Program

CareSource would like to remind providers of resources available for tobacco cessation and wants to help members maintain a healthy lifestyle. This includes not using tobacco products as well as prevention. The tobacco cessation program includes:

- Referrals and member participation in the Indiana Tobacco Quitline.
- Promoting the availability of behavioral counseling.
- Informing member on how to obtain prescribed medications from their providers for assistance with quitting. There are no coverage limits for pharmacotherapy for HHW and HIP members.
- Also, CareSource does not limit tobacco dependence counseling.
- Up to $200 member incentive rewards annually for participating in tobacco cessation activities.
- Links to resources to assist members are available for providers at: **CareSource.com** > Provider Overview > Tools and Resources > Quick Reference Materials.

CareSource offers providers enhanced reimbursement when rendering tobacco dependence counseling to members identified as using tobacco or tobacco related products. As a reminder, providers may prescribe one or more treatment modalities. Any combination of treatment must include counseling.

Interpreter Services

Non-Hospital Providers

CareSource offers sign and other language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. 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 or provider. As a provider, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. Providers who have 24-hour access to health care-related services in their service area or via telephone must provide members with 24-hour language interpreter services, either through in-person or telephone interpreter services. To arrange services, please contact our Provider Services department at **1-844-607-2831**. To request a sign language interpreter, five business days' notice is needed before the scheduled appointment while any other language interpreter services require four business days' notice before the scheduled appointment. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

Hospital Providers

CareSource requires hospitals, at their own expense, to offer sign and other language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. 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. 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. If you do not have access to interpreter services, contact Provider Services at **1-844-607-2831**. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

School-Based Clinics Providing Care

CareSource is committed to helping providers manage the complex needs of our members who receive Indiana Health Coverage Program (IHCP)-covered services as part of an individualized education plan (IEP). All claims for services provided to Hoosier Healthwise members as part of an IEP that are billed by provider specialty 120-school corporation should be submitted as a fee-for-service claim to the State of Indiana.

CareSource is also committed to supporting care coordination efforts between school-based clinics and our members' PMPs. CareSource will coordinate health care services with schools to ensure continuity of care and avoid duplication of services for clients with individualized education plan (IEP) services. We will work collaboratively with the school-based clinic or in partnership with the school nurse, to ensure that the member can access needed services. We will participate in the planning and the evaluation of services as appropriate and necessary. CareSource has a strong history of working with schools and school-based providers, and we will use this experience to assure proper coordination of services for our members with an IEP as well.

We ask school-based clinics to complete the risk assessment form found on the Provider Portal to communicate critical information to us about our members. In turn, participating providers receive payment for submission of each risk assessment form. Payment is made according to the HHW fee schedule and your provider agreement with CareSource.

Guidelines When Submitting Risk Assessment Forms to CareSource:

- You must use the designated form found on the CareSource Provider Portal.
- We must receive the forms, filled out completely, no later than five business days after the member's clinic visit. Please be sure to include services covered under the child's IEP.
- Any change to the status of our member should be reported using designated form to denote these changes.
- There is no member limit to the number of assessments forms that may be completed.
- Please use code H1000 on the associated claim to indicate that an assessment form was submitted. This will help ensure that you are reimbursed appropriately.
- Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance;
- Oral health screening, preventive counseling and referral to a dentist for ongoing dental care;
- Screening for and if suspected, reporting of child abuse and neglect;
- Anticipatory guidance (health education); and
- Referrals/follow-ups where appropriate based on history and exam findings.

Kids First Program

Kids First is a free program offered to members ages 16 months to 18 years. Through this program, members can earn up to $50 per year on a MyCareSource Rewards™ card. The program focuses on encouraging children and teenagers to get regular well-child visits, dental exams, and age-appropriate vaccinations.

Upon completion and verification, the member will be able to purchase items such as toys, books, food, health and wellness items and more from a selection of merchants, such as Walmart, Dollar General, and more. The rewards card blocks the purchase of items such as alcohol and/or tobacco, and cannot be converted to cash.

Members can enroll in Kids First by completing the form at **CareSource.com** > Benefits and Services > Additional Services > Rewards or call Member Services at **1-844-607-2829**.

Immunizations

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during 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). The recommended schedule is included in this section of the manual. This schedule is updated annually and the most current updates are located on www.aap.org.

Vaccines for Children Program

The federal Vaccines for Children (VFC) program makes designated vaccines available at no cost to VFC participating health care providers to administer to children under the age of 19 who are eligible for Medicaid, uninsured, underinsured, or American Indian/Alaskan native.

CareSource encourages providers to participate with the VFC program. Vaccines administered to children under the age of 19 must be obtained through the VFC program, which supplies vaccines to program participating providers at no cost. CareSource will not reimburse costs for vaccines obtained outside the VFC program. CareSource will pay for the administration of the vaccine only.

Immunization Codes

Please bill CareSource with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. For a list of VFC–available vaccines, see the *Injections, Vaccines, and Other Physician-Administered Drug Codes* on the *Code Sets* page at www.in.gov/medicaid. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

Statewide Web-Based Immunization Registry

Participating providers must report all immunizations to the statewide web-based immunization registry called Children and Hoosier Immunization Registry Program (CHIRP), found at chirp.in.gov.

The Children and Hoosiers Immunization Registry Program (CHIRP) is a secure web-based application that is administered by the Indiana State Department of Health. Providers can use the registry to both review vaccination records for their patients and to record all newly administered vaccinations. The State of Indiana mandates use of the registry for certain providers.

Medicaid Transportation

Members in all of our HIP and HHW Package A programs have ride benefits, including an option for mileage reimbursement. All HIP and HHW Package A members can access an unlimited number of non-emergency rides for covered* health care visits throughout the year, without the need for prior authorizations. Additionally, HIP and HHW Package A members have access to non-emergency transportation with respect to the following:

- Unlimited rides to the pharmacy after their visit with the doctor and five additional trips to the pharmacy per month when they have not just visited with their doctor
- Unlimited rides to the local Women, Infants and Children (WIC) office
- Unlimited rides to Medicaid Enrollment events
- Unlimited rides to CareSource events
- Must be enrolled in CareSource Life Services Program which provides 12 round trips a year
- Rides to pick up food from the food pantry or curb-side food pick up from a grocery store (five round trips/month)

HHW Package C members are only eligible for non-emergency ambulance transport between medical facilities when requested by a participating physician with a $10 copay.

*E.g., HIP Basic members that do not receive dental, vision or chiropractic coverage are not eligible for rides to those appointments.

Members are directed to please call **1-844-607-2829 (TTY: 1-800-743-3333 or 711)** for a ride at least two business days before their visit. Our ride benefit is provided through a transportation vendor. They also support the mileage reimbursement option. Members can call us if they have a ride concern or issue. Members are directed to please call 911 or go directly to the nearest ED if they have an emergency.

Transportation Policy

Please look carefully at the list below to understand member responsibilities. These rules will help make rides safer and quicker.

Rides should be easy and enjoyable. Drivers are trained to treat riders with respect and to think of their needs. Members are expected to treat the driver in the way they wish to be treated. Members are asked to follow these steps:

- Call to arrange non-emergency ride two business days in advance. (Saturday, Sunday, and holidays are not business days).
- Be able to provide the complete address, phone number, and who they will be seeing at the doctor's office.
- Be at the pick-up address. Be there at the earliest time given to the member by the transportation service.
- To cancel their ride, they should call at least two hours before their pick-up time.
- When their visit is finished, they should call the transportation company for their return trip.

No Show

Members need to be ready for their pickup. They should be there at the beginning of their pick-up time. The transportation company can only wait 10 minutes before a member will be marked as a no show. If a member cannot keep their appointment, they must call the transportation company as soon as possible.

What is a *No Show*?

- A member is not at the pick-up location
- A member cannot be seen at the pick-up location
- A member is not on-time at the pick-up location

The driver will wait 10 minutes, then will leave. If members have any questions, they are asked to call Member Services.

Telehealth

Telehealth technology makes health care more accessible, cost-effective, and can increase patient engagement. CareSource wants to support your telehealth program by covering select telehealth services you provide to our members. If you do not have a telehealth program or if you need help servicing your patients during busy times, CareSource has partnered with Teladoc® to offer the convenience of telehealth to our Indiana Medicaid members. General medical services are available to all Indiana Medicaid members, and mental health services are available for members 18 years and older.

How Providers Access Services

1. Providers will notify their CareSource Market Health Partner that they would like to offer telehealth services via Teladoc's Core Platform.
2. CareSource will use basic provider information to update a roster file with necessary data that will be shared with Teladoc.
3. Once the required provider information is populated on the roster, the roster file will be sent to Teladoc.
4. The roster file will be ingested by Teladoc, who will then set up the requested provider account.
5. Teladoc's training team will send training details to the provider via email with information on how to access and utilize the platform.
6. Once the provider has completed the required trainings, Teladoc will then send the provider their unique log in credentials and enable access to the Core Platform.
7. Provider will log-in using the credentials sent by Teladoc (*user will be required to change the password at first log-in).
8. Provider will then have access to the Teladoc Core Platform to begin completing scheduled telehealth consultations.

Health Education

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

Online Health Engagement

CareSource uses innovative technology to engage members to manage their own health. MyHealth is a technology-enabled solution to improve population health and well-being. It provides personalized wellness tools for all CareSource members. Through MyHealth, CareSource members have access to tools to help them manage health topics specific to their needs. MyHealth includes:

- Interactive health assessment
- Condition specific digital health tools
- Multi-dimensional daily wellness tracker
- Small steps interactive guides

All of the tools are accessible via web or mobile.

Rewards for Treatment of Substance Use Disorder (SUD)

CareSource rewards members on the road to recovery by offering incentives for taking steps to improve their health. HIP and adult HHW members being treated for Substance Use Disorder (SUD) can attend Intensive Outpatient Program (IOP) groups and earn rewards for completing sessions. CareSource has developed a pathway to rewards for HIP and adult HHW members to earn up to $100 for attending IOP groups, which goes towards their $300 total rewards that can be earned across all incentive programs in the MyHealth Rewards program. Members receive behavioral health rewards for each in-network IOP group session they attend ($10 for each session, up to $100). Members can track their rewards in their MyHealth Rewards account, then use their rewards for gift cards to retailers including TJ Maxx, Home Goods, CVS, iTunes, Panera Bread and more. For questions about the SUD IOP reward, please call Provider Services at **1-844-607-2831**.

Consent Form Requirements

Per Indiana requirements, information about SUD treatment and HIV/AIDS should only be released if you have obtained member consent.

Advanced Directives

An advance directive is a written instruction, such as a living will or durable power of attorney for health care including mental health, recognized under Indiana law, relating to the provision of health care when a member is incapacitated.

Providers delivering medical care to CareSource members must ensure all adult CareSource members 18 years of age and older receive information on advance directives and are informed of their rights to execute advance directives. Information regarding advance directives should be made available in provider's offices and discussed with CareSource members or provider's staff when questions arise.

Providers should discuss advance directives with adult CareSource members during the member's initial office visit and document in the member's medical record whether or not the member has executed an advance directive.

Providers delivering medical care to CareSource members shall not, as a condition of treatment, require a member to execute or waive an advance directive. In addition, providers shall not discriminate against CareSource members based on whether or not the member has executed an advance directive.

MEMBER GRIEVANCE AND APPEALS PROCEDURES

CareSource shall give members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.

Member Grievances

Members have the right to file a grievance or appeal and request a State Hearing or a review by an Independent Review Organization of a decision made by CareSource. As a CareSource provider, we may contact you to obtain documentation when a member has filed a request for one of these reviews. CareSource does not retaliate or discriminate against any member or provider for utilizing the grievance and appeals process.

Members are encouraged to call or write to CareSource to let us know of any complaints regarding CareSource or the health care services they receive. Members or providers, when designated as the authorized representative by the member and with member consent, may file a grievance or appeal with CareSource. Detailed grievance and appeal procedures are explained in the Member Handbook. Members can contact CareSource at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) to learn more about these procedures. Members must exhaust CareSource's internal appeals process before requesting an external review by an independent review organization or a state fair hearing.

CareSource shall provide an expedited grievance review if adhering to the resolution time frame of 30 calendar days would seriously jeopardize the life or health of a member, or the member's ability to regain maximum function. Expedited grievances shall be resolved within 48 hours of receipt. If CareSource denies a request for an expedited review, we shall transfer the grievance to the standard grievance time frame. Further, CareSource shall make a reasonable effort, including a phone call to the member, to provide the member with prompt oral notification of the denial for an expedited review, and shall follow up with a written notice within two calendar days.

Time Frames and Requirements

The member can file a grievance at any time. CareSource responds to all grievances within 30 calendar days of the receipt of the request. This period may be extended up to 14 calendar days if resolution of the matter requires additional time. A letter notifying the member of this extension is required.

Member Appeal of a Grievance Decision

If members are not satisfied with our response to a grievance, they can ask us to reconsider it by contacting CareSource at any time. CareSource will communicate a decision to the member within 30 calendar days of the receipt of the request. This period may be extended up to 14 calendar days if resolution of the matter requires additional time. CareSource must give the member written notice of the reason for the extension.

Member Appeals

CareSource notifies members in writing when a decision is made to:

- Deny or limit authorization of a requested service, including the type or level of service.
- Reduce, suspend or terminate services prior to the member receiving the services previously authorized.
- Deny, in whole or part, of payment for a service.
- Fail to provide services in a timely manner.
- Fail to act within the resolution time frame.

Members have the right to appeal the actions listed in the letter if they contact CareSource within 60 calendar days from the date of the denial letter. CareSource will respond to the appeal in writing within 30 calendar days of when it was received. This period may be extended up to 14 calendar days if resolution of the matter requires additional time. CareSource must give the member written notice of the reason for the extension. Members will receive the appeal decision and any additional appeal rights in writing within five business days of the decision.

If the amount of time necessary to resolve a standard appeal could jeopardize the member's life, health or ability to attain, maintain or regain maximum function, the member may request an expedited appeal. If the request meets the expedited criteria, CareSource will resolve the appeal as quickly as possible, not exceeding 48 hours after receipt of the request. CareSource will review the request and determine if the request meets the expedited criteria, if the expedited request is denied, CareSource must:

- Transfer the request to a standard appeal for resolution.
- Make a reasonable effort to give the member prompt oral notice, and follow up within two calendar days with a written notice of the decision.

External Review by Independent Review Organization and State Hearings

CareSource members can request an external review and state hearing concurrently after they have exhausted all CareSource's internal appeals process. The member or a member's representative must submit the request, with member consent, in writing within 120 calendar days from the date of the appeal decision. To request an external review the member can write to CareSource at:

CareSource
P.O. Box 8738
Attn: External Review
Dayton, OH 45401-8738

The request for a state fair hearing must be sent to the State of Indiana Office of Administrative Law Proceeding at:

Office of Administrative Law Proceedings
402 W. Washington St.
Room E034
Indianapolis, IN 46204

Continuation of benefits while the appeal and the state fair hearing are pending:

In certain member appeals, CareSource is required to continue the member's benefits pending the appeal, in accordance with *42 CFR 438.420*. Members may be required to pay the cost of services provided while the appeal or state hearing is pending.

CARESOURCE MEMBER RIGHTS AND RESPONSIBILITIES

As a CareSource provider, you are required to respect the rights of our members. CareSource members are informed of their rights and responsibilities via their Member Handbook. 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, as stated in the Member Handbook, are as follows:

- To receive information about CareSource, its services, its practitioners and providers, and member rights and responsibilities.
- To receive all services that CareSource must provide.
- To be treated with respect and with regard for their dignity and privacy.
- To ensure medical records and personal information will be kept private.
- To be given information about their health. This information may also be available to someone who the member has legally authorized to have the information or whom the member has said should be reached in an emergency when it is not in the best interest of the member's health to give it to him/her.
- To discuss any appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- To participate in decisions regarding his or her health care, including the right to refuse treatment.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- To be sure that others cannot hear or see the member when he/she is getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To request and receive a copy of his or her medical records and request to amend or correct the record.
- To be able to say "yes" or "no" to having any information about himself/herself given out unless CareSource has to by law.
- To be able to say "no" to treatment or therapy. If the member says "no", the doctor or care management organization (CMO) must talk to him/her about what could happen and a note must be placed in the member's medical record about the treatment refusal.
- To be able to file an appeal, a grievance (complaint) or state hearing about CareSource or the care it provides.
- To be able to get all CareSource written member information from CareSource:
  - At no cost to the member;
  - In the prevalent non-English languages of members in CareSource's service area;
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.

- To be able to get help free of charge from CareSource and its providers if the member does not speak English or needs help in understanding information.
- To be able to get help with sign language if the member is hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will).
- To freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated.
- To know that CareSource must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives the member care whenever possible and appropriate with the ability to seek care from an out of network provider when the necessary covered medical services are not available within 60-miles of the member's residence.
- To be able to get a second opinion from a qualified provider on CareSource's panel. If a qualified provider is not able to see the member, CareSource must set up a visit with a provider not on its panel.
- To not be held liable for the supplier's debts in the event of insolvency.
- To not be held liable for the covered services provided to the member for which OMPP does not pay the supplier.
- To not be held liable for covered services provided to the member for which OMPP or the CMO does not pay the health care provider that furnishes the services.
- To not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the supplier provided the services directly.
- To be responsible for cost sharing.
- To not be billed for any service covered by Medicaid.
- To make recommendations regarding CareSource's member rights and responsibility policy.
- To contact the United States Department of Health and Human Services Office of Civil Rights at the address below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services:

  Office of Civil Rights
  United States Department of Health and Human Services
  233 N. Michigan Ave. Suite 240
  Chicago, Illinois 60601

  (312) 886-2359
  (312) 353-5693 TTY

Members of CareSource are also informed of the following responsibilities:

- Use only approved providers.
- Keep scheduled doctor appointments, be on time and call 24 hours in advance of a cancellation.
- Follow the advice and instructions for care he/she have agreed upon with his/her doctors and other health care providers.
- Always carry his/her ID card and present it when receiving services.
- Never let anyone else use his/her ID card.
- Notify his/her county Department of Family Resources (DFR) and CareSource of a change in phone number or address.
- Contact his/her PMP (primary medical provider) after going to an urgent care center or after getting medical care outside of CareSource's covered counties or service area.
- Let CareSource and the county DFR know if he/she has other health insurance coverage.
- Provide the information that CareSource and his/her providers need in order to provide care.
- Understand as much as possible about his/her health issues and take part in reaching goals that the member and his/her providers agree upon.
- Let us know if he/she suspects fraud, waste or abuse.

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

As a provider/covered entity, please remember that you are obligated to follow the same HIPAA regulations as CareSource and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations. Thank you for your assistance in providing requested information to CareSource in a timely manner.

When a patient has a sensitive health diagnosis (e.g., treatment for drug/alcohol use, genetic testing, HIV/AIDS, or sexually transmitted diseases), you should verify if the patient has granted consent to share health information.

Log in to the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal and search for the CareSource patient using the "Member Eligibility" option. A message displays if the patient has not consented to sharing sensitive health information. If the patient has not consented, you may not have access to all of the patient's health information on the Provider Portal.

Please encourage your CareSource patients who have not consented to complete a Member Consent/ HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located on **CareSource.com** > Members > Tools & Resources > Forms. The Member Consent/HIPAA Authorization Form can also be used to designate a person who can speak on the patient's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the patient specifies.

AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, providers 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, providers' diagnostic equipment must accommodate individuals with disabilities.

The CareSource provider network will reasonably accommodate persons and ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. CareSource and its provider network 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.

Please see the following sections for information about the ADA.

Q. Which providers 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 providers covered by the Title III of the ADA. Title III applies to all private providers, regardless of size. It applies to providers 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. Providers that offer training sessions, health education, or conferences to the general public must make these events accessible to individuals with disabilities.

Policies and Procedures

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

Providers 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 provider determine which auxiliary aid or service is best for a patient?

A. The provider 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 provider 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 provider 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 provider.

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 provider is not in compliance with the ADA?

A. If a provider 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 As" by Deborah Leuchovius, ADA Specialist, PACER (Parent Advocacy Coalition for Educational Rights) 8161 Normandale Blvd., Bloomington, MN 55437.

CARESOURCE HEALTH EQUITY COMMITMENT

As a non-profit, mission driven, member-centric organization, CareSource seeks to provide high-quality, appropriate, evidence-based health services for all members. Social determinants of health are increasingly recognized as significant contributors to member health outcomes and quality of life. Providing equitable and culturally competent care and services is a core value of CareSource.

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

National Standards for Culturally & Linguistically Appropriate Services (CLAS)

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

- Advance health equity
- Improve quality
- Help eliminate health disparities

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

CareSource adheres to the National Culturally & Linguistically Appropriate Standards (CLAS). CLAS consists of 15 standards that encompass the following topic areas:

- Principal Standard: Provision of effective, equitable, understandable, and respectful quality care and services that are response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs
- Governance, Leadership, and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement, and Accountability

Network providers must ensure that:

- Members understand that they have access to free medical interpreter services in their native language, including Sign Language. No cost TDD/TTY services are available to facilitate communication with hearing impaired members.
- Health care is provided with consideration of the members' cultural background, encompassing race/ethnicity, language and health beliefs. Cultural considerations may impact/influence member health decisions related to preventable disease or illness.
- The provider office staff makes reasonable attempts to collect race-and-language-specific member data. Staff is available to answer questions and explain race/ethnicity categories to a member, to assure accurate identification of race/ethnicity for all family members.
- Treatment plans are developed based on evidence-based clinical practice guidelines with consideration of the member's race, country of origin, native language, social norms, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

CareSource encourages our participating providers to visit the Office of Minority Health, Cultural Competency Resources website found at: https://thinkculturalhealth.hhs.gov/ for toolkits and educational resources. Included on the site is a free, nine-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.

CareSource educates its contracted providers, including behavioral health providers, regarding provider requirements and responsibilities. CareSource educates the provider on prior authorization policies and procedures, clinical protocols, member rights and responsibilities, claims submission process, claims dispute resolution process, program integrity, identifying potential fraud, waste and abuse, pay for outcomes programs, and any other information relevant to improving the services provided to HIP and HHW members.

QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM (QMIP)

CareSource is committed to providing evidence-based care in a safe, member-centered, timely, efficient, and equitable manner. The scope of the CareSource Quality Management and Improvement Program (QMIP) is comprehensive, inclusive of both clinical and non-clinical services, and health, safety, and/or welfare concerns. CareSource monitors and evaluates the quality and safety of the care and service delivered to our members emphasizing:

- Accessibility to care
- Availability of services and practitioners
- Medical and behavioral health services
- Internal monitoring, review, and evaluation of program areas, including Utilization Management, Care Management and Pharmacy

Member and provider satisfaction and health outcomes are monitored through:

- Quality improvement activities
- Routine health plan reporting
- Annual Health Effectiveness Data and Information Set (HEDIS®)—measures the quality of our health plan
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)—measures patient experience with the health care system
- Member surveys
- Review of accessibility and availability standards
- Utilization trends

CareSource assesses our performance against goals and objectives that are in keeping with industry standards. Annually, we complete an annual evaluation of our QMIP.

CareSource is accredited by the National Committee for Quality Assurance (NCQA).

Program Purpose

The purpose of the QMIP is to ensure that CareSource Indiana has the necessary infrastructure to:

- Coordinate member care and services to improve health outcomes
- Promote the use of evidence-based best practices for the treatment of member health conditions
- Ensure high performing and efficient systems for delivery of care
- Address the health, safety, and welfare concerns of CareSource members and implement appropriate interventions

The QMIP is revised as needed:

- To remain responsive to member needs
- Based on feedback received from our providers and other health partners
- In response to changes in nationally recognized practice standards and evidence-based research
- To meet CareSource business needs

Program Scope

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

CareSource uses HEDIS as one measure to determine the quality of care delivered to members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by NCQA. The HEDIS tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence-based research and address significant health priorities in the United States.

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

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

The CareSource Quality Management and Improvement Program oversees quality improvement and assessment activities for our CareSource Healthy Indiana Plan and Hoosier Healthwise members to maintain a robust QMIP Program, our scope includes:

- Ensure regulatory and accrediting agency compliance, including:
  - All federal requirements as outlined by CMS and in 42 CFR Part 438, Managed Care
  - Perform HEDIS® compliance audit and performance measurement
  - Ensure compliance with NCQA accreditation standards
- Establish safe clinical practices throughout our network of providers
- Provide quality oversight of all clinical services, including addressing all quality-of-care concerns
- Advocate for members across settings, including review and resolution of quality-of-care concerns
- Meet member access and availability needs for physical and behavioral health care
- Determine interventions for HEDIS® overall rate improvement that increase preventive care rates and facilitate support of member acute and chronic health conditions and other complex health, safety, or welfare needs
- CareSource uses the annual member CAHPS® survey to capture member perspectives on health care quality and establishes interventions based on results to enrich member and provider experience and satisfaction. Use the Institute for Healthcare Improvement (IHI) model for improvement methodologies to evaluate initiatives and effect change
- Ensure CareSource is effectively serving our members with cultural and linguistic needs, as well as identified disparities that may impact member receipt of health care services and achieving positive member outcomes
- Monitor important aspects of care to ensure the health, safety and welfare of members across healthcare settings Ensure e that CareSource is effectively serving members with complex health needs
- Ongoing assessment of member population health characteristics
- Regularly assess the geographic availability and accessibility of primary and specialty care providers
- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies

Our commitment to the Quality Management and Improvement Program is aligned with the Indiana Family Social Services Administration (FSSA) Office of Medicaid Policy and Planning's (OMPP) expectations for Managed Care Entities (MCEs), as emphasized in the State's Medicaid Managed Care Quality Strategy Plan 2022:

Hoosier Healthwise (HHW) Initiatives

- Improvements in children and adolescents well-care
- Improvements in childhood immunization status – Combination 10
- Completion of health needs screen (>70%)
- Annual dental visit
- Lead screening in children

- Asthma medication ratio
- Prenatal depression screening in pregnant members
- Pregnancy Coordination

Healthy Indiana Plan (HIP) Initiatives

- POWER Account rollover (HEDIS Adult Access to Preventive and Ambulatory Health Services)
- Prenatal depression screening in pregnant members
- Timeliness of outgoing prenatal care
- Frequency of post-partum care
- Completion of health needs screen (>70%)
- Follow-up after emergency department visit for alcohol and other drug abuse dependence (7 day)
- Follow-up after emergency department visit for alcohol and other drug abuse dependence (30 day)
- Pregnancy Coordination

CareSource collaborates with OMPP and other MCEs in attaining the goals of the Indiana Medicaid Quality Strategy Plan.

Quality Strategy

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

The Institute for Healthcare Improvement Quintuple Aim for Populations

CareSource aligns with the IHI framework to:

- Improve the member experience of care (including clinical quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care
- Clinician well-being
- Health equity

Centers for Medicaid & Medicare Services National Quality Strategy

CareSource aligns with the CMS National Quality Strategy to optimize health outcomes by leading clinical quality improvement and health system transformation. The CMS Quality Strategy vision for improving health care delivery can be summed up in three words: better, smarter, healthier.

The strategy corresponds to the six priorities from the Agency for Healthcare Research & Quality's National Quality Strategy. Each of these priorities is a goal in the CMS Quality Strategy:

- Make care safer by reducing harm caused while care's delivered
  - Improve support for a culture of safety

  - Reduce inappropriate and unnecessary care
  - Prevent or minimize harm in all settings
- Help patients and their families be involved as partners in their care
- Promote effective communication and coordination of care
- Promote effective preventon and treatment of chronic disease
- Work with communities to help people live healthily
- Make care affordable

Quality Measures

CareSource adheres to the following quality measures as part of our QMIP:

- Achieve and maintain National Committee for Quality Assurance (NCQA) accreditation
- Assure compliance with NCQA accreditation standards
- Receive scores on Healthcare Effectiveness Data and Information Set (HEDIS) that reflect a high level of performance
- Receive scores on Consumer Assessment of Healthcare Providers and Systems (CAHPS) that reflect a high level of performance
- Develop and maintain a comprehensive population health management program
- Develop and maintain a comprehensive provider engagement program
- Assure CareSource is meeting all OMPP requirements for a quality improvement and management program

CareSource continually assesses and analyzes the quality of care and services provided to our members, through use of objective and systematic monitoring and implementation of quality improvement initiatives.

Member Health, Safety & Welfare

A top priority for CareSource is ensuring the health, safety and welfare of our members. The purpose of the CareSource Health, Safety and Welfare initiative is to ensure CareSource provides safe, evidence-based health care and services to prevent medical errors, avoid adverse events and provide an avenue for addressing those social determinants of health that impact health status and contribute to health disparities. CareSource understands that a number of social determinants contribute to a member's health status, ability to seek preventive services and manage chronic health conditions.

Clinical Practice Guidelines & Preventive Guidelines

CareSource approves and adopts evidence-based nationally recognized standards and guidelines and promotes them to practitioners to help inform and guide clinical care provided to members. Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management tools. Guidelines are reviewed at least every two years or more often as needed and updated as necessary. They may be found at **CareSource.com** > Providers > Education > Patient Care > Health Care Links.

The use of these guidelines allows CareSource to measure their impact on member health outcomes. Review and approval of the guidelines are completed by the Market CareSource Provider Advisory Committee (PAC). The CareSource Enterprise PAC and Quality Enterprise Committee (QEC) are notified

of guideline approval. Topics for guidelines are identified through analysis of member population demographics and national or state priorities. Guidelines may include, but are not be limited to:

- Behavioral health (e.g., depression)
- Chronic health (e.g., hypertension and diabetes)
- Population health (e.g., obesity and tobacco cessation)

Guidelines may be promoted to providers through one or more of the following: newsletters, our website, direct mailings, provider manual, and through focused meetings with CareSource Provider Engagement Specialists. Information regarding clinical practice guidelines and other health information are made available to members via member newsletters, the CareSource member website, or upon request.

If you would like more information on our Quality Management and Improvement Program, please visit **CareSource.com** > Provider Overview > Education > Quality Improvement or call Provider Services at **1-844-607-2831**.

Access Standards

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 time frames and to offer hours of operation to their CareSource patients that are no less (in number or 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.

Please keep in mind the following access standards for differing levels of care.

Primary Medical Providers

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 14 calendar days

For primary medical providers (PMPs) only: Provide 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PMP or a back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider, and only recommends emergency room use for after hours.

Non-Primary Medical Providers (Specialists)

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 30 calendar days

Behavioral Health Providers

Type of Visit	Should be seen…
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 routine care	Not to exceed 30 calendar days based off the condition
Follow-up after discharge	Within 7 days from the date of discharge

*A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. It is expected that if a provider is unable to see the member within the appropriate time frame, CareSource will facilitate an appointment with a participating provider or a nonparticipating provider, if necessary.

Services included in the CareSource Medicaid contract must be available 24 hours a day, seven days a week, when medically necessary. Providers may find information about medically necessary services that must be available 24/7 by visiting **CareSource.com** > Tools & Resources > Provider Policies, and selecting Indiana Medicaid.

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

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

How to Submit Changes to CareSource

The CareSource Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Provider Portal, entering your login credentials, and selecting Provider Maintenance from the left hand navigation. You may also use the methods below. If submitting updates by email, mail. Or fax, providers must utilize the HIE form to submit the updates. Please note any demographic changes must first be updated with Indiana Health Coverages Program (IHCP) before submission to CareSource.

Email

ProviderMaintenance@CareSource.com

Fax

937-396-3076

Mail

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

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

Quality of Care Reviews

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

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

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

All providers are expected to return medical record requests related to quality-of-care concerns within 14 days from initial receipt of the request, unless otherwise defined by program guidelines or state or federal law requirements. In the event that a state, federal or regulatory agency, or if the health and safety of a member requires that medical records must be submitted under a shorter time frame, providers are expected to comply with the shorter turnaround time. Providers and facilities that utilize third-party health information management vendors are responsible for providing medical records to CareSource or facilitating delivery of medical records to CareSource by the identified contractor. We are legally bound to interact with providers only and CareSource is not subject to any fees charged by health information management companies for medical record retrieval or submission.

Your health partner representative may contact you if medical records are not received within the 14-day time frame to ensure you received the request. In addition, our market Chief Medical Officer may also be in contact to facilitate and ensure receipt of the required medical records to complete the quality-of-care reviews. Providers or facilities who repeatedly fail to return requested medical records are reported to the Credentialing Committee and may face other directed intervention or penalties up to and including contract termination.

PROVIDER APPEALS PROCEDURE

If you are dissatisfied with a determination made by our Utilization Management department regarding a member's health care services or benefits, you may appeal the decision. Please see the "Appeal Procedures" section in this manual for information on how to file a clinical appeal.

Retrospective Review

Upon written request, CareSource *shall not permit* retrospective authorization submission after the date of service or admission where a prior authorization was required but not obtained (Retro Authorization) except in the following circumstances as outlined in the IAC rule below:

405 IAC 5-3-9 Requirement Sec. 9. Prior authorization will be given after services have begun or supplies have been delivered only under the following circumstances:

(1) Pending or retroactive member eligibility. The prior authorization request must be submitted within 12 months of the date of the issuance of the member's Medicaid card.

(2) Mechanical or administrative delays or errors by the office.

(3) Services rendered outside Indiana by a provider who has not yet received a provider manual.

(4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within 12 months of the date of service.

(5) The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:

(A) The provider's records document that the member refused or was physically unable to provide the member ID number.

(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.

(C) The provider submitted the request for prior authorization within 60 days of the date Medicaid eligibility was discovered.

Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria will need to be met to qualify for a retro authorization review.

Claims not meeting the necessary criteria as described above will be administratively denied. Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal. If the request is received within these time frames and a medical necessity denial is issued, you may submit a request for an appeal within 180 days from the date of the service, date of discharge, or date of denial if service was not yet rendered.

Please Note: If you are appealing on our member's behalf with their written consent, you have 60 calendar days from the date of the action notice.

A request for retrospective review can be made by contacting the Utilization Management department at **1-844-607-2831** and following the appropriate menu prompts, or by faxing the request to 844-432-8924. Clinical information supporting the request for services must accompany the request.

Provider Grievances, Claim Disputes & Appeals Process

Providers may file grievances related to members, other providers, or operational issues of the plan. CareSource will thoroughly investigate each provider complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying the CareSource written policies and procedures.

Claim Dispute Process for participating and nonparticipating providers:

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.

Process for claim disputes for participating and nonparticipating providers:

- Claim disputes must be submitted using one of the methods below:
  - Provider Portal: The Provider Portal is the preferred method of submission to ensure timely receipt and resolution of the dispute. Under the portal, click "Claims" tab on the left, select "Dispute".
  - In writing, by submitting the claim dispute form using one of the following methods:
    - Fax: (937) 531-2398
    - Mail:
      Claim Disputes Department
      P.O. Box 2008
      Dayton, OH 45401-2008
- Claim disputes must be submitted in writing.
- The provider must complete a claim dispute prior to requesting an appeal.
- The dispute must be submitted within 60 days after the provider's receipt of the written determination of the claim.
- If CareSource fails to decision a claim within 30 days after receipt, an appeal may be submitted.

Appeals for participating and nonparticipating providers:

Pre-service authorization denials, based on medical necessity review, can be appealed with member written consent from the date of the action notice. Pre-authorization denials must be within 60 days from the date of the action notice.

Providers may only submit claim appeals after completing the claim dispute process as outlined above. Claim Appeals must be submitted within 60 days of the date of resolution on the informal dispute process. CareSource must issue a written decision within 45 days of receipt of the written request for appeal. If the appeal is not resolved within the 45-day time frame, the appeal will be determined as an approval.

Providers may only submit appeals after completing the claim dispute process as outlined above. Appeals must be submitted within 60 days of the resolution of the informal dispute process. CareSource must issue a written decision within 45 days of receipt of the written request for appeal. If the appeal is not resolved within the 45-day time frame, the appeal will be determined as an approval. Appeal requests must be submitted utilizing one of the methods below.

Pre-service authorization denials, based on medical necessity review, can be appealed with member-written consent from the date of action notice. Pre-authorization denials must be within 60 days from the date of action notice.

Providers must submit appeals using one of the methods below:

- Provider Portal: The Provider Portal is the preferred method of submission to ensure timely receipt and resolution of the appeal. Under the portal, click on the “Appeals” tab on the left.
- Writing: use the Provider Claim Appeal Request Form. Please include:
  - Member’s name and member ID number.
  - The provider’s name and ID number.
  - The code(s) and 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.
- Mail:
  CareSource
  Attn: Provider Appeals
  P.O. Box 2008
  Dayton, OH 45401
  Fax: 937-531-2398

If you are submitting a timely filing appeal, you must send proof of original receipt of the claim by fax or Electronic Data Information (EDI) for reconsideration.

For additional information, contact Provider Services at **1-844-607-2831**.

Appeal requests must include:

- The member's name, member ID number, and date of birth
- The provider's name and CareSource provider billing number
- The place, date, and type of service that had a non-certification determination for medical necessity appeals
- The reason why the determination should be reconsidered
- Any additional available medical information to support your reasons for reversing the determination or support medical necessity
- If the provider is submitting an appeal on behalf of the member, the provider must submit signed member consent authorizing the provider to act on the member's behalf

All appeals are reviewed by an independent panel knowledgeable about the policy, legal and clinical issues involved in the matter subject to the appeal; individuals who have not been involved in any previous consideration of the matter; and all information and material submitted by the provider that bears directly upon an issue involved in the matter is considered. Providers can locate additional information concerning appeal reviews at 405 IAC 1-1.6.

Arbitration:

If the provider is dissatisfied with the decision of the CareSource panel, the provider may submit the matter in accordance with the dispute resolution provisions of the agreement with CareSource. The binding arbitration process must be conducted in accordance with the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the State of Indiana at IC 34-57-2, unless:

- The provider and CareSource mutually agree to some other binding resolution procedure or process in the agreement between the parties; or
- CareSource or the providers are subject to statutorily imposed arbitration procedures for the resolution of these claims. In that case, the statutorily imposed arbitration procedures shall be followed.
- The arbitration process may include, in a single arbitration proceeding, matters from multiple formal claim resolution procedures involving CareSource and the provider.
- The fees and expenses of arbitration or other binding resolution procedure shall be borne by the non-prevailing party.

Providers can submit issues to:
CareSource
Attn: Arbitration
251 N Illinois Street
Suite 300
Indianapolis, IN 46204

PRIMARY MEDICAL PROVIDERS

Primary Medical Provider Concept

All CareSource members may choose a primary medical provider (PMP) upon enrollment in the plan. PMPs should help facilitate a medical home for members. This means that PMPs will help coordinate health care for the member and provide additional health options to the member for self-care or care from community partners. Medicaid members must choose a PMP within 30 days, otherwise a PMP will be assigned to the member.

Members select a PMP from our online Provider Directory available at **CareSource.com** > Members > Tools & Resources > Find a Doctor. Members have the option to change to another participating PMP as often as needed. Members initiate the change by calling Member Services.

Roles and Responsibilities

PMP care coordination responsibilities include at a minimum, the following:

- Assisting with coordination of the member's overall care, as appropriate for the member.
- Serving as the ongoing source of primary and preventive care.
- Recommending referrals to specialists, as required.
- Triaging members.
- Participating in the development of case management care treatment plans, and notifying CareSource of members who may benefit from care management. Please see the "Member Support Services and Benefits" section on page 83 to learn how to refer members for case management.
- Providing care that addresses the needs of HIP members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health.
- Providing a written plan and evidence of ongoing, increased communication between the PMP, the MCE and the behavioral health provider.
- Coordinating management of utilization of behavioral health care services with MRO and 1915(i) services and services for physical health.

CareSource allows PMPs to include not only traditional provider types that have historically served as PMPs but also alternative provider types such as specialists and patient-centered medical homes (PCMH) with documented physician oversight and meaningful physician engagement.

PMPs are Responsible For:

- Treating CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plan and Indiana Office of Medicaid Policy and Planning (OMPP).
- Providing 30 days of emergency coverage to any CareSource patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by CareSource patients for emergency or urgent care if notified of the visit.
- Use best commercial efforts to collect required copayments for services rendered to applicable members.
- Ensuring demographic and practice information is up-to-date for directory and member use.
- Reporting suspected fraud and/or abuse.
- MP's disenrolling from HIP that remain an IHCP provider must provide continuation of care for HIP members for a minimum of thirty (30) calendar days or until the member's link to another PMP becomes effective.

In addition, CareSource PMPs 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

Primary Medical Provider Selection

A member may select a PMP as a medical home from the following types of providers:

- General practice
- Family practice
- Internal medicine
- Pediatrics
- Obstetrics/gynecology
- Endocrinologists (if primarily engaged in internal medicine)
- Certified nurse practitioner
- Psychiatrist/HSPP - CareSource shall include in its network as PMPs psychiatrists who agree to serve as PMPs for members who have primary diagnosis of severe persistent mental illness.

If a member does not select a PMP, we will assign one. CareSource encourages communication between all physicians and other health care professionals who are providing care to CareSource members. CareSource may also attribute a member to a PMP based on the history of the member. If a new provider is attributed, this may change the member's PMP assignment.

Provider Rights

CareSource complies with 42 CFR 438.102, which relates to provider-enrollee communications. CareSource shall not prohibit or otherwise restrict a health care professional, acting within his or her lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding the following:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under the HIP programs;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Medical Records

CareSource providers must maintain medical and other records of all medical services provided to our members for seven years, in accordance with *Indiana Code (IC) 16-39-7-1*. CareSource medical records standards are consistent, to the extent feasible, with NCQA accreditation standards for medical records. The records must at least be legible and must include the following:

- Patient identification information (patient name or identification number) on each written page or electronic file record
- Personal biographical data
- Entry date
- Provider identification
- Allergies
- Past medical history
- Immunizations
- Medical information
- Consultations
- Referrals
- Medical conditions and health maintenance concerns
- Written instructions for living wills or durable power of attorney for health care when the patient is incapacitated and has such a document
- A record of outpatient and emergency care
- Specialist referrals
- Ancillary care

- Diagnostic tests and findings
- Prescriptions for medications
- Inpatient discharge summaries
- Histories and physicals, including a list of smoking and chemical dependencies, including alcohol, legal and illegal drugs (member consent required to share substance use information)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
- Laboratory and X-ray tests and findings

Confidentiality of, and access to, medical records shall be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal requirements, including but not limited to, 42 CFR Part 2 specific to confidentiality of alcohol and drug abuse records.

Providers must maintain medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Health records must be legible, signed, dated and maintained for at least seven years, as required by *IC 16-39-7-1*. Confidentiality of protected health information (PHI) must be maintained, in accordance with the *Health Insurance Portability and Accountability Act (HIPAA)*.

The State (or CareSource) must have access to medical records for medical record reviews. In accordance with *Indiana Administrative Code (IAC) 405 IAC 1-5-1*, the provider must retain all records relating to the provision of CareSource services for at least seven years from the date of record creation. The provider must transfer, at the request of the State or CareSource, a summary or copy of a member's medical records to another provider if the member is reassigned.

Any provider receiving payments from the IHCP for rendered services may not charge an IHCP member for medical record copying or transfers. Federal regulation *42C.F.R.447.15* states that providers participating in Medicaid must accept the State's reimbursement as payment in full (except that providers may charge for deductibles, coinsurance and copayments).

Provider Directory Information Attestation

State and Federal regulations require Health Plans to validate and update published information regarding their contracted provider network every 90 days. This validation ensures we have the most accurate information for claims payment and provider directories. This information is critical to process your claims. In addition, it ensures our Provider Directories are up to date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare. **Providers are required to attest to directory information every 90 days.**

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

What happens if I do not attest to my information?

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

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.

Participating providers are responsible for providing CareSource with advance written notice of any intent to terminate an agreement with us. This must be done 90 days prior to the date of the intended termination and submitted on your organization's letterhead. If you disenroll from CareSource but remain an Indiana Health Coverage Programs (IHCP) provider, you must provide continuation of care for Hoosier Healthwise (HHW) and/or Healthy Indiana Plan (HIP) members for a minimum of 30 calendar days or until the member's link to another PMP becomes effective.

60-day 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 PMPs only:
  - Provide 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PMP or a back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider and only recommends emergency room use for after hours.
  - Be available to see members at least three days per week for a minimum of 20 hours per week, or any combination of visits at no more than two locations.
  - Provide members telephone access to the PMP (or appropriate designate) in English and Spanish 24/7.
- For behavioral health providers only:
  - Notify CareSource of missed appointments.
  - Schedule members receiving inpatient psychiatric services for outpatient follow-up and/or continuing treatment prior to discharge, within seven calendar days from the member's date of discharge.

  - Document and share with physical health providers the following information:
    - Primary and secondary diagnoses,
    - Findings from assessments,
    - Medication prescribed,
    - Psychotherapy prescribed, and
    - Any other relevant information.
  - Notify CareSource within five calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications and other pertinent information.
- Claims should be submitted within 90 days of the date of service or discharge.
- Corrected claims should be submitted within 60 days from the date of the EOP.
- Claims disputes should be submitted 60 calendar days from the date of receipt of the claim decision notification.
- Providers should keep demographic and practice information up-to-date. Email updates to ProviderMaintenance@CareSource.com or submit change on the Provider Portal.

Our agreement also indicates that CareSource is responsible for:

- Paying clean electronic claims within 21 days of receipt.
- Paying clean paper claims within 30 days of receipt.
- 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 "Provider Appeals" section of this manual.
- Offering a 24-hour nurse advice line 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 lesser of the primary carrier allowable or the Medicaid allowable. If the member's primary insurer pays a provider equal to or more than Indiana's HHW and/or HIP fee schedule for a covered service, CareSource will not pay the additional amount. The Hoosier Healthwise fee schedule is based on the Medicaid fee schedule, and the Healthy Indiana Plan fee schedule is based on the Medicare fee schedule.

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

For example:

- Participating providers, or their designee, are expected to make daily visits to their patients who have been admitted as inpatient to an acute care facility or arrange for a colleague to visit.
- Participating PMPs are expected to have a system in place for following up with patients who miss scheduled appointments.

Participating providers are expected to treat members with respect. CareSource members should not be treated any differently than patients with any other health care insurance. Please reference member rights in the "Member Support Services and Benefits" section on page 83 of this manual.

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

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

Timeline of Provider Changes:

Type of Change	Notice required (Please notify CareSource of the change prior to the time frames listed below)
New providers or deleting providers	30 business days
Providers leave the practice	30 business days
Phone number change	30 business days
Address change	30 business days
Change in capacity to accept members	30 business days
Intent to terminate Provider Agreement	90 calendar days

Why Is It Important to Give Changes to CareSource?

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

How to Submit Changes to CareSource:

The CareSource Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Provider Portal, entering your login credentials, and selecting “Provider Maintenance” from the left-hand navigation. You may also use the methods below.

Email: ProviderMaintenance@CareSource.com

Fax: 937-396-3076

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

Americans with Disabilities Act (ADA) Standards:

- Additionally, providers will remain compliant with ADA standards, including but not limited to:
- Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities
- Accessibility along public transportation routes, and/or provide enough parking
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities
- Providing secure access for staff-only areas

FRAUD, WASTE AND ABUSE

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

Definition of Terms

Fraud

Fraud is defined as "an intentional deception or misrepresentation made by a person 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" (42 CFR, Part 455.2).

Waste

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 (Inspector General).

Abuse

Abuse is defined as "provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program" (42 CFR Part 455.2).

Improper Payment

Improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts (Improper Payments Elimination and Recovery Act, IPERA). Any improper payment may constitute fraud, waste and/or abuse. CareSource has the right to recoup improper payments.

Examples of Member Fraud, Waste and/or Abuse:

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions – i.e. changing prescription form to get more than the amount of medication prescribed by their physician
- Sharing a member ID card

- Non-disclosure of other health insurance coverage
- Obtaining unnecessary equipment and supplies
- Member receiving services or picking up prescriptions under another person's name or ID (identity theft)
- Providing inaccurate symptoms and other information in order get treatment, drugs, etc.
- Any other action by a member that CareSource considers to be fraud, waste and/or abuse

Note: This is not an all-inclusive list.

Examples of Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower Medicaid/Medicare reimbursement rates
- Billing for services not provided
- Requiring members to pay for CareSource covered services
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking member ID numbers, resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using member/enrollee lists for the purpose of submitting fraudulent claims
- Billing drugs for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark violations
- Retaining overpayments made in error by CareSource
- Preventing members from accessing eligible or covered services resulting in underutilization of services offered
- Failing to comply with federal and/or state laws

Note: This is not an all-inclusive list.

Examples of Pharmacy Fraud, Waste and/or Abuse:

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

- Dispensing expired, fake, diluted, tainted, or illegal drugs
- Billing prescriptions not filled or picked up

It is also important for you to tell us if a CareSource employee 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 data or reports
- Not reporting or taking action on employees that are debarred
- Billing for services not rendered
- Billing for a more expensive service, but providing a less expensive service

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

Corrective actions can include, but are not limited to:

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

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

Reporting Fraud, Waste and Abuse

You can report your suspicions of fraud, waste or abuse to the CareSource Program Integrity department. Contact information for reporting fraud, waste and abuse is located at **CareSource.com** > Provider Overview > Education > Fraud, Waste & Abuse, in the “Communicating with CareSource” section on page 7 of this manual and at the end of this section.

The Federal and State False Claims Acts and Other Fraud, Waste and Abuse Laws

Using the False Claims Act (the Act), you can help reduce fraud against the federal government. The Act allows everyone to bring "whistleblower" lawsuits on behalf of the government – known as "qui tam" suits – against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

The False Claims Act addresses those who:

- Knowingly* presents, or causes to be presented, a false or fraudulent claim for payment or approval.
- Knowingly* makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim.
- Conspires to commit a violation of any other section of the False Claims Act.
- 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.
- 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.
- 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.
- 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.

*"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 provider, such as a hospital or a physician knowingly "upcodes" or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.

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 Program Integrity department.

Additional information on the False Claims Act and our fraud, waste and abuse policies can be found on **CareSource.com** > Providers > Education > Fraud, Waste & Abuse.

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).

Indiana has enacted an anti-kickback law that is applicable to the Medicaid program. The law prohibits any person who furnishes items or services to an individual for whom payment is or may be made under the Medicaid program from soliciting, offering, or receiving a kickback or bribe in connection with the furnishing if the items or services or the making or receipt of the payment.

- Under the Federal Stark Law, and subject to certain exceptions, providers are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs (42 U.S.C. §1395nn).
- 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).

Section 6402(a) of the Affordable Care Act established section 1128J(d) of the Social Security Act. Section 1128J(d)(1) of the Act requires a person who has received an overpayment to report and return the overpayment with a written explanation of the reason for the overpayment. An overpayment must be reported 60 days after the date on which the overpayment is identified.

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.

The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, CareSource is required to comply with certain provisions of the DRA. One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Acts, and other state laws regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste, and abuse when handling CareSource business.

Indiana Law

- Indiana has enacted a false claims statute that meets the requirements of Section 1909 of the Social Security Act. Section 1909 provides a financial incentive for a state to enact a false claims statute that is at least as effective in rewarding and facilitating qui tam actions for false claims as those described in the federal False Claims Act.
- Indiana's False Claims and Whistleblower Protection Act applies to any individual or entity that knowingly or intentionally:
  - Presents a false claim to the State for payment or approval;
  - Makes or uses a false record or statement to obtain payment or approval of a false claim from the State;
  - With intent to defraud the State, delivers less money or property to the State than the amount recorded on the certificate or receipt the person receives from the State;

- With intent to defraud the State, authorizes issuance of a receipt without knowing that the information on the receipt is true;
- Receives public property as a pledge of an obligation on a debt from an employee who is not lawfully authorized to sell or pledge the property;
- Makes or uses a false record or statement to avoid an obligation to pay or transmit property to the State;
- Conspires with another person to commit a violation of any other section of the statute; or
- Causes or induces another person to violate any other section of the statute.

Indiana's False Claims and Whistleblower Protection Act may be found at Indiana Code 5-11-5.5-1, et seq.

Incentives for Whistleblowers

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement. Additional information on the False Claims Act can be found at **CareSource.com** > Provider Overview > Education > Fraud, Waste & Abuse.

Prohibited Affiliations

CareSource is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities (42 C.F.R. § 438.610). Relationships must be terminated with any trustee, officer, employee, provider, or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that your corporate entity, those with more than five percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us by emailing ProviderMaintenance@CareSource.com.

Confidentiality

Physicians shall prepare, maintain, and retain as confidential the health records of all members receiving health care services, and members' other personally identifiable health information received from CareSource, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Disclosure of Ownership, Debarment and Criminal Convictions

Before CareSource enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment or suspension status and any criminal convictions related to federal health care programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child, or sibling. Please contact us by emailing ProviderMaintenance@CareSource.com.

If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request.

If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations (CFR) 42 CFR 455.100-106 for more information and definitions of relevant terms.

How to Report Fraud, Waste or Abuse

It is CareSource's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act or any state Medicaid fraud laws. If you have knowledge or information that any such activity may be taking or has taken place, please contact our Program Integrity department. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting anonymously:

- **Call: 1-844-607-2831** and follow the appropriate menu option for reporting fraud
- **Write:**
  CareSource
  Attn: Program Integrity
  P.O. Box 1940
  Dayton, OH 45401-1940

Options for reporting that are not anonymous:

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

Or you may choose to use the **Fraud, Waste and Abuse Reporting Form** located on **CareSource.com** > Providers > Tools & Resources > Forms.

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

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

Physician Education Materials

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

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

FREQUENTLY ASKED QUESTIONS

How can I reach CareSource?

Call Provider Services at **1-844-607-2831** to reach CareSource. Provider Services is available Monday through Friday, 8 a.m. to 8 p.m. Eastern Time (ET). See the “Communicating with CareSource” section on page 7 for more information.

How do I check member eligibility?

It is important to verify member eligibility before providing services. Patients must be eligible CareSource members at the time of service in order for services to be covered.

CareSource offers several ways to check member eligibility, including by phone or our secure Provider Portal.

How do I submit a claim?

CareSource accepts paper and electronic claims. We encourage you to submit electronic claims for quicker processing. Please see the “Claim Submission” section on page 22 for more information.

How do I optimize my claim payment time frame?

Claims submitted electronically are typically received and processed more quickly than paper claims. Providers may submit claims electronically through the CareSource Provider Portal or through Electronic Data Interchange (EDI) clearinghouses listed in the "Claim Submission" section on page 32.

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

How do I file a claim appeal?

We hope you will be satisfied with CareSource and the service we provide. However, providers who are unhappy with CareSource's action concerning a medical necessity decision or a claim payment may appeal it. Please see our "Member Grievance and Appeals" section on page 96 for more information.

Can I bill my CareSource patients?

Generally, providers enrolled in the Indiana Health Coverage Programs (IHCP) can bill members only under certain condition. See the "Member Billing Policy" section in the "Claim Submission" chapter on page 22 for more information about billing CareSource members.

How do I obtain a prior authorization?

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

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

Email: INMedMgt@CareSource.com

Phone: **1-844-607-2831** and follow the appropriate menu prompts for the authorization requests, depending on your need.

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

Is authorization needed to make referrals to specialists?

Some health care services provided by specialists do not require a referral from a primary medical provider (PMP) or dental provider. Members may schedule self-referred services from participating providers themselves, provided the service is covered under their specific plan. PMPs or dental providers do not need to arrange or approve these services for members as long as any applicable benefit limits have not been exhausted.

If you have questions about referrals and prior authorizations, please call our Utilization Management department at **1-844-607-2831**.

What benefits does CareSource offer its members?

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

How do I make a referral?

Follow the steps below 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 PMP. 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.

Standing Referrals – A PMP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period. The specialist may provide services in the same manner as the PMP for chronic or prolonged care. The period must be at least one year to be considered a standing referral.

Treating providers must get prior authorization from our health plan before sending a member to an out-of-plan provider.

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. In accordance with 42 CFR 438.206(b)(3), CareSource complies with all member requests for a second opinion from a qualified professional. If our network does not include a provider who is qualified to give a second opinion, CareSource shall arrange for the member to obtain a second opinion from a provider outside the network at no cost to the member.

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

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

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