WORKING WITH CARESOURCE

HEALTH PARTNER ORIENTATION

INDIANA

CareSource®

About CareSource

CareSource®

Our Mission

MISSION

To make a lasting difference in our members' lives by improving their health and well-being

PLEDGE

- Make it easier for you to work with us
- Partner with providers to help members make healthy choices
- Ensure direct communication
- Offer timely and low-hassle medical reviews
- Ensure accurate and efficient claims payment

Health Care with Heart

MISSION-FOCUSED

Comprehensive, member-centric health, and life services

EXPERIENCED

With over 30 years of service, CareSource is a leading non-profit health insurance company

DEDICATED

We serve over 2.1 million members through our: Medicaid, Marketplace, MyCare, Dual Special Needs Plans (D-SNP), and Arkansas PASSE programs.

Our Indiana Plans

MEDICAID

Children, Pregnant Women, and Low-Income Working Families

Risk-based managed care; Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) populations

MARKETPLACE

Commercial Health Plan

Reduced premiums or cost-sharing; Pediatric Dental & Vision; Optional Adult Dental, Vision, and Fitness

Note: We offer all of our plans in all counties of Indiana.

Working with CareSource

CareSource®

Provider Network & Eligibility

CareSource members choose or are assigned a primary medical provider (PMP) upon enrollment. When referring patients, verify that other providers are in-network to ensure coverage. Use our Find-a-Doc tool at **CareSource.com** to help locate a participating CareSource provider by plan. Indiana Medicaid also offers specialty "self-referral" services where members can seek care from actively enrolled Indiana Health Coverage Programs (IHCP) providers with that specialty type. Providers should refer to the IHCP Provider Reference Modules for detailed information.

OUT OF NETWORK SERVICES

Out-of-network services are NOT covered unless they are emergency services, services covered by the No Surprises Act, services prior authorized by CareSource, or services considered by IHCP as "self referral."

MEMBER ELIGIBILITY

Be sure to ask to see each patient's CareSource member ID to ensure you take his or her plan. Confirm which CareSource plan the member is asking that you accept. Providers can confirm eligibility in our system to validate the member's coverage.

NOTE: For Marketplace members routine dental, vision, and hearing services are covered through DentaQuest, EyeMed, and TruHearing network providers. For HHW/HIP members routine vision services are covered through Superior Vision. Provider eligibility to accept CareSource members can be confirmed in the CareSource Provider Portal.

Provider Directory ***Attestation***

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

CMS requires health plans to verify the accuracy of provider directory information **every 90 days.**

We have partnered with Quest Analytics to streamline your verification process through their **BetterDoctor solution**.

QUEST ANALYTICS BetterDoctor

Completing the Attestation Process:

1. You should receive an email or fax from BetterDoctor
2. Go to: betterdoctor.com/validate
3. Locate the access token on the fax or email you received from BetterDoctor (it is an eight-character alphanumeric code (for example ABC123D4), and it is not case sensitive)
4. Enter the access token
5. Click 'Submit'
6. Verify and update your information using the online tool via the BetterDoctor portal
7. Larger practices can submit rosters directly to Quest Analytics

Issues? Contact **support@betterdoctor.com**

Notification of Pregnancy

IHCP recognized that timely identification of risk factors improves birth outcomes.

The Notification of Pregnancy (NOP) form pinpoints risk factors in the earliest stages of pregnancy for women enrolled in HHW and HIP.

The NOP form may be accessed through the Indiana Provider Healthcare Portal

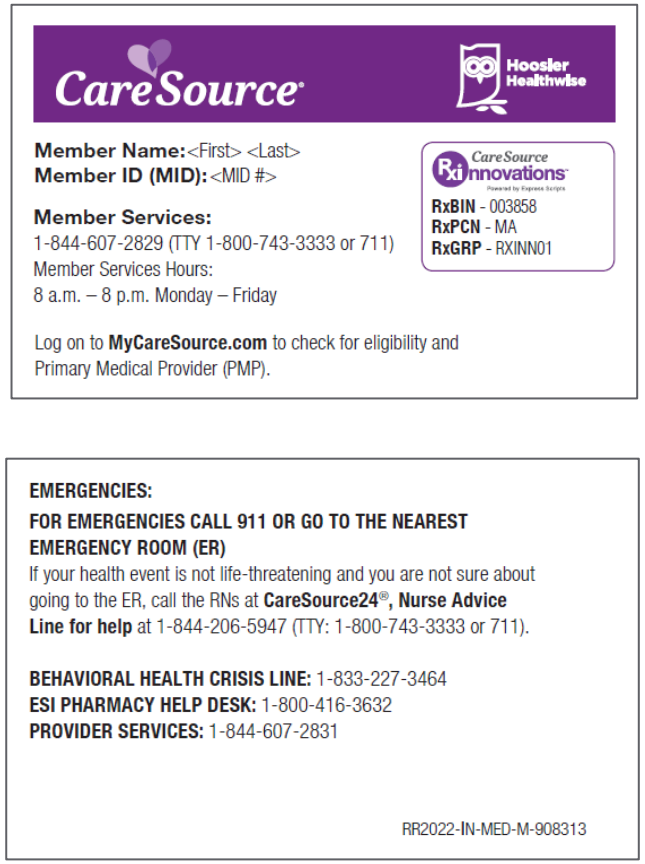
REIMBURSEMENT

A qualified provider is eligible for a $60-$70 reimbursement, limited to one (1) NOP per pregnancy, when successfully completing and submitting the NOP via the IHCP Provider Portal. The submitted information is used by CareSource to determine the risk level associated with the pregnancy and establish areas of follow-up care.

- Submit claim G9997 TH – If the NOP is submitted, providers will be paid $60. If the NOP is submitted within the first trimester, providers are eligible for an additional $10 (total payment of $70).
- The NOP must be submitted via the IHCP Provider Portal no more than five calendar days from the date of the office visit on which the NOP is based.
- The member's pregnancy must be less than 30 weeks' gestation at the time of the office visit on which the NOP is based.
- The member must be enrolled with a managed care entity (MCE) through HIP, or Hoosier Healthwise.
- The NOP cannot be a duplicate of a previously submitted NOP.

ID Cards: Medicaid Members

HOOSIER HEALTHWISE


CareSource
Hoosier Healthwise

Member Name: <First> <Last>
Member ID (MID): <MID #>

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 RxInnovations
Powered by Express Scripts
RxBIN - 003858
RxPCN - MA
RxGRP - RXINN01

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

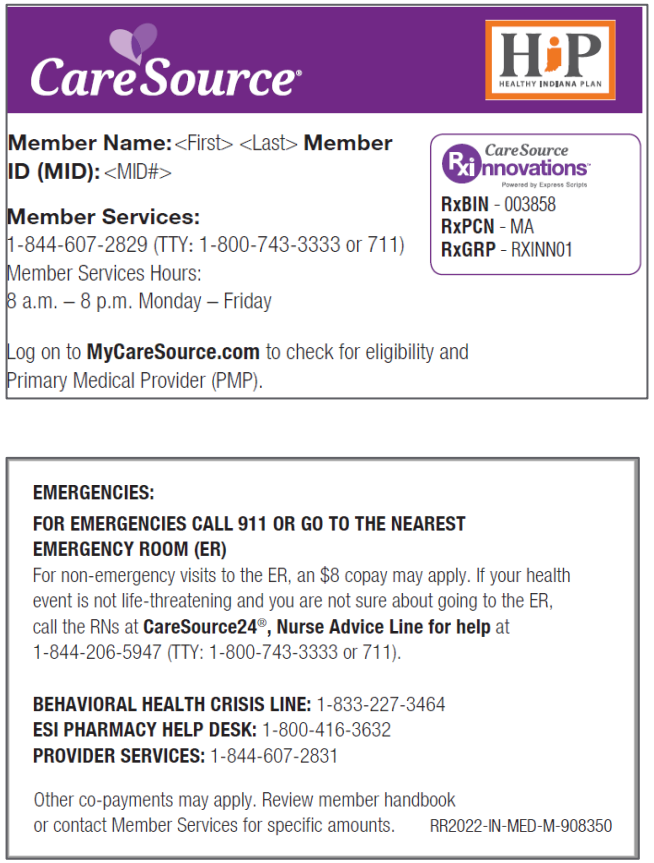
EMERGENCIES:

FOR EMERGENCIES CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM (ER)
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

RR2022-IN-MED-M-908313

HEALTHY INDIANA PLAN


CareSource
HIP HEALTHY INDIANA PLAN

Member Name: <First> <Last> **Member ID (MID):** <MID#>

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

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

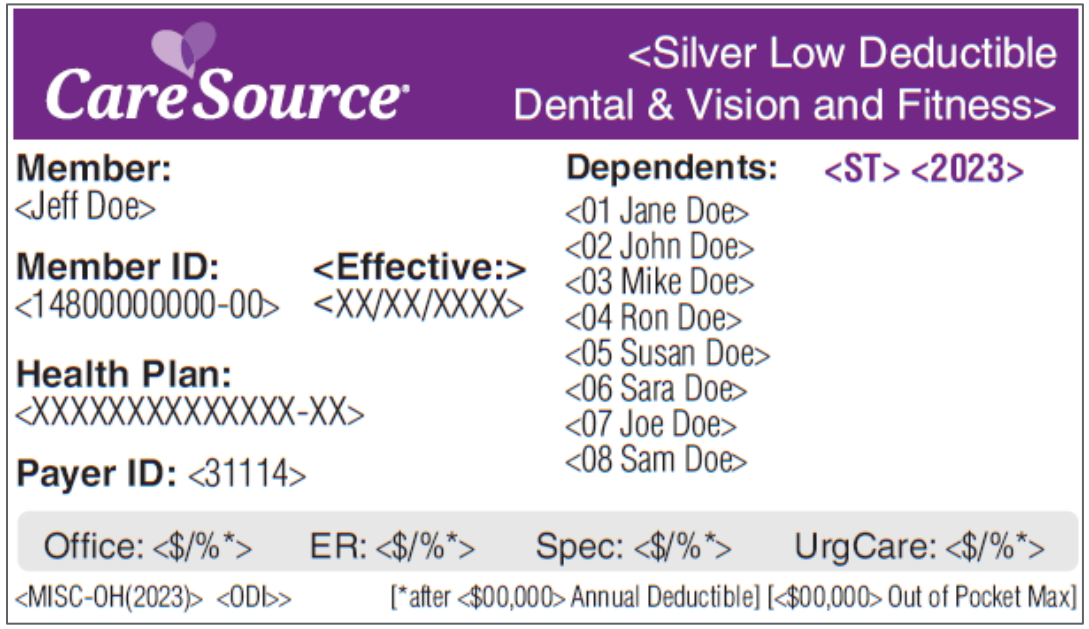
EMERGENCIES:

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. RR2022-IN-MED-M-908350

ID Cards: Marketplace Members



- ✓ Marketplace dependents are indicated by the member ID + dependent suffix (portion after the "-")
- ✓ Example: 14800000000-01

Note: Please make sure you are contracted with the state that the member is enrolled with.

Claim Submissions

To submit claims electronically, health partners must work with an electronic claims clearinghouse. Please provide the clearinghouse with the CareSource payer ID number **INCS1**.

Our exclusive partner is Availity.

For a list of EDI vendors who transmit EDI transactions to Availity EDI Gateway for CareSource transactions, click here.

If your current or desired clearinghouse is not on this list, please contact them to confirm continuity of support for CareSource transactions.

Availity's Client Services can be reached at **1-800-Availity** (1-800-282-4548).

Claim Submissions

CareSource encourages electronic claim submission as the primary submission method. Providers can submit claims through our secure, online Provider Portal at **CareSource.com** > Login > Provider. Here, providers can submit claims along with any documentation, track payments and more. Providers can also upload paper claims for claim submissions on the Provider Portal.

ELECTRONIC CLAIMS SUBMISSION

For electronic data interchange (EDI) transactions, CareSource accepts electronic claims through our clearinghouse, Availity. Providers can find a list of EDI vendors online.

Please Note: All claims should include the National Provider Identifier (NPI) and the correct billing taxonomy code.

ELECTRONIC FUNDS TRANSFER

We partner with ECHO Health for electronic funds transfer (EFT). You must enroll with ECHO Health to participate. Find the enrollment form for ECHO Health online. For questions, call ECHO Support at: 1-888-485-6233.

CLAIMS SUBMISSION TIMELY FILING LIMITS

Medicaid (HHW & HIP) and Marketplace **90 days** from date of service or discharge.

Claim Disputes

DEFINITION

A provider's first response when disagreeing with the adjudication of a claim - this is available to participating and non-participating providers.

All disputes must be:

- Submitted in writing via the CareSource Provider Portal, on paper by accessing the Paper Claims Form via the CareSource Provider Portal at: **CareSource.com** > Provider Portal > Claim Dispute Form
- Submitted within **60 days** after receipt of the Explanation of Payment (EOP) for **Hoosier Healthwise and Healthy Indiana Plan (HIP)**
- Submitted within **90 calendar days** after receipt of the EOP for **Marketplace**
- Submitted and completed **prior** to requesting an appeal

If CareSource fails to render a determination for the dispute **within 30 days** after receipt, an appeal may be submitted.

Claim Appeals

All appeals must be:

- Submitted after completing the dispute process
- Submitted within **60 days** of the resolution of the dispute for **Hoosier Healthwise and HIP**
- Submitted within **365 calendar days of the date of service or discharge**, or as otherwise specified in your contract, for **Marketplace**
- Submitted via the CareSource Provider Portal, fax, or by paper to:

  Claim Appeals Department
  P.O. Box 2008
  Dayton, OH 45401-2008

Claim appeals can be submitted in writing via the CareSource Provider Portal or on paper at: **CareSource.com** > Provider Portal > Paper Claims Form.

Access and Availability

As a CareSource **primary medical provider (PMP)**, you must ensure your practice complies with the following minimum access standards:

- Provide 24-hour availability to your CareSource patients by telephone.
  - Whether through an answering machine or a taped message after hours, patients should have the means to contact their PMP or back-up provider to be triaged for care.
  - It is not acceptable to use a phone message that doesn't provide access to you or your back-up provider and only recommends an emergency room after hours.
- Be available to see members at least three days per week for a minimum of 20 hours per week.
- Provide members telephonic access to the PMP (or appropriate designee) in English and Spanish 24 hours, seven days a week.

Please refer to our Provider Manual at **CareSource.com** > Providers > Tools & Resources > Provider Manual for a complete listing of Access and Availability Standards.

Access and Availability

Primary Medical Providers (PMPs) **Medicaid Members** **Marketplace Members**

Type of Visit	Should be seen…	Should be seen…
Emergency needs	Immediately	Immediately
Urgent care*	Within 48 hours	Within 48 hours
Regular and routine care	Not to exceed 15 calendar days	Not to exceed 6 weeks

*Providers should see members as expeditiously as their condition and severity of symptoms warrant. It is expected that if a provider is unable to see the member within the designated time frame, CareSource will facilitate an appointment with another participating provider, or a non-participating provider, when necessary.

Access and Availability

Non-PMP Specialists	Medicaid Members	Marketplace Members
Type of Visit	**Should be seen…**	**Should be seen…**
Emergency needs	Immediately	Immediately
Urgent care*	Not to exceed 48 hours	Not to exceed 48 hours
Regular and routine care	Not to exceed 30 calendar days	Within 30 business days

*Providers should see members as expeditiously as their condition and severity of symptoms warrant. It is expected that if a provider is unable to see the member within the designated time frame, CareSource will facilitate an appointment with another participating provider, or a non-participating provider, when necessary.

Access and Availability

Behavioral Health Providers	Medicaid Members	Marketplace Members
Type of Visit	**Should be seen…**	**Should be seen…**
Emergency needs	Immediately	Immediately
Non-life-threatening emergency*	Not to exceed 6 hours	Not to exceed 6 hours
Urgent care*	Not to exceed 48 hours	Not to exceed 48 hours
Initial visit for routine care	Not to exceed 10 business days	Not to exceed 10 business days
Follow-up routine care	Not to exceed 30 calendar days	Not to exceed 30 calendar days

*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 health care providers and behavioral health providers.

Hospice Coverage

HIP members receive hospice coverage except for institutional hospice which is only covered in Fee-for-Service (FFS).

HHW members must be disenrolled from managed care in order to receive hospice services. The state of Indiana administers this benefit. The member must be enrolled in traditional Medicaid.

CareSource coordinates with IHCP health partners to provide any information needed to complete the hospice election form for the member.

Members must fill out **Medicaid Hospice Election State Form 48737** to enter hospice care.

For more details regarding hospice provider enrollment, member eligibility, election/discharge, authorizations, billing and more, please refer to the **IHCP "Hospice Services" Provider Reference Module.**

Power Account

HIP Plus members are required to pay for their first $2,500 of covered services out of a Personal Wellness and Responsibility (POWER) account. The state will contribute most of the required amount, plus members will also be responsible for making a small contribution to their account each month. The amount of a member's contribution is based on income.

HIP Basic Copayments

HIP Basic members are required to make the following copayments at the time services are rendered:

$4 copayment for outpatient services, including non-routine office visits

$75 copayment for inpatient services

$4 copayment for preferred drugs

$8 copayment for non-preferred drugs

*An emergency room visit does not require a copay, unless it is non-emergent:

- $8 copayment for each non-emergency emergency room (ER) visit.
- No copayment is required for preventive care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, or family planning services.

School-Based Clinics

- Services designated for HHW members
- Support care coordination efforts between school-based clinics and PMPs
- Coordinate health services with schools for members with individualized education plan (IEP) services
- Reimburse school clinics for providing medically necessary covered services

Access more information at **CareSource.com** > Login > Providers.

Member Communication

HELP YOUR CARESOURCE PATIENTS UNDERSTAND THEIR COVERAGE.

Encourage your patients to visit **CareSource.com/IN**, where they can access:

- MyCareSource.com Member Portal
- Searchable online formulary and prescription cost calculator
- Find-a-Doc tool
- Evidence of Coverage & Schedule of Benefits
- Member Handbook
- Benefit Cost Estimator (only available through the Member Portal)
- Forms and more

For more information, visit: **CareSource.com/members.**

Communicating with Us

	Medicaid	Marketplace
Provider Services	**1-844-607-2831**	**1-833-230-2101**
Hours	Monday – Friday 8 a.m. to 6 p.m. Eastern Time (ET)	
Member Services	**1-844-607-2829**	**1-833-230-2099**
Hours	Monday – Friday 7 a.m. to 7 p.m. ET Please note: From Oct. 1 – Feb. 1 we are open the same hours, seven days a week.	

Provider Portal

CareSource®

CareSource Provider Portal

SAVE TIME AND MONEY

With CareSource's secure online Provider Portal, you can:

✓ Check member eligibility and benefit limits	✓ Submit claims and verify claim status
✓ Find prior authorization requirements	✓ Verify or update Coordination of Benefits
✓ Submit prior authorization requests and check status	✓ And more!

Access the Provider Portal 24 hours a day, seven days a week at **CareSource.com** > Login > Provider.

Register for the Provider Portal

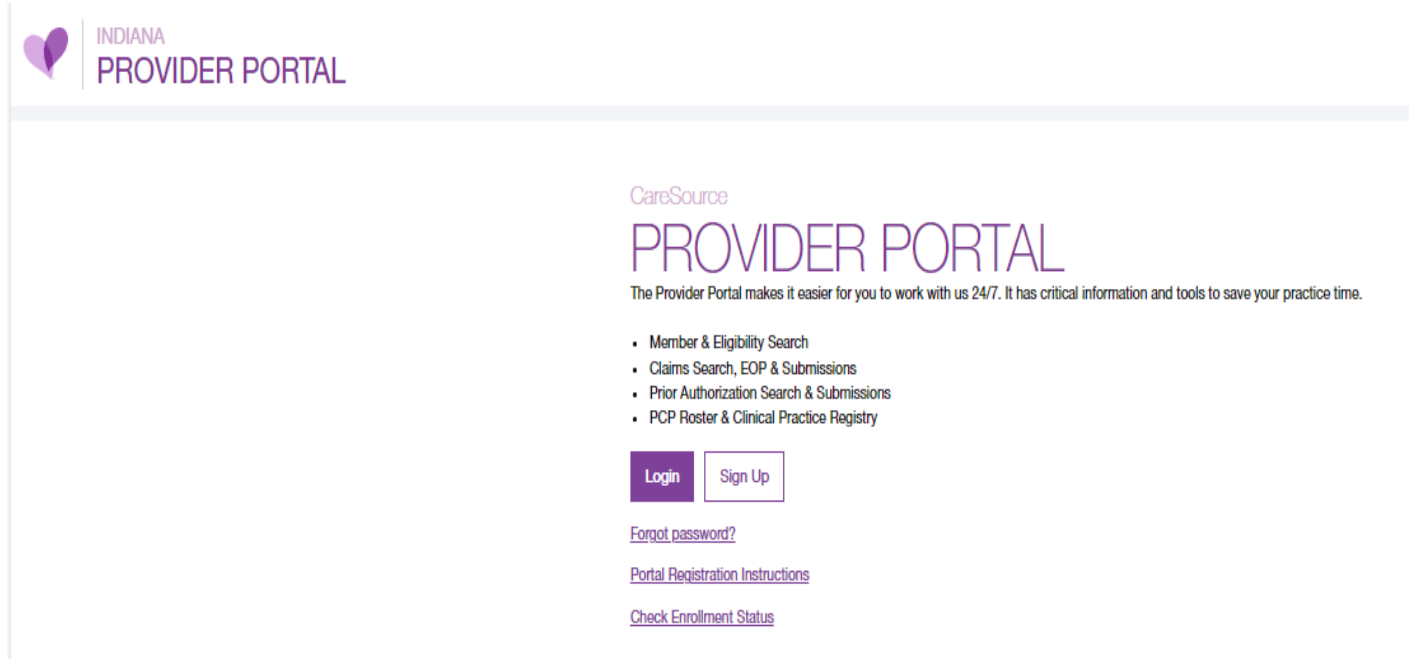
Go to **CareSource.com.** Click Provider from the Log-in drop-down.

Select **Indiana.**

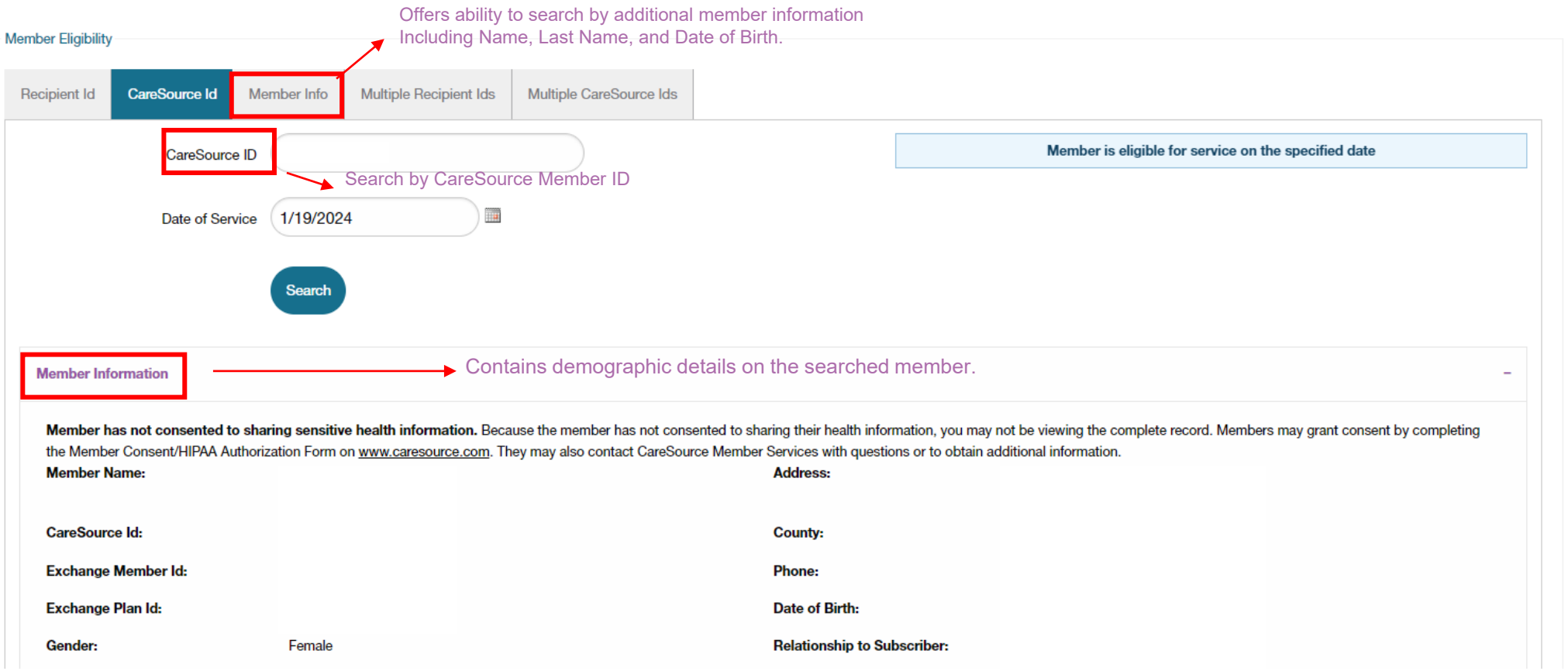
Click Register For an Account under **Provider Portal Login.**

Enter your information, including your CareSource Provider Number (located in your welcome letter).

Follow remaining steps to register.

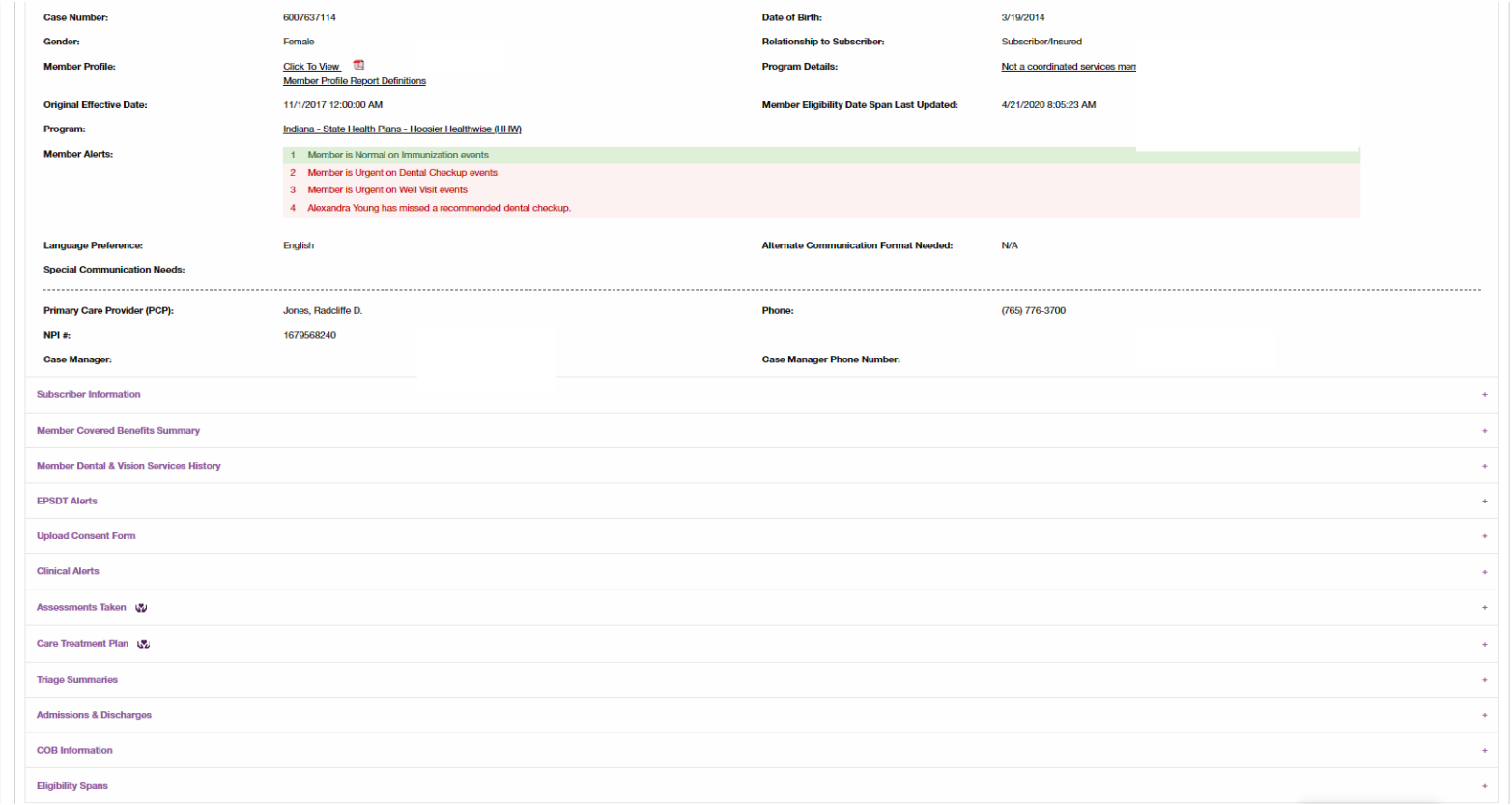


Member Eligibility



Note: Image subject to change due to Provider Portal updates.

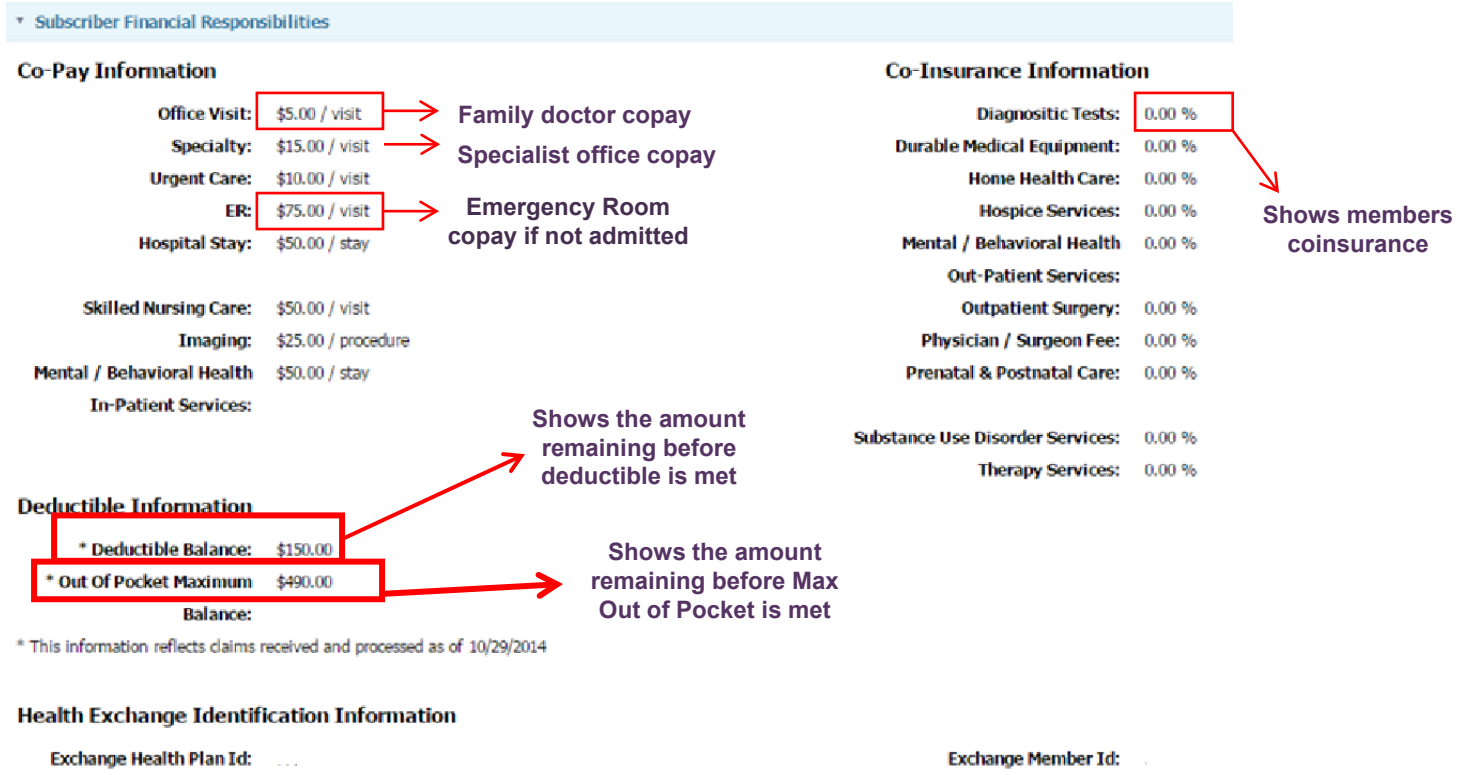
Member Eligibility – Current



Note: Image subject to change due to Provider Portal updates.

Member Benefits

Marketplace Providers



Note: Image subject to change due to Provider Portal updates.

Member Benefits
Marketplace Providers

Member Covered Benefits Summary

Member Out-Of-Pocket Summary *

*** This information reflects claims received and processed as of 1/18/2024**

Deductible Balance:

$700.00 Remaining
of $700.00 Individual / $1,400.00 Family

Out Of Pocket Maximum Balance:

$3,000.00 Remaining
of $3,000.00 Individual / $6,000.00 Family

Benefit Service Limits Consumed *

*** This information reflects claims received and processed as of 1/18/2024**

Maximum Benefits Limits:

Annual Mammography Screening (Age >39) 1/year MOD 26	**1/1 Remaining**	Cardiovascular Disease Risk Reduction 1/yr	**1/1 Remaining**
Chiropractic Services	**12/12 Remaining**	Colorectal Cancer Screening 1/yr	**1/1 Remaining**
DME - Wigs	**1/1 Remaining**	Habilitative Services OT	**20/20 Remaining**
Habilitative Services PT	**20/20 Remaining**	Habilitative Services ST	**20/20 Remaining**
Home Health excludes Infusion 100 per yr	**100/100 Remaining**	Inpatient Rehab Therapy	**60/60 Remaining**
Lung Cancer Screening	**1/1 Remaining**	Lung Cancer Screening (LCST) - 1/Yr	**1/1 Remaining**
Lung Cancer Screening (LDCT) - 1/Yr	**1/1 Remaining**	Lung Cancer Screening 1 Per Year	**1/1 Remaining**
Mammogram Screening (Professional) 40 - 99 years of age	**1/1 Remaining**	Occupational Therapy, Outpatient	**20/20 Remaining**
Physical Therapy Outpatient	**20/20 Remaining**	Preventive Semiannual high intensity behavioral counseling	**1/1 Remaining**
Pulmonary Therapy - Rehabilitative Respiratory Therapy	**20/20 Remaining**	Screening - Prostate Cancer Screening 1/yr	**1/1 Remaining**
Screening Pap Tests 1/yr	**1/1 Remaining**	Skilled Nursing Services	**90/90 Remaining**
Smoking/Tabacco Use Screening / Cessation	**8/8 Remaining**	Speech Therapy, Outpatient	**20/20 Remain**

Marketplace Member – Financial Responsibility

ANNUAL DEDUCTIBLE, COPAYMENTS & COINSURANCE

These costs are applicable for most covered services. It is up to the provider to collect these amounts at the time of service.

BALANCE BILLING

A participating provider **may not** balance bill CareSource members for covered services.

Balance billing is when a provider bills the patient for the difference between the provider's charge and the allowed amount. For example, if the provider charges $100, and the allowed amount is $70, the provider is unable to bill the patient for the remaining $30.

For HHW and HIP, the following are not permitted:

- Balance billing a member for a Medicaid-covered service
- Billing a member in emergency situations

To charge a member for non-covered services, provider must disclose in writing the following:

- Service to be rendered is not covered by Medicaid
- Whether procedures or treatments that are covered by Medicaid are available in lieu of non-covered services
- The provider must offer, on a disclosure form, the member's willingness to accept the financial responsibility of the non-covered service, the amount to b charged for the non-covered service and the specific date the service is to be performed
- Documentation must be signed by the member prior to rendering the specific non-covered service

Marketplace Member – Financial Responsibility

GRACE PERIOD

Members have a federally mandated 90-day grace period if they are receiving Advanced Premium Tax Credit (APTC), or a 31-day grace period if they are not receiving APTC in which to make their payment.

- Not applicable for their initial payment
- For APTC-receiving members, 30 days after their due date CareSource will
  - Flag the member in the eligibility file and on the Provider Portal
  - Suspend pharmacy benefits, and pend claims rendered
- For non-APTC members, the day after their due date, CareSource will:
  - Flag the member in the eligibility file and on the Provider Portal
  - Suspend pharmacy benefits, and pend any claims rendered

If members bring their account into good standing before the expiration of the grace period, pharmacy benefits will start again, and pended claims will be processed.

TERMINATION

After the grace period has expired, the member is terminated for non-payment of premium.

- CareSource will retroactively terminate the member to either the last day of the first month of the grace period (APTC) or the last paid date (non-APTC).
- CareSource will then deny any claims that are pended during the grace period and reserves the right to recover any amounts paid in this period.

Member Billing

BALANCE BILLING

State and federal regulations prohibit providers from billing CareSource members for services provided to them except under limited circumstances. CareSource monitors this activity based on our reports of billing from members. We will implement a stepped approach in working with our providers to resolve any member billing issues that includes notification of excessive member complaints and education regarding appropriate practices.

For HHW and HIP, the following are not permitted:

- Balance billing a member for a Medicaid-covered service
- Billing a member in emergency situations

To charge a member for non-covered services, provider must disclose in writing the following:

- Service to be rendered is not covered by Medicaid
- Whether procedures or treatments that are covered by Medicaid are available in lieu of non-covered services
- The provider must offer, on a disclosure form, the member's willingness to accept the financial responsibility of the non-covered service, the amount to be charged for the non-covered service and the specific date the service is to be performed
- Documentation must be signed by the member prior to rendering the specific non-covered service

Failure to comply with regulations after intervention may result in potential termination of your agreement with CareSource.

Provider Portal Training

Please access the *Provider Education Series: Provider Portal* presentation to learn more about our portal's functionality and how to work with us through the portal's many self-service features.

Visit **CareSource.com** > Providers > Trainings and Events to access the training.

USER GUIDE

https://www.caresource.com/documents/in-caresource-portal-user-submission-guide/

Covered Benefits & Services

CareSource

Covered Services

BENEFITS OVERVIEW

PMP and specialist office visits
Emergency services
Inpatient hospital
Mental health and substance use disorder services
Urgent care
Diagnostic services (lab, radiology)
Preventative services (routine well-visits and screenings)
Maternity services
Pharmacy
Vision services (except HIP Basic)
Dental services
Chiropractic care (except for HIP Basic)

ENHANCED BENEFITS

Life Services
Non-emergent transportation (additional above NET, for certain special populations in Medicaid)
Wellness
Incentives for well-care, preventive screenings, tobacco cessation, prenatal care, and more
Medication therapy management
Infant scales for eligible HIP and HHW members
Adult dental, vision, and fitness for Marketplace

Services Not Covered

Medically unnecessary services
Services received from a non-participating provider, with specific exceptions
Experimental or investigational services
Alternative or complimentary medicine
Cosmetic procedures
Assisted reproductive therapy
Maintenance therapy treatments
Routine dental services and eyewear not provided by a DentaQuest or EyeMed provider (Marketplace only)
Routine hearing services and hearing aids not provided by a TruHearing provider (Marketplace only)

For more details on each plan's covered services, visit **CareSource.com**

Supplemental Benefits Overview

ABOUT OUR BENEFIT MANAGERS

CareSource partners with select vendors to provide expanded benefits and services, including expertise in the services and broadened networks. **These are exclusive relationships for the services considered** – meaning our members must use a provider within the benefit manager's network for CareSource to contribute. See **CareSource.com** for a full listing of benefits in the Marketplace plan.

Marketplace Plan Supplemental Benefits

Benefit Category	Eligible Members	Services	Benefit Overview	Member Contact
Routine Dental (DentaQuest)	✓ All pediatric members (until the end of the month they turn 19) ✓ Adults 19+ years of age on dental & vision plans	▪ Member Services ▪ Provider network ▪ Claims adjudication ▪ EOBs	Preventive, diagnostic, restorative, comprehensive and medical necessary orthodontics for pediatric only	**855-209-3945**

Note: You may refer your CareSource patients to these vendors using the numbers provided above.

HIP Maternity Benefits

HIP Maternity: This benefit plan offers access to all benefits available under the State Plan, with no cost-sharing, to pregnant women who are enrolled in or determined eligible for HIP. During the member's pregnancy and 12 months postpartum period, HIP Maternity offers enhanced benefits including vision, dental, and chiropractic services; nonemergency transportation; and enhanced smoking cessation services.

HIP Maternity does not mimic Presumptive Eligibility for Pregnant Women (PEPW) or emergency services with coverage for pregnancy, which only covers emergent and pregnancy-related services. For additional information about Presumptive Eligibility benefits, visit the state's Provider Reference Module.

QUESTIONS?

Please contact CareSource Provider Services at **1-844-607-2831** or reach out to your Health Partner Engagement Specialist.

CareSource Benefit Information

VISIT CARESOURCE.COM FOR MORE DETAILS ON:

Medicaid Plan Benefits
CareSource.com > Medicaid > Benefits & Services > Medical Benefits
Marketplace Plan Benefits
CareSource.com > Marketplace > Benefits & Services > Medical Benefits

Prior Authorizations

CareSource®

Prior Authorization Services

Some services requiring prior authorization include:

- Most services provided out of network
- Partial hospitalization programs
- Advanced diagnostic imaging through NIA Magellan (i.e., PET, MRI, MRA, CT/CTA, CCTA, etc.)
- Skilled nursing facilities
- Home infusion therapy
- Accidental dental (reconstruction due to accident)
- Pain management services
- Behavioral health: inpatient and outpatient services including alcohol and substance use, intensive outpatient treatment, transcranial magnetic stimulation, SUD residential, and applied behavioral analysis (ABA)

HHW/HIP

- Purchase or rental of specified medical supplies, durable medical equipment (DME) supplies, or appliances
- Some orthotics and prosthetics

Marketplace

- Purchase or rental of specified medical supplies, DME supplies or appliances
- Orthotics and prosthetics

For more information, please see the CareSource Prior Authorization List.

Please Note: The above list is not all-inclusive. Prior authorization of a service does not guarantee payment. Log in to the Provider Portal at **CareSource.com** > Login > Provider to view a more comprehensive list of covered services and limitations. Please monitor network notifications for changes that may occur to the prior authorization (PA) list.

Prior Authorization NIA Magellan Imaging

CareSource utilizes NIA Magellan to implement a radiology benefit management program for outpatient advanced imaging services.

Procedures Requiring PA Through NIA	Services Not Requiring PA through NIA	NIA Magellan Authorization Phone Number
• CT/CTA • MRI/MRA • PET Scan	• Inpatient advanced imaging services • Observation setting advanced imaging services • Emergency room imaging services	• Medicaid: **1-800-424-4883** • Marketplace: **1-800-424-5660**
NIA Magellan Customer Service: 1-410-953-1042 | mamurphy@magellanhealth.com		

Expedited authorizations are accepted. Register at: RadMD.com.

More resources on NIA Magellan imaging may be found at **CareSource.com/Providers**.

Procedure Code Lookup Tool

PRIOR AUTHORIZATIONS

CareSource evaluates prior authorization requests based on medical necessity, medical appropriateness, and benefit limits.

COVERED SERVICES AND PRIOR AUTHORIZATION REQUIREMENTS

Please access our covered services and prior authorization requirements to check what services require prior authorization.

Please refer to the Procedure Code Lookup Tool at **CareSource.com** > Providers > Procedure Code Lookup Tool to check whether a service requires prior authorization. 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.

Prior Authorization Submissions

	Medicaid	Marketplace
Online	At **CareSource.com** through the Provider Portal	At **CareSource.com** through the Provider Portal
Phone	**1-844-607-2831**	**1-833-230-2101**
Fax	844-432-8924	888-716-9480
Mail	CareSource Attn: IN Utilization Management P.O. Box 1307 Dayton, OH 45401-1307	

Prior Authorization Information Checklist

PRIOR AUTHORIZATION SUBMISSION REQUIREMENTS

- Member/patient name and CareSource member ID number
- Provider name, National Provider Identifier (NPI), Tax Identification Number (TIN)
- Anticipated date(s) of service
- Diagnosis code and narrative
- Procedure, treatment, or service(s) requested
- Number of visits/units requested, if applicable
- Reason for referring to an out-of-plan provider if applicable
- Clinical information to support the medical necessity of a service
- Inpatient services need to include whether the service is elective, urgent, or emergency, admitting diagnosis, symptoms, and plan of treatment

Note: We **do not** require a referral to see a patient. However, prior authorizations may still be requested for services provided by specialists.

Note: The IHCP Universal PA form is required for all faxed Medicaid PA requests.

You can find more information on prior authorizations in our Provider Manual, located at **CareSource.com** > Providers > Tools & Resources > Provider Manual.

Self-Referral Services

CareSource includes self-referral health partners in our network. For both HHW and HIP, members may self-refer to any IHCP-enrolled provider for the following services eligible for self-referral:

- Chiropractic
- Diabetes self-management
- Emergency
- Eye care services (except surgical services)
- Family planning
- Immunizations
- Podiatry
- Psychiatric services
- Urgent care

HHW & HIP MEMBERS

- Must go to an in-network health partner OR receive PA from CareSource to go to an out-of-network health partner for nonpsychiatric behavioral health services.

The Indiana Administrative Code, 405 IAC 5 (Hoosier Healthwise) and 405 IAC 9-7 (Healthy Indiana Plan) provide further detail.

Care Management & Quality

CareSource®

Care & Disease Management

CARE MANAGEMENT

Our care management approach includes:

- Providing education on chronic and acute illness
- Creating personalized programs to address barriers
- Helping connect your patient to community supports
- Explaining benefits and services
- Ensuring after-hours support

Providers can refer patients for care management by calling **1-844-607-2831** (Medicaid) and **1-833-230-2101** (Marketplace). Members can also be referred via the Provider Portal. Providers can also refer members with high-risk pregnancy to Mom and Baby Beginnings at: **1-833-230-2034** and children needing neonatal intensive care to the NICU team at: **1-833-230-2036.**

DISEASE MANAGEMENT

If you have a patient with a chronic condition such as asthma, diabetes, or hypertension who you believe would benefit from a program and is not currently enrolled, please call **1-844-438-9498.**

MEMBER EDUCATION

- MyHealth online self-management tool
- Disease-specific newsletters
- Coordination with outreach teams who provide topic-specific information
- One-to-one care management (if members qualify)

Tobacco Cessation

TOBACCO CESSATION PROGRAM

To help members maintain a healthy lifestyle, CareSource would like to remind providers of resources available for tobacco cessation. This includes not using tobacco products as well as prevention. The Indiana Tobacco Quitline aims to increase members' knowledge of the risks associated with tobacco use and the benefits of cessation. The program provides regular health coaching as well as information on how to obtain pharmacotherapy from a provider, to assist with quitting. For tobacco cessation assistance, contact the Indiana Tobacco Quitline at **1-800-QUIT NOW** (1-800-784-8669) or go to http://www.quitnowindiana.com.

To support our providers to help Hoosiers quit smoking, CareSource is offering a monetary incentive to eligible providers for qualifying services. Please refer to the Tobacco Dependence Counseling Provider Incentive network notification for additional information.

Access the Tobacco Cessation Toolkit here.

Cultural Competency

Providers are expected to provide services in a culturally competent manner, including:

- Removing all language barriers to service
- Accommodating unique cultural, ethnic and social needs of members
- Understanding the social determinants of health are recognized as significant contributors to member health outcomes and quality of life
- Meeting the requirements of all applicable state and federal laws, including contractual requirements

RESOURCES

Cultural competency training resources are available on the Training and Events page and in the Provider Manual on the provider website at **CareSource.com**. The National Culturally and Linguistically Appropriate Services (CLAS) Standards provide specific guidelines on developing a culturally competent practice.

CareSource Health Equity Commitment

At CareSource, we are dedicated to the communities in which we serve and in making a positive impact in the lives of our members by eliminating health disparities, supporting our organization's health equity initiatives, and partnering with community stakeholders to carry out this much needed work.

LIFE SERVICES

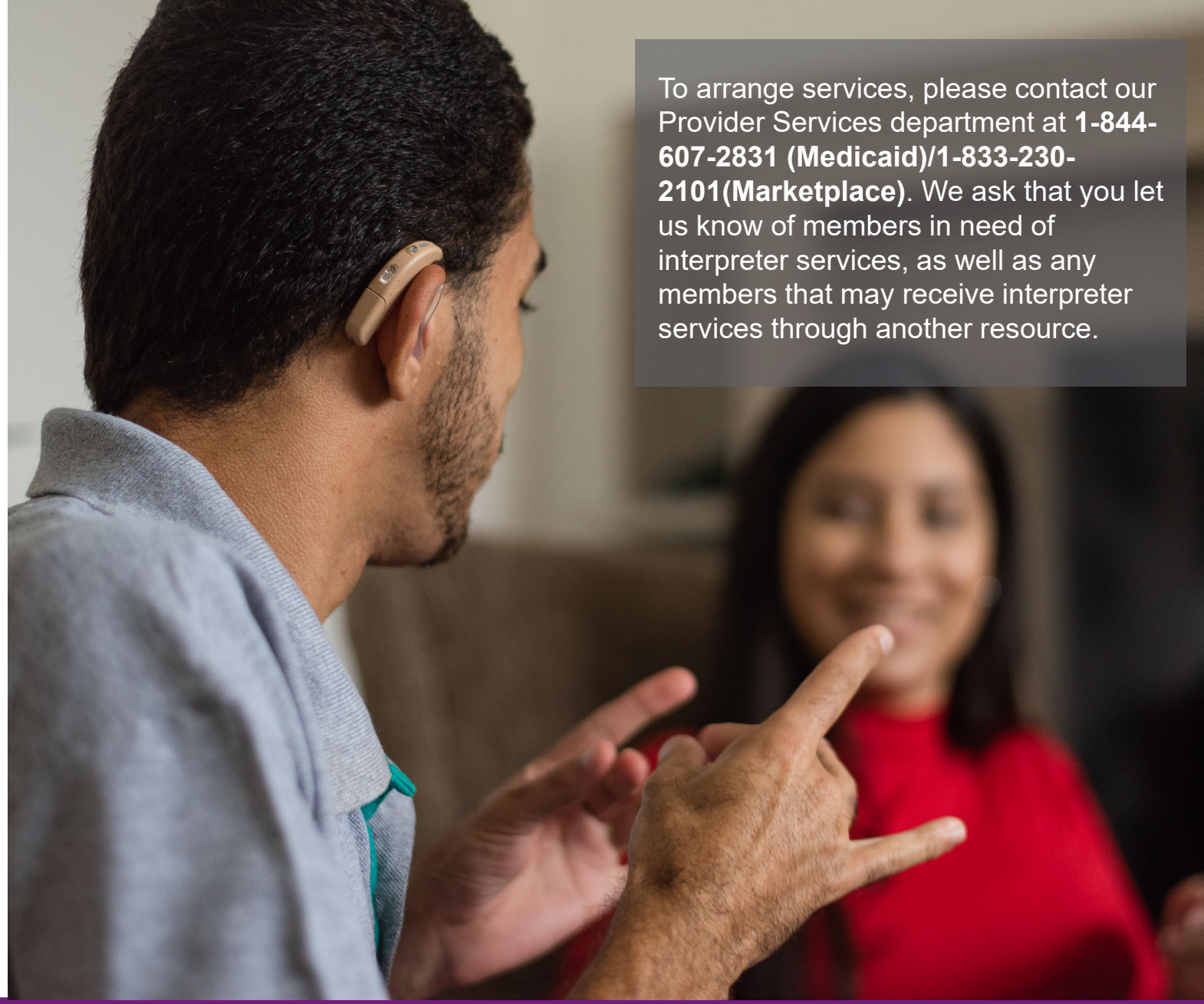
Our enterprise Life Services department is dedicated to serving marginalized communities and to making a positive impact in the lives of diverse member populations to eliminate health disparities.

Life Services is taking an integrated approach to health equity and embedding it across CareSource. As a result, we have developed our objectives based on Pillars of Life Services:

- **Workforce Development**: promote long-term employment opportunities, financial literacy, connection to job training, and increasing assets such as home ownership
- **Housing**: increase the quality of safe and affordable housing, enhanced financial tools to develop and preserve housing units, and improved affordability of housing
- **Food & Nutrition**: regular and consistent access to healthy foods, education on nutrition, and overall health impacts, addressing food deserts and inequalities
- **Health Equity**: pursuit of Health Equality for Black, Indigenous and People of Color (BIPOC), LGBTQIA+, and complex populations; elimination of health disparities, partnerships with outside organizations, drive policy, and advocate for change

Translation Services

- Sign and Language Interpretation
- CareSource offers onsite sign and language interpreters as well as over-the phone (OPI) and video remote interpreting (VRI) Services are available to CareSource members who are hearing impaired, do not speak English or have limited English-speaking proficiency
- 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 to offer assistance appropriately



To arrange services, please contact our Provider Services department at **1-844-607-2831 (Medicaid)/1-833-230-2101(Marketplace)**. 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.

Quality Improvement Patient Safety Program

CareSource recognizes that patient safety is the cornerstone of high-quality health care contributing to the overall health and welfare of our members. Our CareSource Patient Safety Program evaluates patient safety trends with the goal of reducing avoidable harm.

Our Patient Safety Program is developed in the context of our Population Health Management approach and includes:

- Regulatory/Accreditation
- Policies & Procedures
- Training & Implementation
- Continuous Monitoring
- Program Evaluation & Improvement

Safety events are monitored through retrospective review of Quality of Care concerns and real-time reporting of claims data. Data analysis of our provider and health system network ensures situational risks can be identified in a timely manner, reviewed and mitigated by proactive corrective action or performance improvement steps.

Quality Measures

HEDIS® MEASURES

CareSource monitors member quality of care, health outcomes, and satisfaction through the collection, analysis and the annual review of the Healthcare Effectiveness Data and Information Set (HEDIS).

HEDIS includes a multitude of measures that look at different domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Data Systems

Visit our Quality Improvement page for HEDIS Coding Guides.

POTENTIAL HEDIS MEASURES

Wellness & Prevention

- Childhood vaccinations
- Immunizations for adolescents
- Lead screenings for children
- Breast cancer and cervical cancer screenings
- Colorectal cancer screening

Cardiovascular Diabetes Conditions

- Controlling high blood pressure
- Comprehensive diabetes care
- Kidney Health Evaluation for patients with diabetes

Behavioral Health

- Follow-up after Hospitalization for Mental Illness (FUH)
- Follow-up care for children prescribed attention deficit/hyperactivity disorder (ADHD) medications

Access to Care

- Children and adolescents' access to PMPs
- Annual dental visit
- Prenatal and postpartum care

Quality Measures

CAHPS® & QHPEE MEASURES

CareSource also monitors Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and Qualified Health Plans Enrollee Experience (QHPEE) for Marketplace plans.

POTENTIAL QHP MEASURES

- Access to Care
- Access to Information
- Care Coordination
- Ratings of Health Care, Health Plans, Personal Doctors, and Specialists

POTENTIAL CAHPS MEASURES

Customer Service

- Providing necessary information and service
- Providing courteous and respectful service

Getting Care Quickly

- Ease in getting necessary care, tests, or treatment
- Getting appointment with specialists as soon as needed

Getting Needed Care

- Ease in getting care for illness as soon as needed
- Getting non-urgent appointment as soon as needed

Ratings of All Health Care Plans, Doctors & Specialists

- Rating of all health care
- Rating of personal doctor
- Rating of specialist
- Rating of health plan

Doctor Communication

- Understandable explanations
- Careful listening
- Demonstrating respect

Value-Based Reimbursement Program

Provider incentives are available through our Value-Based Reimbursement Programs. Providers participating in a Value-Based Reimbursement Program are eligible to earn incentives for providing preventative care and other initiatives identified by CareSource contributing to increased quality of care.

- CareSource monitors preventative care HEDIS measures to ensure a high-quality of care for our members. Members who have not met their preventative care visits are identified and considered a “gap”. CareSource would like to close these gaps and offer an incentive payment to providers who are able to assist us and complete the necessary services.
- If you have any questions or are interested in this program, please contact your Health Partner Engagement Specialist.

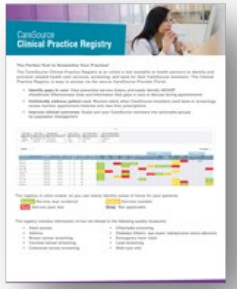
Quality ***Resources***

Quality Onboarding Training

CAHPS Survey Tips

Clinical Practice Registry Training

HEDIS Coding Guides



Clinical Practice Registry Quick Tips

Clinical Practice Guideline Information

Clinical Practice Registry

The **CareSource Clinical Practice Registry** is an online tool available to providers to identify and prioritize needed health care services, screenings and tests for their CareSource members. It is easy to access via the secure CareSource Provider Portal.

The registry includes information on, but not limited to, the following measures:

- Adult access
- Asthma
- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- Diabetes (HbA1c, eye exam, kidney/urine micro-albumin)
- Emergency room visits
- Lead screening
- Well-care visits

Identify Gaps in Care

View preventive service history and easily identify HEDIS gaps in care to discuss during appointments

Holistically Address Patient Care

Receive alerts when CareSource members need tests or screenings, review member appointment histories, and view their prescriptions

Improve Clinical Outcomes

Easily sort your CareSource members into actionable groups for population management

Note: CareSource provides performance reports for these metrics to enhance practice procedures. Reports can be exported to PDF or Excel files for enhanced use.

Telehealth Overview

The landscape of telehealth has evolved during the COVID-19 pandemic and recent policy changes have expanded the use of telehealth.

- Providers should code telehealth claims as if the visit has occurred in the office and include the appropriate CPT/CPT II code, procedure code, modifier, and point of service (POS) code.
- Please note that an in-office visit continues to be the preferred standard of care. An in-person exam should occur at the next scheduled visit when possible.

For additional information, please visit **CareSource.com** > Tools & Resources > Updates & Announcements.

Use the following link to access IHCP's provider updates regarding telehealth:
https://www.in.gov/medicaid/providers/provider-references/news-bulletins-and-banner-pages/

Medical Records

You 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 record standards are consistent, to the extent feasible, with NCQA accreditation standards for medical records.

STANDARDS

For full medical record standards, please see the Provider Manual at **CareSource.com** > Provider > Provider Manual.

Fraud, Waste & Abuse

Help CareSource stop fraud.
Contact us to report any suspected fraudulent activities.

CALL Provider Services

- Medicaid: **1-844-607-2831**
- Marketplace: **1-866-286-9949**

FAX 800-418-0248

EMAIL fraud@caresource.com

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

Behavioral Health & Pharmacy

CareSource®

Behavioral Health Overview

SUPPORTING MEMBERS WITH SUBSTANCE USE & MENTAL HEALTH DISORDERS

We provide resources to help providers take action:

Online drug formulary – our easy-to-use tool helps you facilitate care for our members in all substance use clinical scenarios

Controlled medications

- Buprenorphine
- Vivitrol
- Naloxone

Medication Assisted Treatment (MAT) program – the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders

Online toolkits – find resources to support you and help you find the best practices in behavioral health treatment, such as tobacco cessation, substance use disorder, opioid use, depression, suicide prevention, and ADHD

Controlled substance report – a tool to provide awareness of controlled substance over-prescribing

Addiction line – allows members to speak with a CareSource staff member who can answer questions related to addiction and assist members in finding available treatment options

Additional Behavioral Health *Resources*

BEHAVIORAL HEALTH MEMBER PROFILE

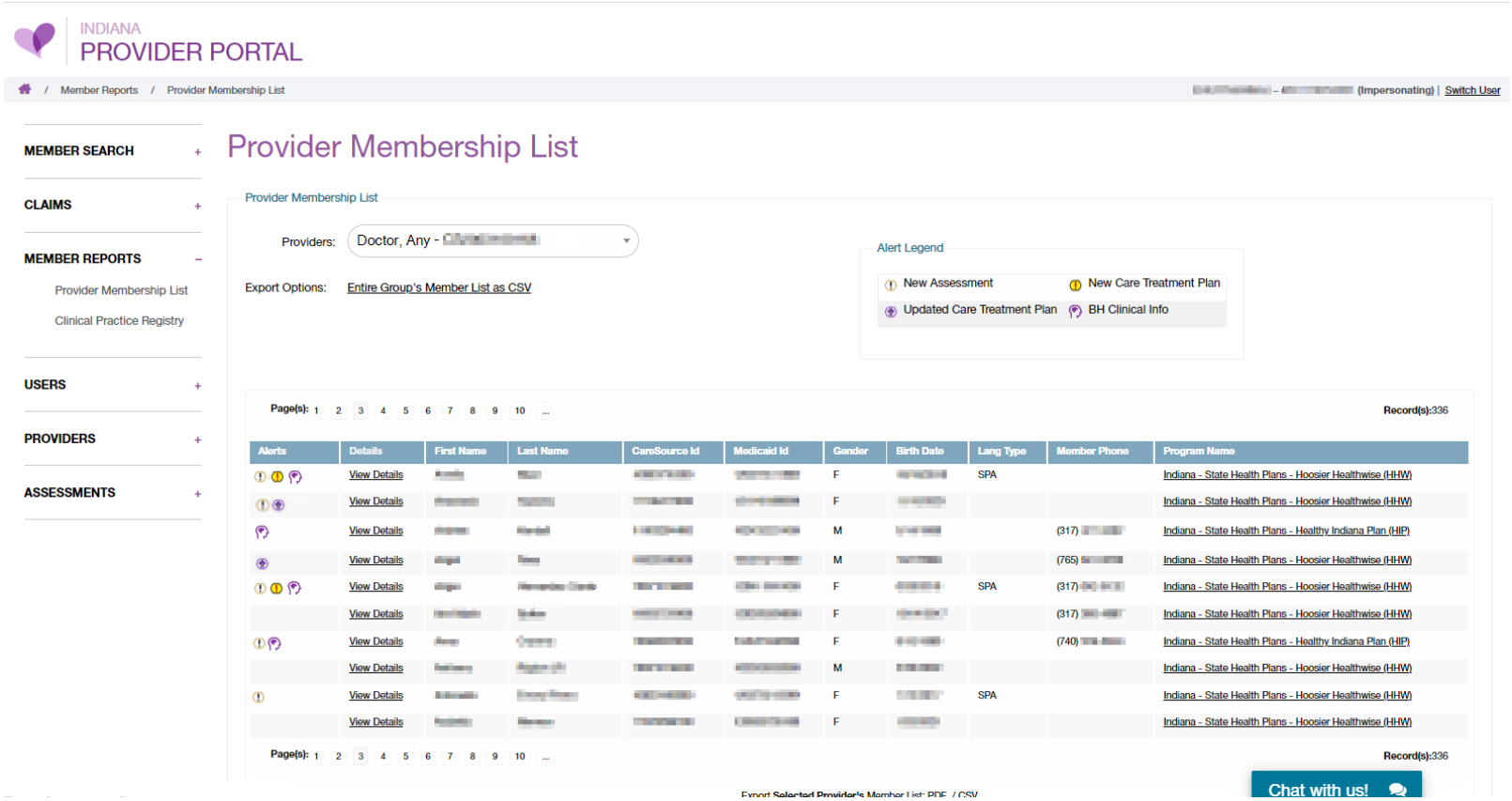
On a daily basis, CareSource sends information to the Provider Portal, including a member profile, to the assigned PMP on file. This profile lists the physical and behavioral health treatment received by that member. Information about substance use disorder and HIV is only released if the member has a signed consent form.

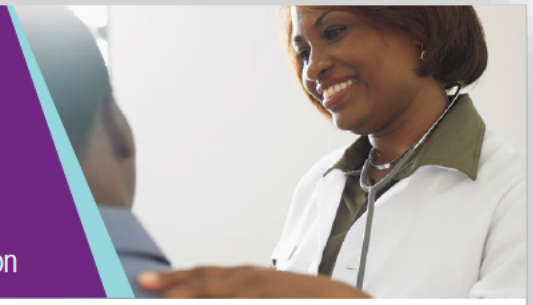
The member profile contains content for outpatient behavioral health visits, including service code, service description, and location of services rendered. The profile displays outpatient behavioral health visits and substance use disorder (SUD) residential stays.

Providers can access the member profiles on the Provider Portal at: **CareSource.com** > Login > Provider.

Behavioral Health Member Profile

The Provider Portal now allows providers to view when new member behavioral health information is available on the member profile.





COORDINATING SERVICES FOR PATIENTS WITH COEXISTING CONDITIONS

Physical/Behavioral Health Integration

CareSource understands the importance of patients with both behavioral and physical health diagnoses receiving follow-up care after a discharge from a behavioral health hospitalization. Coexisting conditions complicate the management of treatment and can be exacerbated after hospitalization if there is no follow-up care with the appropriate providers. CareSource encourages providers to collaborate when managing coexisting behavioral and physical health conditions.

It is important that inpatient behavioral health providers, including discharge planners, understand the importance of follow-up care with a primary medical provider (PMP) within 30 days of discharge for this population. Individuals diagnosed with a serious mental illness (SMI) are known to have poor physical health outcomes and a lower life expectancy. The behavioral health and medical conditions of this population are often intertwined with one diagnosis creating complications for another diagnosis. Provider collaboration for the management of coexisting behavioral and physical health conditions is essential to improving overall health outcomes for patients.

Helpful Suggestions for Providers:

- Identify any medical issues that may impact the treatment plan.
- Identify any potential barriers, including transportation, housing, food and prescriptions, so that your patients can focus on their follow-up care.
- Coordinate with your patients' PMP to ensure a follow-up appointment occurs within 30 days of discharge after a behavioral health inpatient admission.
- Assist in scheduling regular follow-up visits with the PMP to monitor ongoing care and medications.
- Communicate with other providers managing the care of the patient by phone, letter or electronic medical record to coordinate care and reduce duplication of services.

Benefits of Coordination

Coordination of care between behavioral health and primary care impacts:

- Patient satisfaction
- Malpractice risk
- Duplication of medications
- Duplication of services
- Medication adherence
- Quality of life and patient outcomes
- Better communication between behavioral health and physical health providers
- Development of professional expectations and ethics between behavioral health and physical health providers for coordination of care

CareSource's Transitions team is available to assist members with any barriers that might prevent them from keeping their 30-day appointment, including lack of transportation, missed appointments and adherence to prescription regimens. Please call us at **1-844-607-2831** to refer a patient to care management or for any questions. Providers may also make a care management referral through the Provider Portal: www.caresource.com/in/providers/provider-portal/medicaid/.

RR2022-IN-MED-P-127376 | Issued Date: 01/05/2023 | OMPP Approved: 06/27/2022

CareSource

CareSource

Behavioral Health and Primary Care Provider Coordination of Care Form

The coordination of physical and behavioral health care among treating providers is essential for safe and effective care. Please complete applicable sections of this document and include signed consent for releasing information, as appropriate.

	Date:
Patient name:	Date of Birth:
Medicaid/Marketplace/Medicare ID:	
Behavioral Health Provider	Physical Healthcare Provider
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Dear Colleague:

I am treating the member for the following diagnosis(es): _____

The member is engaged in the following intervention(s): ☐Psychotherapy ☐Medication Management ☐ Other (specify) _____

Frequency of intervention(s):

Lab Tests: ☐ CBC ☐ Thyroid Studies ☐ EKG ☐ Lipid Profile ☐ Serum drug level (specify drug)

Medications prescribed (or attach list)

Medication	Dose	Frequency

☐Member Refused Medication

Adherence to Medications: ☐ Most of the time ☐ Half of the time ☐ Less than half ☐ Never ☐ No information

Adherence to Appointments: ☐ Most of the time ☐ Half of the time ☐ Less than half ☐ Never ☐ No information

Response to Treatment: ☐ Improving with treatment ☐ Stable with treatment ☐ Not improving ☐ No information

Coordination of care issues or other significant information affecting medical or behavioral health care:

Provider signature: _____ Date: _____

CareSource has Case Managers available to assist with coordination of care. Please return a copy of this form via fax to (937) 396-3964 or email Indiana_BH@caresource.com and a Case Manager will assist with care coordination efforts.

Please check if you DO NOT want the following protected health information released:
☐ Substance Abuse ☐ HIV/AIDS

This authorization will expire on _____. I authorize the use and/or disclosure of my protected health information as described above. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. My health care provided by _____ will not be affected if I do not sign this form. The information disclosed by this release may be re-disclosed by the recipient and may no longer be protected.

Patient Signature: _____

Date: _____

RR2022-IN-MED-P-420098 Issued Date: 3/11/21 OMPP Approved: 3/11/21

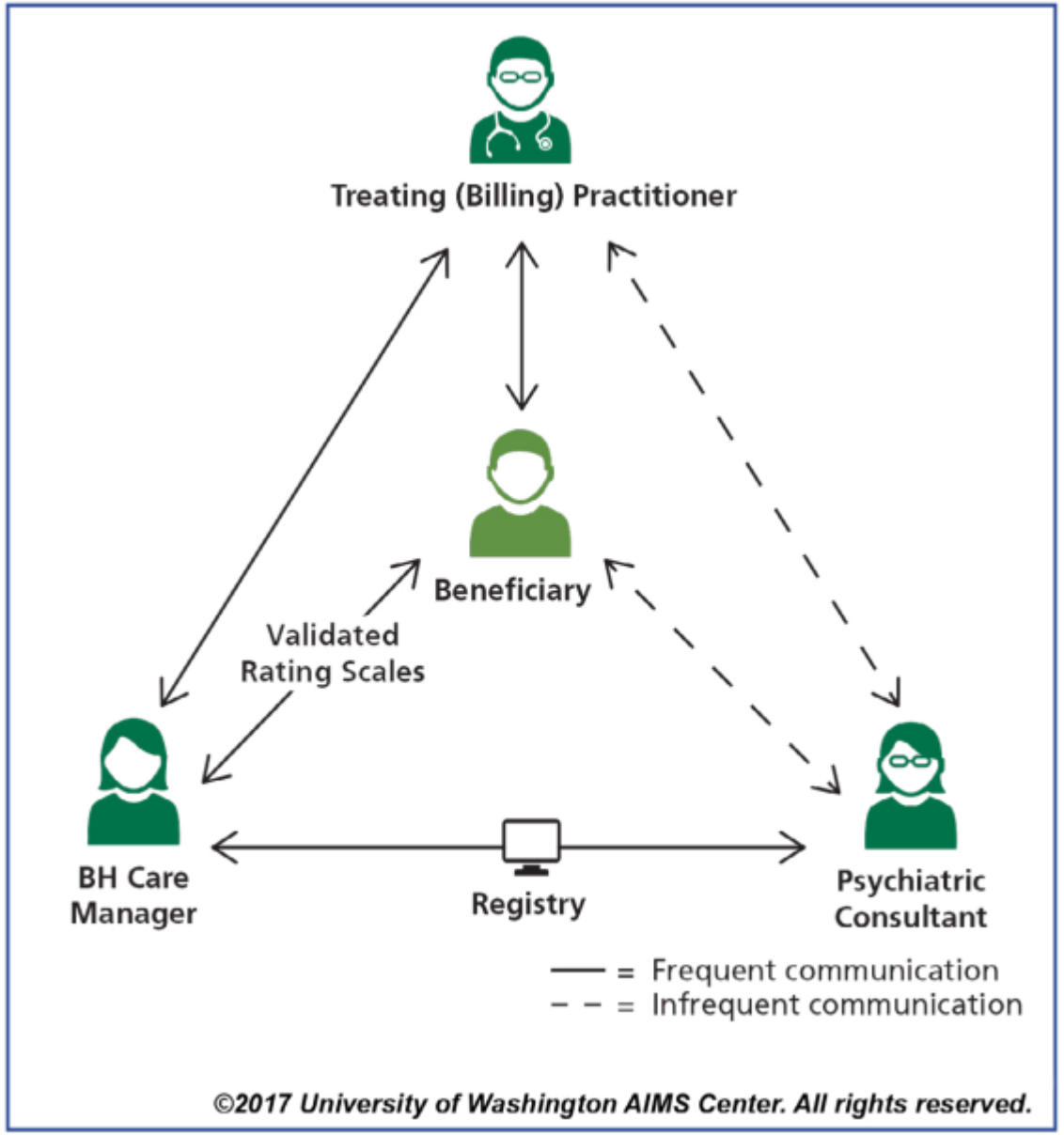
Psychiatric Collaborative Care Model (CoCM)

- What is the Collaborative Care Model?
  - The CoCM is a type of integrated care developed at the University of Washington to treat BH conditions in PH care settings like primary care
    - The most common BH conditions are Depression, Anxiety, and Substance Use Disorders
  - The CoCM can also improve PH outcomes for patients with Cancer, Diabetes, Cardiovascular Disease or HIV
- Five principles of Collaborative Care
  - Patient-centered team care
  - Population-based care
  - Measurement-based treatment to target
  - Evidence-based care
  - Accountable care

Collaborative Care Team

Interdisciplinary team-based approach

The CoCM team is led by the Primary Medical Provider and adds two key roles to the primary care team:
a BH Care Manager and a Psychiatric Consultant



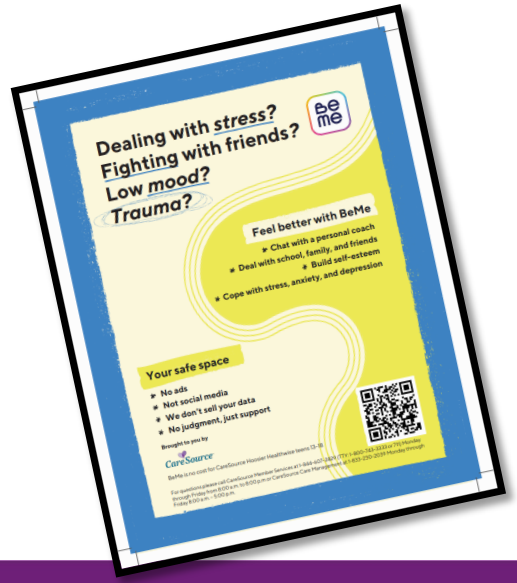
Psychiatric Collaborative Care Model (CoCM)

- As of Jan. 1, 2024, CareSource will provide reimbursement of specific codes that eligible providers may use (99492, 99493, 99494, and G2214)
- The model has been shown to:
  - ❖ Improve medication adherence
  - ❖ Decrease hypertension
  - ❖ Improve hemoglobin A1c
  - ❖ Increase the number of depression-free days
- To learn more about the CoCM, please visit the Collaborative Care | University of Washington AIMS Center (uw.edu).
- For questions, please email questions directly to the Behavioral Health Clinical inbox at Indiana_BH@caresource.com.

BeMe Health App

- Digital mental health and wellness solution built for the teen population which combines engaging technology and live support to improve the mental health and well-being of teens
- Free for CareSource Hoosier Healthwise members ages 13 to 18.
- Four Components that comprise BeMe Health:
  - Content and Activities
  - Coaching
  - Clinical Care
  - Crisis Support
- Referrals can be made using QR code or BeMe.com/CSHP

bemeteen.com/CSHP



Pharmacy Overview

PARTNERSHIP WITH EXPRESS SCRIPTS

CareSource works collectively with Express Scripts, our delegated pharmacy innovation partner, to manage our prescription drug costs and develop and implement plan-specific formulary or formularies.

SPECIALTY DRUGS

Accredo is our preferred specialty provider and can provide specialty medications directly to the member or the prescribing physician and coordinate nursing care if required.

E-PRESCRIBING

CareSource formulary files are available through your electronic medical records (EMR), electronic health record (EHR), or e-prescribing vendor.

RESOURCES

- Find authorization requirements for prescriptions at **CareSource.com** > Pharmacy. Select your plan's drop-down for specific requirements.
- The Formulary search tool and prior authorization lists are available on **CareSource.com.**
- Medication Therapy Management (MTM) allows pharmacists to work collaboratively with physicians to prevent or address medication-related problems, decrease member costs, and improve prescription drug adherence.

INSPECT Overview

CareSource works collectively with Express Scripts, our delegated pharmacy innovation partner, to manage our prescription drug costs and develop and implement plan-specific formulary or formularies.

What is INSPECT?

INSPECT was designed to serve as a tool to address the problem of prescription drug abuse and diversion in Indiana. By compiling controlled substance information into an online database INSPECT performs two critical functions: 1. Maintain a clearinghouse of patient information for health care professionals. 2. Provide an important investigative tool for law enforcement.

INSPECT seeks to enhance the ability of prescribers such as physicians, advanced practice nurses, physician's assistants, and dispensers as they perform critical public health functions. The program does this while maintaining the security of Hoosiers' important prescription information. Please visit the INSPECT website for more information.

What is EHR Integration?

The Indiana Professional Licensing Agency (IPLA) is partnering with Appriss Health, the service provider of INSPECT, to provide options to all Healthcare Entities (HCE) in Indiana to integrate INSPECT data into their clinical workflow utilizing a service called PMP Gateway. PMP Gateway is a web service that performs automated, multi-state, queries to integrate patient-controlled substance prescription history within Electronic Health Record (EHR) systems. PMP Gateway facilitates communication, information transfer, integration, and support for the state approval process and the EHR vendor development process. Integrating INSPECT data within an EHR provides a streamlined clinical workflow for providers. The integration eliminates the need for providers to leave their workflow to access the INSPECT web portal to request a patient's-controlled substance prescription history. Instead, the EHR or Pharmacy Management System automatically initiates a patient query using PMP Gateway and returns the patient's prescription history directly within the provider's EHR or Pharmacy Management System.

- Register for the PDMP and to perform patient look-up requests here
- **Prescription data submissions** are now being submitted through the Appriss Clearinghouse.
- Data Submission Guide

Medicaid Plan Pharmacy Benefits

HOOSIER HEALTHWISE

Package A (Standard Plan)	No copays
Package C (Children's Plan)	Copays apply

HEALTHY INDIANA PLAN

HIP Basic	Copays apply
HIP Plus	No copays
State Basic Plan	Copays apply
State Plus Plans	No copays

Marketplace Plan Pharmacy Benefits

MEDICATION STRUCTURE

Tier 0	Tier 1	Tier 2	Tier 3	Tier 4
Available without a copayment or coinsurance Includes preventive medications	**Low-cost generic drugs** Includes generic drugs	**Higher coinsurance or copayment than those in Tier 1** Includes preferred medications that may be generic drugs or single/multi-source brand name drugs	**Higher coinsurance or copayment than those in Tier 2** Includes non-preferred medications; medications considered single/multi-source brand name drugs	**Higher coinsurance or copayment than those in Tier 3** Includes preferred specialty medications
Visit **CareSource.com** > Pharmacy if you wish to access our full formulary list.				

Provider Resources

CareSource®

Provider Resources

CARESOURCE UPDATES & ANNOUNCEMENTS

Marketplace

CareSource.com > Provider > Indiana Marketplace > Updates & Announcements

HHW and HIP

CareSource.com > Provider > Indiana Medicaid > Updates & Announcements

Also visit **CareSource.com** to access the downloadable Provider Manual, Provider Orientation, Quick Reference Guides, and more.

INDIANA HEALTH COVERAGE PROGRAMS (IHCP)

https://www.in.gov/medicaid/providers/provider-references/news-bulletins-and-banner-pages/

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

https://www.cms.gov/

CareSource ***Contacts***

	Medicaid	Marketplace
Provider Services	**1-844-607-2831**	**1-833-230-2101**
Utilization Management Fax	1-844-432-8924	1-877-716-9480
Provider Portal	https://providerportal.caresource.com/GL/User/Login.aspx SKYGEN Dental Portal (HHW/HIP): https://pwp.sciondental.com/PWP/Landing DentaQuest Dental Portal (HIX): http://www.DentaQuest.com/	
Electronic Funds Transfer	ECHO Health: 1-888-485-6233	
Electronic Claims Submission	INCS1	
Claim Address	CareSource, Attn: Claims Department, P.O. Box 3607, Dayton, OH, 45401-3607	
Timely Filing	**90 days from date of service or discharge**	

Health Partner Engagement Specialists

HEALTH PARTNER ENGAGEMENT REPRESENTATIVES

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HEALTH PARTNER ENGAGEMENT SPECIALIST

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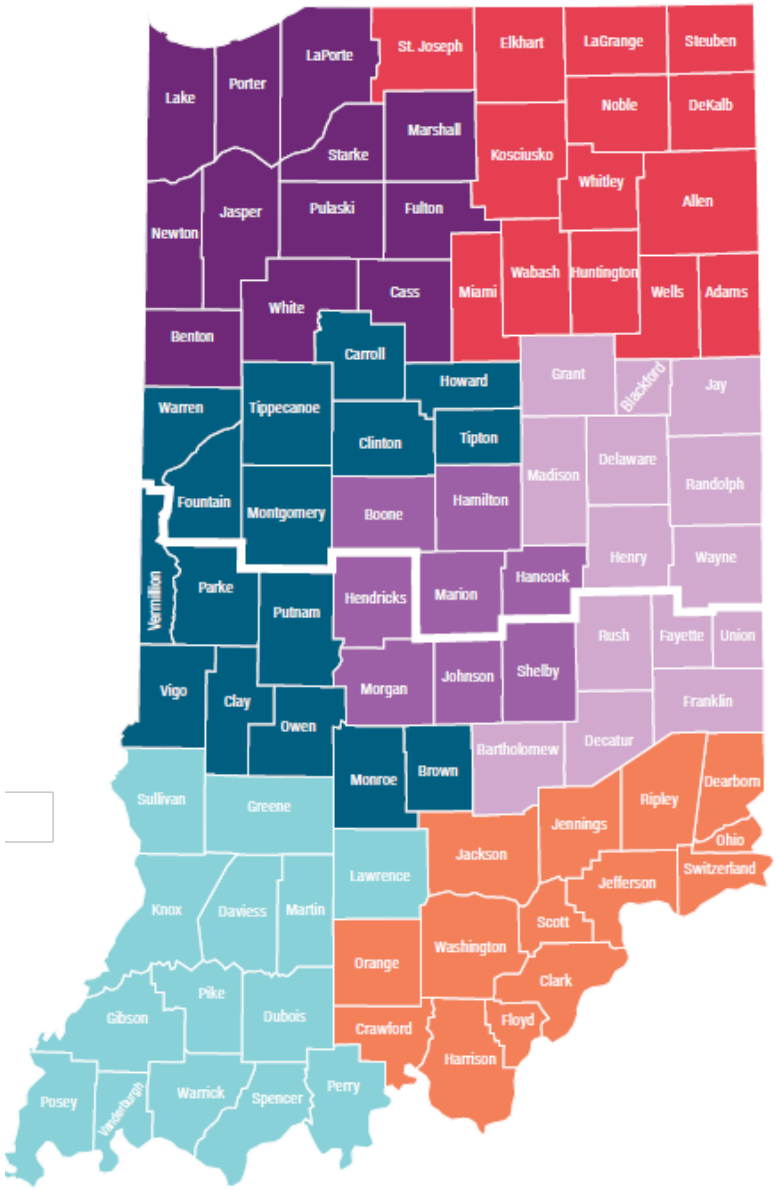

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