CareSource®

Health Care with Heart

CareSource Medicare Advantage Plans

Health Partner Manual

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

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About CareSource

Welcome

Welcome and thank you for becoming a participating health partner with CareSource.

At CareSource, we call health care providers our **health partners**. A “health partner” is any health care provider who participates in CareSource’s provider network. You may find “health partner” and health care provider used interchangeably in our manual, agreements and website.

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 together to facilitate a high level of care and a respectful experience for our members.

We are a non-profit, community-based health plan that currently serves Ohio, Indiana and Kentucky consumers that are enrolled in our CareSource Medicare Advantage plans. We offer three Medicare Advantage Health Maintenance Organization (HMO) plans:

- CareSource Advantage Zero Premium™ (HMO)
- CareSource Advantage® (HMO)
- CareSource Advantage Plus™ (HMO)

Our goal is to create an integrated medical home for our members. We focus on prevention and partnering with local health partners to offer the services our members need to remain healthy.

As a managed health care organization, we improve the health of our members by utilizing a contracted network of high-quality participating health partners. Primary care providers (PCPs) within the network provide a range of services to our members, and also 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.

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

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

About Us

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

Vision and Mission

Our vision is transforming lives through innovative health and life services.

Our mission is to make a lasting difference in our members' lives by improving their health and well-being.

At CareSource, our mission is one we take to heart. In fact, we call our mission our "heartbeat." It is the essence of our company, and our unwavering dedication is the hallmark of our success.

Our Services Include:

- Health partner relations
- Health partner services
- Member eligibility/enrollment information
- Claims processing
- Credentialing/recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory
- Compliance
- Special investigations for fraud, waste and abuse
- Member services, including a member call center and a 24-hour nurse advice line

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

- High-risk case management
- Emergency department diversion – high emergency department utilization focus (targeted at members with frequent utilization)
- CareSource24® (Nurse Advice Line)
- Healthcare home
- Outreach programs in partnership with community agencies to target members at greatest risk
- Care Transitions – Bridge to Home® (discharge planning and transitional care support)
- Disease management programs for asthma and diabetes management

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

CareSource Foundation

The CareSource Foundation was launched in 2006 to add another component to our professional services: community response. Since its inception, the Foundation has responded at significant levels and made some great friends, including non-profit organizations and other charitable funders who were equally committed to better health for all communities. We are addressing tough issues and growing together.

To date, the CareSource Foundation has awarded grants totaling over $14 million. Grants focus on issues of the uninsured, critical trends in children's health and special populations. Several large signature grants were made specifically to address issues of access to coverage in the new health care reform landscape and elevating children from the cycle of poverty through the power of education.

The Foundation believes in people, organizations and initiatives that actively work to improve the physical health and well-being of individuals residing in the CareSource service areas. We believe that passion, knowledge and vision generate positive, long-lasting change, and that meaningful collaboration creates strong partnerships with grantees.

Corporate Compliance

At CareSource, we serve a variety of audiences – members, health partners, 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 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 should conduct themselves. 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 health partners, consultants and vendors.

Health Partner Expectations

- Act according to the compliance standards
- Let us know about suspected violations or misconduct
- Let us know if you have questions

For questions about health partner expectations, please call your Health Partner Engagement Specialist or call Health Partner Services:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

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

- Ethics & Compliance Hotline: 877-LINKCSM (877-546-5276) or http://caresource.safe2say.info
- Compliance Officer: 937-531-2028 or Kurt.Lenhart@CareSource.com

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

The CareSource Corporate Compliance Plan is posted on the CareSource website at **CareSource.com** for your reference.

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 its health partners routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide that PII be appropriately protected wherever it is stored, processed and transferred in the course of conducting normal business. As a health partner, you should be taking measures to secure your sensitive health partner data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure personal 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.
- 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.

The Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, health partners may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities and follow ADA accessibility standards for new construction and alteration projects. Furthermore, health partners' diagnostic equipment must accommodate individuals with disabilities. The CareSource health partner 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 health partner 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 pages for information about the ADA. More information on this subject may be obtained at www.cdihp.org.

Q. Which health partners are covered under the ADA?

A. Private hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists and health clinics are among the health partners covered by the Title III of the ADA. Title III applies to all private health partners, regardless of size. It applies to health partners of both physical and mental health care. If a professional office is located in a private home, the portion of the home used for public purposes is covered by the ADA. Hospitals and other health care facilities that are operated by state or local governments are covered by Title II of the ADA. Health partners that offer training sessions, health education, or conferences to the general public must make these events accessible to individuals with disabilities.

Policies and Procedures

Health partners are required to modify policies and procedures when necessary to serve a person with a disability. The ADA, however, does not require health partners 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 & Services

Health partners must find appropriate ways to communicate effectively with persons who have disabilities affecting their ability to communicate. Various auxiliary aids and services such as interpreters, written notes, readers, large print or Braille text can be used depending on the circumstance and the individual.

Q. Why are auxiliary aids and services so important in the medical setting?

A. Auxiliary aids and services are often needed to provide safe and effective medical treatment. Without these aids and services, medical staff runs the risk of not understanding the patient's symptoms, misdiagnosing the patient's medical problem, and prescribing inappropriate treatment. Similarly, patients may not understand medical instructions or warnings that may have a serious impact on their health.

Q. How does a health partner determine which auxiliary aid or service is best for a patient?

A. The health partner can choose among various alternatives consulting with the person and carefully considering his or her expressed communication needs in order to achieve an effective result.

Q. Can a patient be charged for part or all of the costs of receiving an auxiliary aid or service?

A. No. A health partner cannot charge a patient for the costs of auxiliary aids and services, either directly or through the patient's insurance carrier.

Q. In what medical situations should a health partner obtain a sign language interpreter?

A. If a patient or responsible family member usually communicates in Sign Language, an interpreter should be present in all situations in which the information exchanged is lengthy or complex (for example, discussing a patient's medical history, conducting psychotherapy, communicating before or after major medical procedures, and providing complex instructions regarding medication). If the information to be communicated is simple and straightforward, such as prescribing an X-ray or a blood test, the physician may be able to communicate with the patient by using pen and paper.

Existing Facilities / Barrier Removal

Q. When must private medical facilities eliminate architectural and communication barriers that are structural in nature from existing facilities?

A. When the removal of those barriers is readily achievable, meaning easy to accomplish, without much difficulty or expense. Like undue burden, readily achievable is determined on a case-by-case basis in light of the resources available to an individual health partner.

Q. How does one remove "communication barriers that are structural in nature?"

A. For instance, install permanent signs, flashing alarm systems, visual doorbells and other notification devices, volume control telephones, assistive listening systems, and raised character and Braille elevator controls.

Complaints

Q. What if a patient thinks that a health partner is not in compliance with the ADA?

A. If a health partner cannot satisfactorily work out a patient's concerns various means of dispute resolution, including arbitration, mediation, or negotiation, are available. Patients also have the right to file an independent lawsuit in federal court, and to file a formal complaint with the U.S. Department of Justice.

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

Claims

In general, CareSource follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. For expedited claims processing and payment delivery, please ensure addresses and phone numbers on file with CareSource are up to date. You can email providermaintenance@caresource.com to update this information.

Billing Methods

CareSource accepts claims in a variety of formats, including paper and electronic claims. We encourage health partners to submit routine claims electronically to take advantage of the following benefits:

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

Electronic Funds Transfer

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

Benefits of EFT:

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

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

Electronic Claims Submission

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

EDI Clearinghouses

CareSource prefers electronic claim submission. To submit electronic claims, health partners may use any clearinghouse (trading partner), if it can be validated that the clearinghouse will send the claims to CareSource. If you do not currently use a clearinghouse, please contact the clearinghouse of your choice from our preferred list below or use our free Provider Portal.

Please provide the clearinghouse with the CareSource payer ID number.

- Indiana: INCS1
- Kentucky: KYCS1
- Ohio: 31114

Clearinghouse	Phone	Website
Availity	www.availity.com	1-800-282-4548
Change Healthcare (formerly Emdeon)	www.changehealthcare.com	1-800-845-6592
Quadax	www.quadax.com	440-777-6305
Relay Health	connectcenter.relayhealth.com	1-800-527-8133

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 Payment / Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 278 Health Care Services Review (Prior Authorization Requests)
- 834 Benefit Enrollment and Maintenance
- 820 Group Premium Payment for Insurance Products
- NCPDP Version D.0

Please include the full physical address for billing 5010 transactions. P.O. boxes are no longer accepted for the billing address. However, a P.O. Box or lock box can be used for the Pay-to Address (Loop 2010AB).

NPI and Tax ID Numbers

Your National Provider Identifier (NPI) number and Tax 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 health partner's NPI 24J and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating health partner's NPI and (if applicable) Box 49 for the group NPI

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

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

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

- Z2310B Loop – Rendering health partner name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Rendering health partner NPI

The billing health partner TIN must be submitted as the secondary health partner 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 health partner TIN or SSN

Institutional Claims

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

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

The billing health partner TIN must be submitted as the secondary health partner 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 health partner TIN or SSN

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

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

Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. Paper claim forms are encouraged for services that require clinical documentation or other forms to process. If you submit paper claims, please submit on one of the following claim form types:

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

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

We cannot accept handwritten claims or SuperBills. Detailed instructions for completing each form type are available at the websites below:

- CMS 1500 Form Instructions: www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf
- UB-04 Form Instructions: www.nucc.org

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

- CMS 1500: Box 24J for the rendering health partner's NPI 24J and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating health partner's NPI and (if applicable) Box 49 for the group NPI All Claims (EDI and paper)

All claims must include the following information:

- Patient (member) name.
- Patient address.
- Insured's ID number – Be sure to provide the complete CareSource member ID number of the patient. For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.
- Patient's birth date – Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service – Use standard CMS (HCFA) location codes.
- ICD-10 diagnosis code(s).
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable.
- Units, where applicable (anesthesia claims require minutes).
- Date of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain From/To formats. Please enter each date individually.
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information.
- Federal tax ID number or physician social security number – Every health partner practice (e.g., legal business entity) has a different tax ID number.
- Signature of physician or supplier – The health partner's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

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

What to include on claims that require NDC

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

Instructions for NDC on paper claims

- 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 3 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.

Claim Submission Timely Filing

Claims must be submitted within 365 calendar days of the date of service or discharge. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim. If this happens, health partners have 365 calendar days from the date of service or discharge to submit a corrected claim or file a claim appeal.

Claims Processing Guidelines

- Health partners have 365 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after 365 calendar days, the claim will be denied for timely filing.
- If you do not agree with the decision of the processed claim, you will have 365 calendar days from the date of service or discharge to file an appeal.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a member has other insurance and CareSource is secondary, the health partner may submit for secondary payment within 365 calendar days of the original date of service.
- If a claim is denied for Coordination of Benefits (COB) information needed, the health partner must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.
- There will be times when a member is hospitalized for a longer period of time. The health partner 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 health partner 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 health partner will have 365 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 CareSource ID number. Do not submit newborn claims using the mother's CareSource ID number; the claim will deny. Claims for newborns must include the birth weight.

Claims that Require Completed Consent Forms

- Abortion – This type of service requires a completed Abortion Certification Form and prior authorization. Please refer to the Referral and Prior Authorization Section of this manual for information on the Prior Authorization process.
  - JFS 03197
- Sterilization – This type of service requires a completed Consent for Sterilization Form.
  - HHS-687
- Hysterectomy – This type of service requires a completed Acknowledgment of Hysterectomy Information Form.
  - JFS 03199 (Rev. 4/2011)

For additional information please see the Covered Services and Exclusions Section of this manual. The forms referenced above are available on our health partner website at **CareSource.com.**

Searching for Claims Information Online

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

Additional claim enhancements on the Provider Portal:

- Claim history available up to 24 months from the date of service
- Submit claim appeal
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date
- Dental claim information
- Vision claim information

Procedure and Diagnosis Codes

HIPAA specifies that the health care industry use the following four code sets when submitting health care claims electronically. CareSource also requires HIPAA- compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on health partners 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 http://www.amaassn.org/ama/pub/physician-resources/solutions-managing-your-practice/ coding-billing-insurance/cpt.page.
- HCFA Common Procedure Coding System (HCPCS). Available at http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/ MedHCPCSGeninfo/http://www.cms.hhs.gov/default.asp%20 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 http://www.fda.gov/.

Procedures That Do Not Have a Corresponding CPT Code

- If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
  - A full, detailed description of the service provided.
  - A report, such as an operative report or a plan of treatment.
  - Any information that would assist in determining the service rendered. For example, 84999 is an unlisted lab code that would require additional explanation.
- Drug injections that do not have specific J code (J3490 thru J3999) and any assigned HCPCS J code that is not listed on the Medicare 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.
- Abortion Sterilization and Hysterectomy procedures
  - Consent forms must be attached (Please go to the “Forms” Section of **CareSource.com** for these forms).
- 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. Claim status is updated daily on our Provider Portal, and you can check claims that were submitted for the previous 24 months.

Code Editing

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

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

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

CareSource Health Partner Coding and Reimbursement Guidelines

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

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

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

CareSource seeks to apply fair and reasonable coding edits. We maintain a health partner appeals function that will review, upon request, any claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review will take into consideration all the previously mentioned ODM, 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 health partner's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Explanation of Payment (EOP)

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

Information Included on EOPs

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA compliant remark code indicating the reason the claim was denied. It is the health partner's responsibility to resubmit claims with the correct or completed information needed for processing.

Check Claim Status Online

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

Pended Claim Report

Pended claims are claims that have been entered into our system, but have not yet been processed completely.

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

Other Coverage – Coordination of Benefits (COB)

Coordination of Benefits

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.

Coordination of Benefits (COB) helps to safeguard a member's benefits when covered by more than one health plan. Taking steps to coordinate coverage helps to administer accurate claims payment while ensuring the member receives the benefits to which they are entitled. The Medicare Secondary Payer provisions protects the Medicare Trust Fund by ensuring Medicare does not pay for services and items for which other health insurance or coverage is responsible. Medicare regulations require all entities that bill Medicare for services or items rendered to Medicare members must determine if Medicare is the primary payer. As a Medicare Advantage Plan, CareSource Medicare Advantage follows these same provisions. In order to ensure accurate claims payment, it is important that our health partners have access to accurate, up-to-date information regarding our member's health insurance or coverage.

When providing services to CareSource members, please ask members whether they have other coverage in addition to CareSource Medicare Advantage. For more information about Medicare Coordination of Benefits, visit www.cms.gov/Medicare/Coordination-of-Benefits/COBGeneralInformation.

Search COB on the Provider Portal by:

- Member 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 (0 balance) must still be submitted to CareSource for processing. This is due to regulatory requirements.

COB Overpayment

If a health partner 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 health partner, or health partners can issue refund checks to CareSource for any overpayments. Health partners should not refund any money received from a third party to a member.

Workers' Compensation

Claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The health partner will be advised to submit the charges to Workers' Compensation for reimbursement. 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.

Third-Party Liability / Subrogation

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

Communicating with CareSource

Phone/Fax Numbers

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

Phone Numbers	**Indiana**	**Kentucky**	**Ohio**
Health Partner Services	1-855-202-0557	1-855-202-1059	1-844-679-7865
Prior Authorizations	1-855-202-0557	1-855-202-1059	1-844-679-7865
Claims Inquiries	1-855-202-0557	1-855-202-1059	1-844-679-7865
Credentialing	1-855-202-0557	1-855-202-1059	1-844-679-7865
Member Services	1-800-418-0172	1-800-833-3239	1-844-607-2827
CareSource24® – Nurse Advice Line	1-866-206-0078	1-866-206-7808	1-866-206-0569
Care & Disease Management	1-866-415-0585	1-866-415-0584	1-844-679-7865
Fraud, Waste & Abuse Reporting	1-855-202-0557	1-855-202-1059	1-844-679-7865
TTY for the Hearing Impaired	1-800-743-3333	1-800-648-6056	1-800-750-0750

Fax Numbers	Indiana	Kentucky	Ohio
Care & Disease Management Referral	1-866-619-6122	1-855-685-0003	866-206-0610
Contract Implementation	1-937-396-3632	1-937-396-3632	1-937-396-3632
Fraud, Waste and Abuse	1-800-418-0248	1-800-418-0248	1-800-418-0248
Medical Prior Authorization Form	1-855-761-9058	1-855-763-6790	1-844-417-6153
Medicare Part D Formulary Exception/ Prior Authorization Form	1-855-633-7673	1-855-633-7673	1-855-633-7673
Health Partner Appeals	1-866-317-2233	1-855-202-1085	1-844-417-6261
Health Partner Maintenance (i.e. office changes, adding/deleting health partners)	1-937-396-3076	1-937-396-3076	1-937-396-3076

Website/Online Provider Portal

Accessing our website, **CareSource.com,** is quick and easy. On the Provider section of the site you will find commonly used forms, newsletters, updates and announcements, our Health Partner Manual, claims information, frequently asked questions and much more. Health Partners can also find information on our product lines.

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

Our secure online Provider Portal allows you instant access at any time to valuable information, tools including the Member Profile and CareSource Clinical Practice Registry, clinical and preventive guidelines and other resources. Simply enter your user name and password (if already a registered user), or submit your information to become a registered user. Assisting you is one of our top priorities in order to deliver better health outcomes for our members.

Provider Portal Benefits

- Free access to important resources
- Availability 24 hours a day, 7 days a week
- Secure, convenient access to time-saving services and critical information
- Accessibility on any PC without any additional software

Provider Portal Functions

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

- **Payment history** – Search for payments by check number or claim number
- **Claims** – Search for status of claims, submit appeals and view claim history (including vision benefits)
- **Coordination of Benefits (COB)** – Confirm COB for patients
- **Prior authorization** – Request authorization for medical and behavioral inpatient/outpatient services and Synagis
- **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 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
- **Monthly membership lists** – View and download current monthly membership lists
- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization
- **Information exchange** – Share relevant member information to facilitate better integration of behavioral health, dental and medical care
- **CareSource clinical practice registry** – 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
- **Portal Registration**

Portal Registration

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

1. Click on the "Register Now" button and complete the three-step registration process.
   Note: you will need to have your Tax ID number.
2. Click the "Continue" button.
3. Note the username and password you create so that you can access the Portal's many helpful tools.
4. If you do not remember your username/password, please call Health Partner Services:
   - Indiana: 1-855-202-0557
   - Kentucky: 1-855-202-1059
   - Ohio: 1-844-679-7865

How to Communicate with CareSource by Mail

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

Health Partner Appeals Mailing Address:
CareSource
P.O. Box 1432
Dayton, OH 45401-1432

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

Member Appeals & Grievances Mailing Addresses:
CareSource
P.O. Box 1432
Dayton, OH 45401-1432

Medicare Pharmacy Appeals:
CareSource Part D Appeals
c/o CVS Caremark
P.O. Box 52000 MC109
Phoenix, AZ 85072-2000

Medicare Pharmacy Grievances:
CareSource
P.O. Box 1432
Dayton, OH 45401-1432

Claims Mailing Addresses:

Indiana	Kentucky	Ohio
CareSource Attn: Claims Department P.O. Box 3607 Dayton, OH 45401-3607	CareSource Attn: Claims Department P.O. Box 824 Dayton, OH 45401-824	CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401-8730

Fraud, Waste and Abuse Address:
CareSource
Attn: Special Investigations Department
P.O. Box 1940
Dayton, OH 45401-1940

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

Newsletters

CareSource communicates with health partners in a variety of ways. Our Health Partner News newsletter is available online and contains operational updates, clinical articles and new initiatives underway at CareSource. Please visit **CareSource.com** for the newsletter.

Network Notifications

Network Notifications are published for CareSource health partners to regularly communicate updates to policies and procedures. Network Notifications are found on our website and are sent via email to registered health partners.

Health Partner Demographic Changes and Updates

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

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

Covered Services

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

Benefit Limits

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

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

This section describes the services and exclusions to benefits that are provided to our CareSource members. CareSource covers all medically necessary covered services for members. These services are available to our health plan members at no charge. Covered services may require prior authorization. Please visit CareSource.com for the most up-to-date information about prior authorization. Under the Provider section, click on your state & plan, then "Patient Care."

Medical Necessity Determinations

Some services require prior authorization. If a request for authorization is submitted, CareSource will notify the health partner and member in writing of the determination. If a service cannot be covered, health partners and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary.

Please see the “Appeal Procedures” section of this manual for information on how to file an appeal.

Covered services and exclusions for CareSource members can be found by logging into the Provider Portal at **CareSource.com.**

Covered services and exclusions for CareSource Medicare Advantage plans are also listed in the Evidence of Coverage (EOC). The EOC is located on our website.

Credentialing and Recredentialing

CareSource credentials and recredentials all licensed independent practitioners including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action.

Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners. Our Vice President/Senior Medical Director is responsible for the credentialing and recredentialing program.

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

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

CAQH Application

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

1. Logging onto the CAQH website at www.CAQH.org utilizing your account information.
2. Selecting the Authorization tab.
3. Making sure CareSource is listed as an authorized health plan. If not, please check the “Authorized” box to add.

It is essential that all documents are complete and current. Please also include copies of the following documents:

- Malpractice Insurance Face Sheet
- Drug Enforcement Administration (DEA) certificate (current)
- Clinical Laboratory Improvement Amendment (CLIA) certificate (if applicable)
- Standard Care Arrangement (if an advanced practice nurse)

Debarred Health Partner Employee Attestation

CareSource must verify that its health partners and the health partners' employees have not been debarred or suspended by any state or federal agency. CareSource must also require that its health partners and the health partners' employees disclose any criminal convictions related to federal health care programs. "Health partner employee" is defined as directors, officers, partners, managing employees or persons with beneficial ownership of more than 5 percent of the entity's equity.

CareSource Debarment/Criminal Conviction Attestation

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

CareSource conducts credentialing and recredentialing activities utilizing the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and individual state requirements.

Contracted health partners listed in the Provider Directory and the following are credentialed:

- Practitioners who have an independent relationship with CareSource. This independent relationship is defined through contracting agreements between CareSource and a practitioner or group of practitioners and is defined when CareSource selects and directs its enrollees to a specific practitioner or group of practitioners.
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Practitioners who are hospital-based, but see the organization's members as a result of their independent relationship with the organization.
- Dentists who provide care under the organization's medical benefits.
- Non-physician practitioners who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.
- Covering practitioners (locum tenens).
- Medical Directors of urgent care centers and ambulatory surgical centers.

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

- Practitioners who practice exclusively within the inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting.

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

Health Partner Selection Criteria

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

Quality of care delivery, as defined by the Institute of Medicine, states: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

CareSource has developed comprehensive care management and quality improvement programs to facilitate this level of quality-of-care delivery, as well as a comprehensive credentialing program to ensure that our health partners have the appropriate training and expertise to serve our members from a care delivery and service perspective. CareSource bases selection on quality-of-care and service aspects, in addition to business and geographic needs for specific health partner types in a nondiscriminatory manner.

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

Selection Criteria:

A. Active and unrestricted license in the state issued by the appropriate licensing board.
B. Current DEA certificate (if applicable).
C. Successful completion of all required education.
D. Successful completion of all training programs pertinent to one's practice.
E. For MDs and DOs, successful completion of residency training pertinent to the requested practice type.
F. For dentists and other health partners where special training is required or expected for services being requested, successful completion of training.
G. Board certification is not required for primary care specialties. PCPs who are approved by the CareSource Credentialing Committee will appear in CareSource provider directories.
H. Health partners 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.
I. A certified nurse practitioner may be credentialed as a "primary care provider" if the following are present:
    i. The contracted registered professional nurse is currently licensed in the state,
    ii. The contracted registered professional nurse meets the state's requirements governing the qualifications of nurse practitioners, and
    iii. The contracted registered professional nurse is duly certified as a provider of primary care services.

J. A certified nurse practitioner may be credentialed as a PCP and as an "independent practitioner" if the above criteria (a) through (c) are met and the nurse practitioner's practice type is independent as defined by OAC 5101:3-8-22.
K. Education, training, work history and experience are current and appropriate to the scope of practice requested.
L. Malpractice insurance at specified limits established for all practitioners by the credentialing policy.
M. Good standing with Medicaid and Medicare.
N. Quality of care and practice history as judged by:
- **i.** Hospital medical staff performance.
- **ii.** Licensure or specialty board actions or other disciplinary actions, medical or civil.
- **iii.** 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.
- **iv.** Other quality of care measurements/activities.
- **v.** Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing.
- **vi.** Lack of issues on HHS-OIG; EPLS or MDCH site (fraud and abuse).

O. Signed, accurate credentialing application and contractual documents.
P. Participation with care management, quality improvement and credentialing programs.
Q. Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
R. Agreement to comply with plan formulary requirements or acceptance of plan preferred drug list as administered through the pharmacy benefit manager.
S. Agreement to access and availability standards established by the health plan.
T. Compliance with service requirements outlined in the health partner agreement and health partner manual.

Organizational Credentialing and Recredentialing

The following organizational health partners are credentialed and recredentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers

Additional organizational health partners are also credentialed:

A. Hospice health partners
B. Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
C. Urgent care facilities, free-standing and not part of a hospital campus
D. Dialysis centers
E. Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
F. Free-standing facilities that provide outpatient, non-emergent advanced radiology services (including MRI/MRA, CT and PET scans)

In addition to the urgent care and ambulatory surgical facilities being credentialed, the Medical Director or senior health partner responsible for medical services will be credentialed using the standard credentialing and recredentialing processes.

The following elements are assessed for organizational health partners:

- Health partner is in good standing with state and federal regulatory bodies
- Health partner has been reviewed and approved by an accrediting body
- Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body
- Liability insurance coverage is maintained
- CLIA certificates are current
- Completion of a signed and dated application

Health partners will be informed of the credentialing committee decision within 10 business days of the committee meeting. Health partners will be considered recredentialed unless otherwise notified.

Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks (Rev. 24, 06-06-03)

Excluded Health Partners

The Office of the Inspector General (OIG) maintains a sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. CareSource checks the sanction list with each new issuance of the list, as we are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. CareSource checks the OIG website at www.oig.hhs.gov/fraud/exclusions/listofexcluded.html for the listing of excluded health partners and entities. The OIG has a limited exception that permits payment for emergency services provided by excluded health partners under certain circumstances.

Opt-Out Health Partners

If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of two years. The only exception to that rule is for emergency and urgently needed services where a private contract had not been entered into with a beneficiary who receives such services. CareSource pays for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in our CareSource plan who has not signed a private contract with a beneficiary, but does not otherwise pay opt-out health partners. Information on health partners who opt-out of Medicare may be obtained from the local Medicare Part B carrier. CareSource checks this list on a regular basis.

Practitioner Rights

- Practitioners have the right to review information submitted to support their credentialing application upon request to the CareSource Credentialing Department. CareSource keeps all submitted information locked and confidential.
- Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing Department prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner will be notified and given the opportunity to correct this information prior to presenting to the credentialing committee.
- Practitioners have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing Department.

Health Partner Responsibilities

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

Recredentialing

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

Board Certification Requirements

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

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

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

Physicians whose boards require periodic 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 re-credentialing, if board certification status has expired, a letter will be sent to the physician to request explanation.

Health partners are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Physicians applying to become participating health partners must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board, 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 and listed in the directory under that subspecialty, physicians must:

1. Complete an approved fellowship training program in the respective subspecialty, and
2. Be board-certified by a board recognized by the American Board of Medical Specialties (ABMS). If no subspecialty board exists or the board is not a member of ABMS, then subspecialty recognition will be determined based on education, training and experience requirements of the fellowship training program and/or other suitable board certification recognition.

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/or 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 health partner file review

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

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

Appeals of Credentialing/Recredentialing Decisions

CareSource may decide that an applying or participating health partner may pose undue risk to our members and should be denied participation or be removed from CareSource's network. If this happens, the applying or participating health partner will be notified in writing. Appeal opportunities are available to a participating health partner if he/she has been affected by an adverse determination. To submit an appeal request, the following steps apply:

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

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

All appeal requests must be received by CareSource within 30 calendar days of the date the health partner is notified of the decision. The request, along with any supporting information, will be presented to the credentialing committee for review at the next meeting. The committee will respond within 30 calendar days of that meeting, and the health partner will be notified in writing of the committee's decision.

Step 2 – If the committee maintains the original decision, an appeal may be made consistent with provisions of the CareSource Fair Hearing Plan. Any appeal request must be submitted in writing and received by CareSource within 30 calendar days of the date the health partner is notified of the first appeal decision. Appeals may be sent to:

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

Applying health partners do not have appeal rights. However, they may submit additional documents for reconsideration by the credentialing committee to the address above.

If you would like to review the CareSource Fair Hearing Plan, please visit **CareSource.com**. Search "Fair Hearing."

Health Partner Disputes

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

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

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

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

Summary Suspensions

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

Fraud, Waste and Abuse

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

Definition of Terms

Fraud – is defined as, “knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.” (18 U.S.C. § 1347).

Waste – is defined as, “the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources”. (Chapter 21 Medicare Managed Care Manual).

Abuse – is defined as, “actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.” (Chapter 21 Medicare Managed Care Manual).

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]).

Examples

Examples of Member Fraud, Waste and/or Abuse:

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

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

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower Medicaid/Medicare reimbursement rates
- Billing for services not provided
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Purchasing drugs from outside the U.S
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking member ID's, 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 patient lists for the purpose of submitting fraudulent claims
- Drugs billed for inpatients as if they were outpatients
- Payments stemming from kickbacks or Stark Violations
- Not reporting overpayments or overbilling
- Preventing members from accessing covered services resulting in underutilization of services offered

Examples of Pharmacy Fraud, Waste and/or Abuse:

- Prescription drugs not dispensed as written
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed
- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees

- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted or illegal drugs
- Billing prescriptions not filled or picked up

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

Examples of Employee Fraud, Waste and/or Abuse:

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

Examples of Vendor Fraud, Waste and/or Abuse:

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

We routinely monitor our claims data and review medical records looking for billing discrepancies or potential fraud, waste and abuse. 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 health partner education
- Written corrective action plan
- Health partner termination with or without cause
- Health partner summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Contract termination
- Employee disciplinary actions
- Reporting to one or more applicable state and federal agencies
- Legal actions

Refer to your Health Partner Agreement for specific information on each type of health partner termination/suspension. Also, refer to the Fair Hearing Plan for the information on the appeal process. The CareSource Fair Hearing Plan is available at **CareSource.com**. Search “Fair Hearing Plan.”

Reporting Fraud, Waste and Abuse

You can report your suspicions of fraud, waste or abuse to the CareSource Special Investigations Unit. Contact information for reporting fraud, waste and abuse is located at **CareSource.com**, in the “Communicating with CareSource” section of this Health Partner 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.

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

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

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

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

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

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

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

Protection for Reporters of Fraud, Waste or Abuse

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

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

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.

Other Fraud, Waste and Abuse Laws

Anti-Kickback Statute - 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).

Stark Law - Under the Federal Stark Law, and subject to certain exceptions, health partners are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs. 42 U.S.C. §1395(a) and §1903(s).

HIPAA - 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.

Prohibited Affiliations/ 42 C.F.R. § 438.610

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

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

Disclosure of Ownership, Debarment and Criminal Convictions

Before CareSource enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment 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.

You must also notify CareSource of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child or sibling. Please contact us by using the contact information in the reporting section below.

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

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

A Roadmap to Avoid Medicare and Medicaid Fraud and Abuse

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

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 or has taken place, please contact our Special Investigations Unit. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting anonymously:

- Call your Health Partner Services line and follow the appropriate menu option for reporting fraud:
  - Indiana: 1-855-202-0557
  - Kentucky: 1-855-202-1059
  - Ohio: 1-844-679-7865

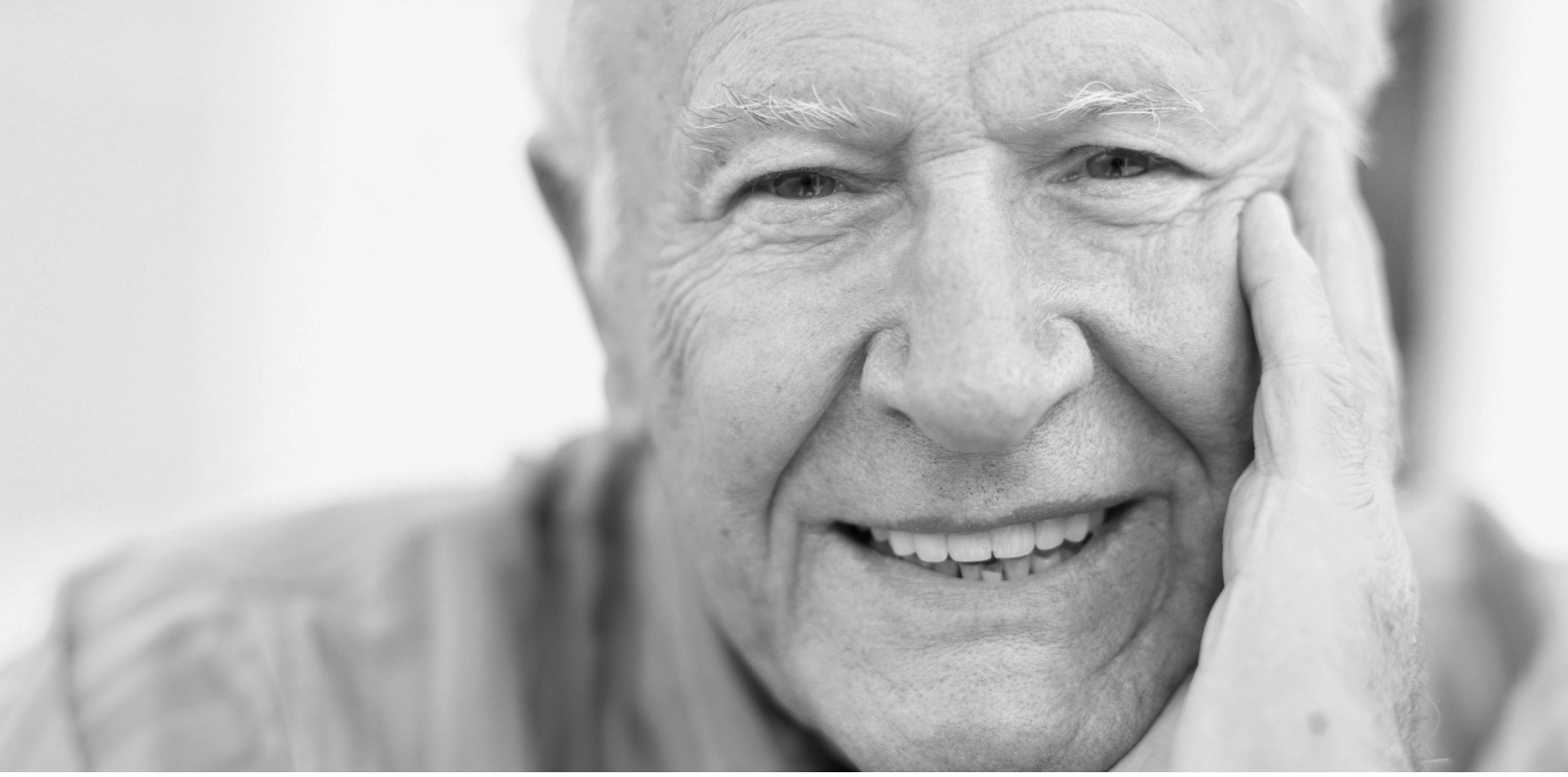
- Write: CareSource
  Attn: Special Investigations Unit
  P.O. Box 1940
  Dayton, OH 45401-1940

Options for reporting that are not anonymous:

- Fax: 1-800-418-0248
- Email*: fraud@caresource.com
- Or you may choose to use the Fraud, Waste and Abuse Reporting Form located at **CareSource.com.**

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



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.

Health Partner Responsibilities

Participating health partners are responsible for:

- Providing CareSource with advance written notice of any intent to terminate an agreement with us. This must be done 90 days prior to the date of the intended termination and submitted on your organization's letterhead. 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 PCPs only: providing 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or a taped message used after-hours, patients should be given the means to contact their PCP or a back-up health partner to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up health partner and only recommends emergency room use for after hours.
- Submission of claims or corrected claims should be submitted within 365 days of the date of service or discharge.
- Appeals must be filed within 365 days of the date of service or discharge.
- Health partners should keep all demographic and practice information up-to-date. Email updates to providermaintenance@caresource.com.

CareSource Responsibilities

Our agreement also indicates that CareSource is responsible for:

- Paying 90 percent of clean claims within 30 days of receipt. We adhere to both federal and state prompt pay guidelines
- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the "Health Partner Appeals" section of this manual.
- Offering a 24-hour nurse triage service for members to reach a medical professional at any time with questions or concerns.
- When CareSource coordinates benefits with the primary carrier, the Carve- Out method is used. Carve-out involves subtracting the primary payment from the lesser of the primary carrier allowable or Medicaid allowable. If the primary payment is more than the determined allowable amount, then CareSource pays zero.
- These are just a few of the specific terms of our agreement. In addition, we expect participating health partners to follow standard practice procedures even though they may not be spelled out in our health partner agreement. For example:
  - Participating health partners, or their designee, are expected to make daily visits to their patients who have been admitted as inpatient to an acute care facility or arrange for a colleague to visit.
  - Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.
  - Participating health partners are expected to treat members with respect. CareSource members should not be treated any differently than patients with any other health care insurance. Please reference member rights in the "Member Support Services and Benefits" section of this manual.

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

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

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:

- Email: providermaintenance@caresource.com
- Fax: 937-396-3076

Americans with Disabilities Act (ADA) Standards:

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

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

Medicare Standards

CMS requires that specific terms and conditions be incorporated into the agreement between a Medicare Advantage organization or first tier entity and a first tier entity or downstream entity to comply with the Medicare laws, regulations, and CMS instructions.

The topics covered in these requirements are as follows:

- Record retention
- Privacy and accuracy of records
- Hold harmless
- Compliance with MAO's contractual obligations
- Prompt payment
- Compliance with applicable Medicare laws and regulations

These provisions will be included in contracts with CareSource health partners who serve CareSource Medicare Advantage members.

Medicare Member Enrollment and Eligibility

CareSource Medicare Advantage Plans are health care plans committed to helping members get the care they need. CareSource Medicare Advantage is a Medicare Advantage contract available to those who are eligible for Medicare Part A and Part B.

The Centers for Medicare and Medicaid Services (CMS) determines eligibility for Medicare. CareSource verifies a member's eligibility Medicare Part A, and enrollment in Medicare Part B, before the applicant can be enrolled in CareSource Medicare Advantage. New members are effective on the first day of the month.

To be eligible to receive services through CareSource Medicare Advantage, a person must:

- Be entitled to Medicare Part A and enrolled in Part B
- Not have end-stage renal disease (ESRD)
- Live in our CareSource Medicare Advantage service area
- Choose CareSource Medicare Advantage during a valid election period
- Agree to the rules of the CareSource Medicare Advantage plan
- Continue to pay Medicare Part B premiums if not paid by Medicaid or another third party Medicare

Member ID Cards

Each new CareSource Medicare Advantage member receives a member ID card. An ID card for CareSource Medicare Advantage is issued when a member joins CareSource. Members can continuously use the same CareSource Medicare Advantage ID card as long as they maintain eligibility. CareSource will issue a new ID card only when the information on the card changes, if a member loses a card, or if a member requests an additional card. Because ID cards do not guarantee eligibility, health partners must verify a member's eligibility on each date of service.

We encourage health partners to visit our secure Provider Portal to view up-to-date member eligibility information. Health partners can also call our Health Partner Services Department and follow the appropriate menu options to use our automated member eligibility verification system:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

Members must be eligible for CareSource Medicare Advantage plans on the date of service in order for services to be covered.

Billing CareSource

CareSource Medicare Advantage members should not present their red, white and blue card for Original Medicare. If a CareSource Medicare Advantage member uses their red, white and blue Medicare card instead of their CareSource Medicare Advantage card and you bill the Medicare program instead of CareSource, the Medicare program will not pay for these services.

Members are asked to present a CareSource ID card each time services are accessed. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification. If you suspect fraud, please contact our Special Investigations Unit by and follow the appropriate menu options to report fraud:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

Member Eligibility Verification

To verify member eligibility, please use one of the following methods:

- Provider Portal: Log on to **CareSource.com** and select Provider Portal from the menu options. You can check CareSource member eligibility up to 24 months after the date of service on our Provider Portal. You can search by date of service plus any one of the following: member name and date of birth, Medicare number or CareSource member ID number.
- Phone: Call Health Partner Services and follow the appropriate menu options to reach our automated member eligibility verification system 24 hours a day:
  - Indiana: 1-855-202-0557
  - Kentucky: 1-855-202-1059
  - Ohio: 1-844-679-7865
- The automated system will prompt you to enter the member ID number and the month of service to check eligibility.

PCPs can obtain a monthly list of eligible members who have chosen them or were assigned to them from the CareSource Provider Portal. This list does not prove eligibility for benefits or guarantee coverage. Please use one of the above methods to verify member eligibility. Log onto our Provider Portal to view or print your list. All health partners should always verify member eligibility before rendering services except in an emergency. This helps prevent unpaid claims.

Medicare Member Disenrollment

A member may end their membership with CareSource Medicare Advantage only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, they may also be eligible to leave the plan at other times of the year. One situation is if the member moves out of the CareSource Medicare Advantage service area.

A member may request disenrollment by notifying CareSource Medicare Advantage. Refer members to the CareSource Medicare Advantage Member Services Department if they need information on disenrollment:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

Members are advised to continue to use their CareSource Medicare Advantage ID card and to coordinate all services through their PCP until their disenrollment becomes effective.

If you learn that a member plans to disenroll, you may avoid payment delays by reminding the member to notify CareSource Medicare Advantage, and validating eligibility with CareSource Medicare Advantage on the date of each visit.

CareSource Involuntary Termination

Each member's enrollment is generally in effect as long as the member retains eligibility and chooses to stay with CareSource Medicare Advantage. The plan cannot and will not terminate a member because of the amount or cost of services.

CareSource can terminate members with CMS's approval for any of the following:

- If the member loses entitlement to Medicare Part B coverage
- If the member loses entitlement to Medicare Part A coverage
- If the member permanently moves or resides outside the service area
- If the member is temporarily absent from the service area for more than six consecutive months
- If the member is incarcerated
- If the member has committed fraud
- If the member has abused the CareSource plan beneficiary ID card and/or benefits
- If the member has demonstrated disruptive behavior that interfered with care for the member or others

Please notify CareSource if any of the situations listed above occur so we can discuss the disenrollment request with the member and, if necessary, initiate a request to CMS for member disenrollment. CMS will review all cases and determine whether or not the member should be disenrolled from CareSource Medicare Advantage, but members have the right to appeal the cancellation of coverage.

Procedures for Dismissing Non-Compliant Members

Participating health partners can request that a CareSource Medicare Advantage member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include non-compliance with medication schedules, no-show office policies, or failure to modify behavior as requested. Any time a member misses three or more consecutive appointments, health partners are expected to notify our Care Management Department for assistance.

It is strongly recommended that your office make at least three attempts to educate the member about non-compliant behavior and document them in the patient's record. Please remember that CareSource's outreach staff can assist you in educating the member. After three attempts, health partners may initiate the dismissal by following the guidelines below.

- The health partner office must notify the member of the dismissal by certified letter.
- A copy of the letter must be sent to CareSource at the following address:
  CareSource
  Attn: Member Services Manager
  P.O. Box 1947
  Dayton, OH 45401-1947
  Fax: (937) 396-3095
- For PCPs only, the letter must contain specific language stating that:
  – The member must contact Member Services Department to choose another PCP.
  – The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal.

Please call Health Partner Services if you have questions about disenrollment reasons or procedures:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

Member Enrollment and Health Partner Marketing

It is common for health partners to inform their patients about their affiliations with managed care plans. However, advocating enrollment in a specific health plan is unacceptable according to the CMS Medicare Marketing Guidelines.

CMS allows health partners to discuss participation under specified circumstances. CMS holds plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting health partners. The plan sponsor must ensure that any health partners contracted (and its subcontractors, including health partners or agents) with the plan sponsor comply with the requirements outlined in the Medicare Marketing Guidelines.

The plan sponsor must ensure that any health partners contracted (including subcontractors or agents) with the plan sponsor to perform functions on their behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education, agree to the same restrictions and conditions that apply to the plan sponsor through its contract. In addition, the plan sponsor (and

subcontractors, including health partners or agents) are prohibited from steering, or attempting to steer an undecided potential enrollee toward a particular health partner, or limited number of health partners, offered either by the plan sponsor or another plan sponsor, based on the financial interest of the health partner or agent (or their subcontractors or agents). While conducting health screenings, health partners may not distribute plan information to patients since both activities are prohibited marketing activities.

Health Partner Marketing

Health partners should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Health partners may not be fully aware of plan benefits and costs, and it's important that beneficiaries receive the right information needed to make an informed decision about their health care options.

It is inappropriate for health partners to be involved in any of the following actions:

- Offering sales/appointment forms
- Accepting Medicare enrollment applications
- Making phone calls or directing, urging or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests
- Mailing marketing materials on behalf of plan sponsors
- Offering anything of value to induce plan enrollees to select them as their health partner
- Offering inducements to persuade beneficiaries to enroll in a particular plan or organization
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities
- Distributing materials/applications within an exam room setting
- Health screening is a prohibited marketing activity

Health partners should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions.

Health partners contracted with plan sponsors (and their contractors) are permitted to do the following:

- Provide the names of plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the low income subsidy.
- Make available and/or distribute plan marketing materials including health partner affiliation materials for a subset of contracted plans only as long as health partners offer the option of making available and/or distributing marketing materials from all plans with which they participate. CMS does not expect health partners to proactively contact all participating plans to solicit the distribution of their marketing materials. Rather, if a health partner agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates. To that end, health partners are permitted to:
  - Provide objective information on plan sponsors' specific plan formularies, based on a particular patient's medications and health care needs.
  - Provide objective information regarding plan sponsors' plans, including information, such as covered benefits, cost sharing and utilization management tools.
- Make available and/or distribute PDP enrollment applications, but not MA or MA-PD enrollment applications for all plans with which the health partner participates.
- Refer their patients to other sources of information, such as SHIPS, plan marketing representatives, their State Medicaid Office, local Social Security Office, the CMS website at http://www.medicare.gov or 1-800-MEDICARE.

- **Note**: The “Medicare and You” Handbook or “Medicare Options Compare” (from www.medicare.gov) may be distributed by health partners without additional approvals.

There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plan sponsors and health partners without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plan sponsors should advise contracted health partners of the provisions of these rules.

Note: Per guidance from CMS, a health partner should not attempt to switch or steer plan enrollees or potential plan enrollees to a specific plan or group of plans to further the financial or other interests of the health partner.

Member Support Services & 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.

New Member Kits

Each new member, at the time of enrollment, receives the following information and documents:

- Welcome letter
- Evidence of Coverage (EOC)
- Abridged formulary
- Information about finding doctors and pharmacies online, as well as a request card for a printed version of the Provider and Pharmacy Directory
- Health risk assessment
- Privacy notices

Following the initial enrollment process, the member receives the following:

- Acknowledgement/confirmation letter
- Identification card

Member Services Department

CareSource Medicare Advantage members can access the Member Services Department by calling our toll-free number and following the menu prompts:

- Indiana: 1-800-418-0172 (TTY: 1-800-743-3333)
- Kentucky: 1-800-833-3239 (TTY: 1-800-648-6056)
- Ohio: 1-844-607-2827 (TTY: 1-800-750-0750)

Representatives are available by telephone Monday through Friday. We are open 8 a.m. – 8 p.m. Monday through Friday, and from Oct. 1 – Feb. 14 we are open the same hours 7 days a week.

CareSource24®, Nurse Advice Line

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 care provider (PCP) by explaining the importance of their role in coordinating the member's care.

Key features of this service include nurses who:

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

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

Care Management/Outreach

CareSource's Care Management program is a fully integrated health management program that strives for member understanding of and satisfaction with their medical care. We promote integration of physical and behavioral health to manage the member across the continuum of care with a holistic approach. More importantly, it's designed to support the care and treatment you provide to your patient. We stress the importance of establishment of the medical home, identification of barriers and keeping appointments. This one-on-one personal interaction with outreach specialists and nurse care managers provides a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional community resources.

CareSource encourages you to take an active role in your patient's care management program. This profile provides information on pharmacy 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 participate in the development of a care plan individualized to the needs of your patient. We believe communication and coordination are integral to ensure the best care for these patients.

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

- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Members with special health care needs

Care Management for Complex Members

CareSource provides a community-based care coordination model for our highest-risk members. Utilizing nurses, social workers and community health workers, this multi- disciplinary approach integrates the Case Management Society of America Standards of Practice utilizing "Community Health Workers" to help patients overcome health care access barriers. It also strengthens our health partner 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 complex-risk members served by this model may have multiple medical issues, socioeconomic challenges and behavioral health care needs.

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

CareSource Disease Management Program

CareSource offers disease management programs that can provide a broad spectrum of educational and follow-up services for your patients. CareSource Medicare Advantage members with chronic conditions, including asthma and diabetes, will be automatically enrolled into CareSource's enhanced disease management program. If they choose not to participate in the Disease Management Program they may opt out by calling Health Partner Services:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

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

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

If you have a CareSource patient with asthma or diabetes who you believe would benefit from this program and is not already enrolled, call Health Partner Services:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

Interpreter Services

Interpreter Services – Non-Hospital Health Partners

CareSource offers sign and 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 health partner.

As a health partner, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. To arrange services, please contact our Health Partner Services Department:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

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.

Interpreter Services – Hospital Health Partners

CareSource requires hospitals, at their own expense, to offer sign and language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking ability. 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 Health Partner Services:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

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.

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.

Medicare Member Rights and Responsibilities

As a CareSource Medicare Advantage health partner, you are required to respect the rights of our members. CareSource Medicare Advantage members are informed of their rights and responsibilities via their member handbook (also known as the Evidence of Coverage). The list of our member's 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:

Our plan must honor your rights as a member of the plan. We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.) To get information from us in a way that works for you, please call Member Services. Our plan has people and free translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you. If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

We must treat you with recognition of your dignity, fairness and respect at all times. Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY: 1-800-537-7697) or your local Office for Civil Rights. If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

We must ensure that you get timely access to your covered services and drugs. As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange

for your covered services (The Evidence of Coverage explains more about this). Call Member Services to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of health partners within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, the Evidence of Coverage tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, the Evidence of Coverage tells what you can do.)

We must protect the privacy of your personal health information Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws:

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan, as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used.
- We give you a written notice, called a "Notice of Privacy Practice" that tells about these rights and explains how we protect the privacy of your health information.

How we protect your privacy:

- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law:
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others. You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records.

If you ask us to do this, we will consider your request and decide whether the changes should be made. You have the right to know how your health information has been shared with others for any purposes that are not routine. If you have questions or concerns about the privacy of your personal health information, please call Member Services.

We must give you information about the plan, its network of health partners and your covered services. As a member of CareSource Medicare Advantage, you have the right to get several kinds of information from us. (As explained above, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.) If you want any of the following kinds of information, please call Member Services:

- Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- Information about our network health partners, including our network pharmacies.
  - You have the right to get information from us about the qualifications of the health partners and pharmacies in our network and how we pay the health partners in our network.
  - For a list of the health partners in the plan's network, see the Provider Directory.
  - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
  - For more detailed information about our health partners or pharmacies, you can call Member Services or visit **CareSource.com**.
- Information about your coverage and rules you must follow in using your coverage.
  - The Evidence of Coverage explains what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see the Evidence of Coverage plus the plan's List of Covered Drugs (Formulary).
  - These documents tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services.
- Information about why something is not covered and what you can do about it.
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network health partner or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see the Evidence of Coverage. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (The Evidence of Coverage also tells about how to make a complaint about quality of care, waiting times and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see the Evidence of Coverage.

We must support your right to make decisions about your care.

You have the right to know your treatment options and participate in decisions about your health care. You have the right to get full information from your doctors and other health partners when you go for medical care. Your health partners must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a health partner has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. The Evidence of Coverage tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness.

You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members, as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital:

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed? If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state department of insurance.

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, the Evidence of Coverage tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in the Evidence of Coverage, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services.

What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights. If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else? If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services.
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to the Evidence of Coverage.
- Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of the cost or benefit coverage.

You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

How to get more information about your rights:

There are several places where you can get more information about your rights:

- You can call Member Services.
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to your Evidence of Coverage.
- You can contact Medicare.
  - You can visit the Medicare website (http://www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections."
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have some responsibilities as a member of the plan.

What are your responsibilities? Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services. We're here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services. Use the Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - The Evidence of Coverage gives the details about your medical services, including what is covered, what is not covered, rules to follow and what you pay.
  - The Evidence of Coverage gives the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services to let us know.
  - We are required to follow rules set by Medicare and Medicaid to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits.
- Tell your doctor and other health partners that you are enrolled in our plan. Show your plan membership card and Medicaid card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other health partners help you by giving them information, asking questions, and following through on your care.
  - To help your doctors, other health partners and your health plan give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over- the-counter drugs, vitamins and supplements
  - If you have any questions, be sure to ask. Your doctors and other health partners are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
  - Participate in developing mutually agreed upon treatment goals, to the degree possible.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals and other offices.
- Supply information (to the extent possible). We expect you to provide needed information that the organization and its practitioners and health partners need in order to provide care.
- Understand and be active in your care. You are responsible for making an effort to understand your health problems and participate in developing mutually agreed treatment goals, to the degree possible.

- Follow physician plans of care. In order to ensure the best care, you have a responsibility to follow the plans and instructions for care that you agree to with your practitioners/health partners.
- Pay what you owe. As a plan member, you are responsible for these payments:
  - In order to be eligible for our plan, you must maintain your eligibility for Medicare Part A and Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The Evidence of Coverage tells what you must pay for your medical services. The Evidence of Coverage tells what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost. Or, if you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see the Evidence of Coverage for information about how to make an appeal.
  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must pay the extra amount directly to the government to remain a member of the plan.
  - If you did not join a Medicare drug plan when you first became eligible or if you had a continuous period of 63 days or more when you did not have creditable prescription drug coverage, you may be required to pay a late enrollment penalty (LEP). The late enrollment penalty is added to the plan's monthly premium. Your premium amount will be the monthly plan premium plus the amount of the late enrollment penalty.
- Tell us if you move. If you are going to move, it's important to tell us right away by calling Member Services.
  - If you move outside of our plan service area, you cannot remain a member of our plan. We can help you figure out whether you are moving outside our service area.
  - If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.
- Call Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are on the back cover of the Evidence of Coverage.
  - For more information on how to reach us, including our mailing address, please see the Evidence of Coverage.

HIPAA Notice of Privacy Practices

Members are notified of CareSource's privacy practices as required by HIPAA. This notice includes a description of how and when medical information about CareSource members is used or disclosed and how members can access it. CareSource takes measures across our organization internally to protect oral, written and electronic personal health information of members.

Please remember that disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the HIPAA regulation 45 CFR 164. For example, health partners may disclose patient information to CareSource for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others. Thank you for your assistance in providing requested information to CareSource in a timely manner.

Medicare Member Grievance and Appeals Procedures

Any time a member informs us that they are dissatisfied with CareSource Medicare Advantage, or a health care partner, it is a grievance. A grievance may include any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which CareSource or our delegated entity provides health care services. An expedited grievance may also include a complaint that CareSource refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. In addition, grievances may include complaints regarding timeliness, appropriateness, access to, and/ or setting of a provided health service, procedure or item. Grievances may also include complaints that covered health service procedures or items during a course of treatment did not meet accepted standards of delivery or health care. CareSource investigates all grievances. If the grievance is about a health partner, CareSource calls the health partner's office to gather information and attempt a possible resolution. CareSource responds to member grievances in accordance with CMS time frames.

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

For appeals on behalf of the member, please refer to the CareSource Medicare Advantage member's Evidence of Coverage. The Evidence of Coverage is located on **CareSource.com**, search "Evidence of Coverage."

Level 1: Appeal

Reconsideration

A member starts the appeal process by making an appeal. It is called the first level of appeal or a Level 1 Appeal.

The member contacts CareSource and makes the appeal. If their health requires a quick response, they must ask for a fast appeal. To start an appeal, the member, their representative, or in some cases their doctor, must contact CareSource. An appeal request must be within 60 calendar days from the date on the written notice sent concerning a coverage decision. If the member misses this deadline and has a good reason for missing it, we may give more time to make the appeal. Examples of good cause for missing the deadline may include if the member had a serious illness that prevented he/she from contacting us or if we provided the member with incorrect or incomplete information about the deadline for requesting an appeal. If the member wishes, their doctor may give additional information to support the appeal. A standard appeal must be in writing and must be completed within 30 calendar days after being received by CareSource.

If we are using the standard deadlines, we must give the member our answer within 30 calendar days after we receive the member's appeal if their appeal is about coverage for services they have not yet received. We will give the member our decision sooner if their health condition requires us to. However, if the member asks for more time, or if we need to gather more information that may benefit the member, we can take up to 14 more calendar days. If the member believes we should not take extra days, the member can file a "fast complaint" about our decision to take extra days. When the member files a fast complaint, we will give the member an answer to their complaint within 24 hours.

If we do not give the member an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send the member's request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. If our answer is yes to part or all of what the member requested, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive the member's appeal. If our answer is no to part or all of what the member requested, we will send the member a written denial notice informing the member that we have automatically sent the member's appeal to the Independent Review Organization for a Level 2 Appeal.

A fast appeal is also called an expedited appeal. An expedited appeal can be a verbal or written request and must be completed within 72 hours after being received by CareSource. We can provide our answer sooner if the member's health requires us to do so. If a member asks for more time, or if we need to gather more information that may benefit the member, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell the member in writing. If our answer is yes to part or all of what the member requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive the member's appeal.

Level 2: Independent Review Entity – IRE

If CareSource says no to the Level 1 Appeal, the case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision made when we said no to the first appeal. This organization decides whether the decision we made should be changed. The Independent Review Organization reviews the appeal.

The Independent Review Organization is an outside independent organization that is hired by Medicare. This organization is not connected with CareSource and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work. CareSource will send information about the appeal to this organization. This information is called the "case file." The member has the right to ask for a copy of the case file. The member has a right to give the Independent Review Organization additional information to support their appeal. Reviewers at the Independent Review Organization will take a careful look at all of the information related to the appeal.

If there was a "fast" appeal at Level 1, there will also be a "fast" appeal at Level 2. The Independent Review Organization will tell the member its decision in writing and explain the reasons for it. If the review organization says yes to part or all of what you requested, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review. If the organization says no to part or all of your appeal, they will tell the member in writing if their case meets the requirements for continuing with the appeals process.

Level 3: Administrative Law Judge – ALJ

The notice received from the Independent Review Organization will tell the member in writing if the case meets the requirements for continuing with the appeals process. The written response will explain who to contact and what to do to ask for a Level 3 Appeal. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage being requested must meet a certain minimum. If the dollar value of the coverage being requested is too low, the member cannot make another appeal, which means that the decision at Level 2 is final.

If the Administrative Law Judge approves the appeal, the appeals process may or may not be over. CareSource will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), CareSource has the right to appeal a Level 3 decision that is favorable to the member. If CareSource does not appeal the judge's decision, we must authorize or provide the member with the service within 60 days after receiving the judge's decision. If we decide to appeal the judge's decision, we will send the member a copy of the Level 4 Appeal request with accompanying documents.

If the Administrative Law Judge says no to the decision, the member can either accept the decision and end the appeals process, or the member can continue to the next level of the review process. The member will receive a notice that tells what to do next.

Level 4: The Medicare Appeals Council

The Medicare Appeals Council will review the member's appeal and give the member an answer. The Medicare Appeals Council works for the federal government.

If the member's Level 4 appeal is approved, or if the Medicare Appeals Council denies CareSource's request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over. CareSource Medicare Advantage will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), CareSource Medicare Advantage has the right to appeal a Level 4 decision that is favorable to the member. If CareSource Medicare Advantage decides not to appeal the decision, CareSource Medicare Advantage must authorize or provide the member with the service within 60 days after receiving the Appeals Council's decision. If CareSource Medicare Advantage decides to appeal the decision, CareSource Medicare Advantage will let the member know in writing.

If the member's Level 4 appeal is denied or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over.

If the member decides to accept this decision, the appeals process is over. If the member does not want to accept the decision, the member might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to the member's appeal, the notice the member receives will tell the member whether the rules allow the member to go on to a Level 5 Appeal. If the rules allow the member to go on, the written notice will also tell the member who to contact and what to do next if the member chooses to continue with the next level of review.

Level 5: A Judge at the Federal District Court

A judge at the Federal District Court will review your appeal if permitted based on the Level 4 response. This is the last stage of the appeals process.

Pharmacy

Medication Therapy Management Program

CareSource offers a medication therapy management (MTM) program for all CareSource members. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs, and provide health care to patients in a cost-effective manner. You may be contacted by a pharmacist to discuss your patient's medications.

Network Pharmacy

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

Tell us the Medical Reasons for Exceptions

Our preferred drug list includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. You must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information when you ask for the exception. A member can also initiate an exception request, however if the request needs additional information related to medical necessity then we will reach out to you to obtain the required information.

Approval/Denial of Drug Exceptions

If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as you continue to prescribe the drug for your patient and that drug continues to be safe and effective for treating the condition.

If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Please review the "Appeals" section for details on how to submit appeals.

Appeals

An appeal is defined as a special kind of complaint a member may make if he/she disagrees with a decision to deny a request for health care services and/or prescription drugs or payment for services and/or prescription drugs they already received. A member may also make a complaint if he/she disagrees with a decision to stop services that they are receiving. For example, a member may ask for an appeal if our plan doesn't pay for a drug, item or service they think they should be able to receive.

Our members' health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first. Please contact us for grievances, organization determinations, coverage determinations and appeals questions:

- Indiana: 1-800-418-0172
- Kentucky: 1-800-833-3239
- Ohio: 1-800-607-2827

We will work with you to try to find a satisfactory solution to your problem.

Medicare Formulary (List of Covered Drugs)

More information about how to use our pharmaceutical management procedures is available in the introduction of the formulary. The CareSource formulary is the list of drugs that are covered as a pharmacy plan benefit for CareSource members. The CareSource Medicare Advantage formulary was selected in consultation with a team of health partners, which represents the prescription therapies believed to be a necessary part of a quality treatment program. CareSource Medicare Advantage will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a CareSource Medicare Advantage network pharmacy, and other plan rules are followed.

For a complete listing of all prescription drugs covered by CareSource Medicare Advantage, please visit our website at **CareSource.com**.

Limits & Quotas

Some drugs have limits on how much can be given at one time. Quantity limits are based on the drug makers' recommended doses frequencies. Patient safety is also considered.

Step Therapy, Therapeutic Interchange & Generic Substitution

Certain drugs will be covered only if step therapy is used. Members may need to try one drug before taking another; a medicine on the formulary must be tried before a non-formulary drug would be approved by CareSource.

Through a process of generic substitution, a pharmacy will provide, if available, a generic drug in place of a brand-name drug. Members and health partners can expect the generic to produce the same effect and have the same safety profile as the brand-name drug. If a brand name product is requested when a generic equivalent is available, a prior authorization request will need to be submitted. Additionally, if a member would have a drug allergy or intolerance, or a certain drug might not be effective and a non-formulary agent is requested, referred to as Therapeutic Interchange, a coverage determination (prior authorization) request would be required.

Tiered Medications – Five Cost-Sharing Tiers

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

- Cost-Sharing Tier 1 includes preferred generic drugs. This is the lowest tier.
- Cost-Sharing Tier 2 includes non-preferred generic drugs.
- Cost-Sharing Tier 3 includes preferred brand drugs.
- Cost-Sharing Tier 4 non-preferred brand drugs.
- Cost-Sharing Tier 5 includes specialty brand and generic drugs. This is the highest tier.

To find out which cost-sharing tier your drug is in, look it up in the plan's drug list. You can access the formulary (List of Covered Drugs) online by visiting **CareSource.com.**

Tiered Cost-Sharing Exceptions

In certain circumstances, a member may request a reduction in the copayment or coinsurance amount for a drug on the Formulary.

A member must meet appropriate medical necessity criteria before the tiered cost- sharing exceptions will be approved. To determine medical necessity, the CareSource Medicare Advantage Plan Pharmacy Benefit Manager will verify, through the health partner's supporting statement(s) and/or standards documented in clinical guidelines adopted by the Plan, that all drugs in the lower preferred tiers:

1. Would not be as effective for the member as the requested drug.
2. Would have adverse effects for the member, or both. Tiered cost-sharing exception requests will be processed through CareSource's pharmacy benefit manager's prior authorization review process.

Medicare Part D Phone Numbers for Coverage Determination (Prior Authorization)

CareSource uses a Pharmacy Benefit Manager to handle prior authorization requests.

All requests for pharmaceutical prior authorizations should be directed to CareSource by calling toll-free:

- Indiana: 1-800-418-0172
- Kentucky: 1-800-833-3239
- Ohio: 1-800-607-2827

Please follow the prompts for Medicare prior authorization.

Written request via fax: 855-633-7673 for oral medications and injectable/ specialty medications, or visit **CareSource.com.**

Medicare Pharmacy Coverage Determination (Prior Authorization)

CareSource will process coverage determinations and exception requests in accordance with Medicare Part D regulations. Requests will be handled through the prior authorization review process. Prior authorization requires a drug to be "pre-approved" in order for it to be covered under a benefit plan.

The prior authorization staff will adhere to the CMS approved criteria. The Pharmacy Benefit Manager's National Pharmacy and Therapeutics Committee establishes clinical guidelines, and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines.

Health partners can submit prior authorization requests by phone or fax. Health partners will be required to submit pertinent medical/drug history, prior treatment history, and any other necessary supporting clinical information with the request.

Standard requests will be reviewed and determinations will be made within 72 hours. An expedited coverage determination will be made within 24 hours.

Primary Care Providers

Primary Care Provider (PCP) Concept

All CareSource members choose or are assigned to a PCP upon enrollment in the plan. PCPs should help facilitate a medical home for members. This means that PCPs will help coordinate health care for the member and provide additional health options to the member for self-care or care from community partners.

Members select a PCP from our health plan's Provider Directory. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling our Member Services Department.

PCP Roles and Responsibilities

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

1. Assisting with coordination of the member's overall care, as appropriate for the member.
2. Serving as the ongoing source of primary and preventive care.
3. Recommending referrals to specialists, as required.
4. Triaging members.
5. Participating in the development of case management care treatment plans, and notifying CareSource of members who may benefit from case management. Please see the "CareSource Disease Management" section on how to refer members.

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

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

PCPs are Responsible For:

- Treating CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week. Members select a PCP from our health plan's Provider Directory.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plan.
- Providing 30 days of emergency coverage to any CareSource patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by CareSource patients for emergency or urgent care if notified of the visit.
- Ensuring demographic and practice information is up-to-date for directory and member use.

Health Partner Appeals Procedures

Appeals of Claims Denials or Adverse Decisions

If you do not agree with the decision of the processed claim, you will have 365 days from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied. If the appeal is denied, health partners will be notified in writing. If the appeal is approved, payment will show on the health partner's Explanation of Payment (EOP).

Please note: If you believe the claim processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim; you do not need to file an appeal. Health partners have 365 days from the date of service or discharge to submit a corrected claim.

How to Submit Appeals

Claims Appeals

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

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

Under the Provider Portal, click on the "Claims Appeals" tab on the left.

Writing: Use the “Health Partner Claim Appeal Request Form” located on our website.

CareSource
P.O. Box 1432
Dayton, OH 45401-1432

Please include:

- The member’s name, CareSource member ID number.
- The health partner’s name and ID number.
- The code(s) and reason why the determination should be reconsidered.
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or Electronic Data Information (EDI) for reconsideration.
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.

CareSource Medicare Advantage Health Partner Appeals/Clinical Appeals

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

Clinical appeals submitted by or for the CareSource Medicare Advantage member follow the same process as the Medicaid process (see above process).

For appeals on behalf of the member, please refer to the CareSource Medicare Advantage member’s Evidence of Coverage. The Evidence of Coverage is located on our website at **CareSource.com**. Search “Evidence of Coverage.”

Level 1: Appeal – Reconsideration

A member starts the appeal process by making an appeal. It is called the first level of appeal or a Level 1 Appeal.

Level 1 Appeal Details

The member contacts CareSource Medicare Advantage and makes the appeal. If their health requires a quick response, they must ask for an expedited appeal. To start an appeal, the member, their representative or in some cases their health partner must contact CareSource Medicare Advantage. Appeal requests must be within 60 calendar days from the date on the written notice sent concerning a coverage decision. If the member wishes, their health partner may give additional information to support the appeal.

A standard appeal must be in writing and completed within 30 calendar days after being received by CareSource Medicare Advantage.

Expedited Appeal

An expedited appeal can be a verbal or written request and must be completed within 72 hours after being received by CareSource Medicare Advantage.

Level 2: Independent Review Entity – IRE

If CareSource Medicare Advantage says no to the Level 1 Appeal, the case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision made during the first appeal. This organization decides whether the decision made should be changed.

Steps of the Level 2 Appeal Process

Step 1: The Independent Review Organization reviews the appeal. The Independent Review Organization is an outside independent organization that is hired by Medicare. This organization is not connected with CareSource Medicare Advantage and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization.

Medicare oversees its work. CareSource Medicare Advantage will send information about the appeal to this organization. This information is called the "case file." The member has the right to ask for a copy of the case file. The member has a right to give the Independent Review Organization additional information to support their appeal. Reviewers at the Independent Review Organization will take a careful look at all of the information related to the appeal. If there was an "expedited" appeal at Level 1, there will also be an "expedited" appeal at Level 2.

Level 3: Administrative Law Judge – ALJ

The notice received from the Independent Review Organization will tell the member in writing if the case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage being requested must meet a certain minimum. If the dollar value of the coverage being requested is too low, the member cannot make another appeal, which means that the decision at Level 2 is final.

Level 4: The Medicare Appeals Council

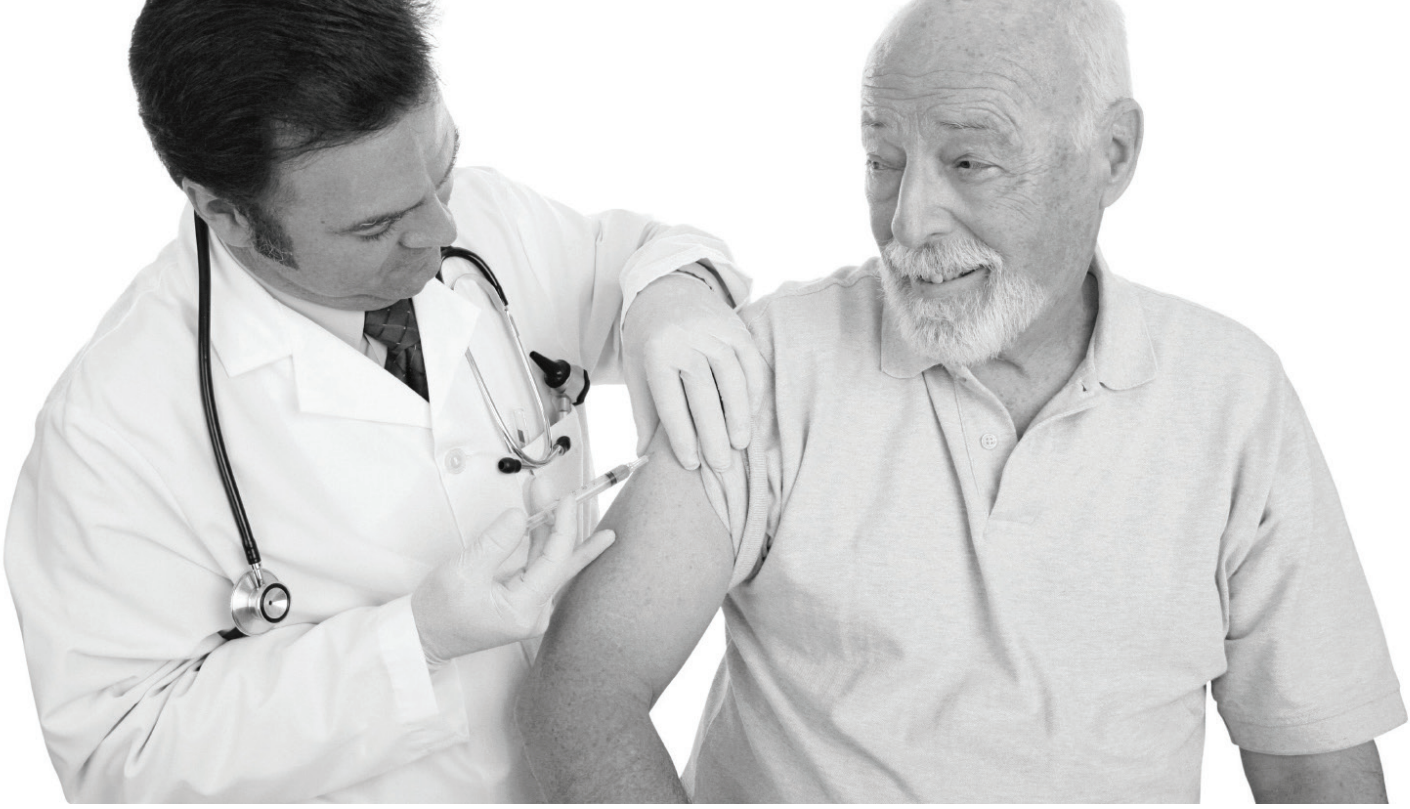
The Medicare Appeals Council will review the member's appeal and give the member an answer. The Medicare Appeals Council works for the federal government.

If the member's Level 4 appeal is approved, or if the Medicare Appeals Council denies CareSource Medicare Advantage's request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over. CareSource Medicare Advantage will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), CareSource Medicare Advantage has the right to appeal a Level 4 decision that is favorable to the member. If CareSource Medicare Advantage decides not to appeal the decision, CareSource Medicare Advantage must authorize or provide the member with the service within 60 days after receiving the Medicare Appeals Council's decision. If CareSource Medicare Advantage decides to appeal the decision, CareSource Medicare Advantage will let the member know in writing.

If the member's Level 4 appeal is denied or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over. If the member decides to accept this decision, the appeals process is over. If the member does not want to accept the decision, the member might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to the member's appeal, the notice the member receives will tell the member whether the rules allow the member to go on to a Level 5 Appeal. If the rules allow the member to go on, the written notice will also tell the member who to contact and what to do next if the member chooses to continue with the next level of review.

Level 5: A Judge at the Federal District Court

A judge at the Federal District Court will review your appeal if permitted based on the Level 4 response. This is the last stage of the appeals process.



Medicare Advantage Quality Improvement Program

Program Purpose

The purpose of the CareSource Quality Improvement Program is to ensure that CareSource has the necessary infrastructure to:

- Coordinate care
- Promote quality
- Ensure performance and efficiency on an ongoing basis
- Improve the quality and safety of clinical care and services provided to Medicare Advantage members

There are two guiding tenets for the program:

> Our mission, which is our heartbeat, is to make a lasting difference in our members' lives by improving their health and well-being. Our vision is to transform lives through innovative health and life services.
>
> The Institutes for Healthcare Improvement's Triple Aim: Simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and the per capita cost of care for the benefit of communities.

The Medicare Advantage Quality Improvement Program includes both clinical and non-clinical services and is revised as needed to remain responsive to member needs, health partner feedback, standards of care, and business needs.

Program Goals and Objectives

CareSource strives to be a top performing health plan nationally. Performance goals are determined and aligned with national benchmarks where available.

The goals and objectives of the program are:

- NCQA Excellent Accreditation
  - Compliance with NCQA Accreditation standards
  - High level of HEDIS® performance
  - High level of CAHPS® performance
  - Comprehensive population health management program
  - Comprehensive health partner engagement program
- 5 STAR NCQA Health Plan Rating
  - High level of HEDIS performance
  - High level of CAHPS performance
  - Comprehensive population health management program
  - Comprehensive health partner engagement program
- Medicare Advantage 5-Star Health Plan
  - High level of HEDIS performance
  - High level of CAHPS performance
  - Comprehensive population health management program
  - Comprehensive health partner engagement program

Program Scope

The Medicare Advantage Quality Improvement Program governs the quality assessment and improvement activities for CareSource Medicare Advantage plans. The scope includes:

- Meeting the quality requirements of the Centers for Medicare and Medicaid Services (CMS) as outlined in the CMS's Medicare Managed Care Manual, Chapter 5, Quality Assessment; and 42 CFR§422.152;
- Establishing safe clinical practices throughout the network of health partners;
- Providing quality oversight of all clinical services;
- Compliance with NCQA accreditation standards;
- HEDIS compliance audit and performance measurement;
- Monitoring and evaluation member and health partner satisfaction;
- Managing all quality of care and quality service complaints;
- Developing organizational competency of the Plan Do Study Act (PDSA) Improvement Methodology;
- Ensuring that the CareSource Medicare Advantage Program is effectively serving members with culturally and linguistically diverse members;
- Ensuring that the CareSource Medicare Advantage Program is effectively serving members with complex health needs;
- Assessing the characteristics and needs of the member population; and
- Assessing the geographic availability and accessibility of primary and specialty care health partners.

The quality program is overseen by the Chief Medical Officer in conjunction with the Medical Director, and implementation is facilitated by the Vice President, Quality Improvement and Performance Outcomes. On an annual basis, CareSource makes information available about its Quality Program to health partners on the web. CareSource gathers and uses health partner performance data to improve quality of services.

Quality Metrics

CareSource monitors member quality of care, health outcomes, and satisfaction through the collection, analysis, and the annual review of the Medicare Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcomes Survey (HOS), and Medicare Consumer Assessment of Health Providers and Systems (CAHPS). Medicare HEDIS, HOS, and Medicare CAHPS form the basis for the Centers for Medicare& Medicaid Services (CMS) Star Ratings used to evaluate the quality of care provided to CareSource Medicare Advantage members.

CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plan and the health care system. Star Ratings are based on measures of the health plan's rating across five categories:

- Staying healthy: screenings, tests and vaccines: Includes whether members got various screening tests, vaccines, and other check-ups that help them stay healthy.
- Managing chronic (long-term) conditions: Includes how often members with different conditions got certain tests and treatments that help them manage their condition.
- Member experience with the health plan: Includes ratings of member satisfaction with the plan.
- Member complaints and changes in the health plan's performance: Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- Health plan customer service: Includes how well the plan handles member appeals.

For health plans covering drug services, the overall score for quality of those services covers many different topics that fall into 4 categories:

- Drug plan customer service: Includes how well the plan handles member appeals.
- Member complaints and changes in the drug plan's performance: Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- Member experience with plan's drug services: Includes ratings of member satisfaction with the plan.
- Drug safety and accuracy of drug pricing: Includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is safer and clinically recommended for their condition.

Health partners can use tools available via the CareSource Provider Portal to look up services and tests needed and historical medical and pharmacy data.

Preventive Guidelines and Clinical Practice Guidelines

CareSource approves and adopts nationally accepted standards and guidelines and promotes them to practitioners and members to help inform and guide clinical care provided to Medicare Advantage members. Guidelines are reviewed at least every two years or more often as appropriate, and updated as necessary. The use of these guidelines allows CareSource to measure the impact of the guidelines on outcomes of care. Review and approval of the guidelines are completed by the CareSource Clinical Advisory Committee every two years or more often as appropriate. The guidelines are then presented to the CareSource Quality Enterprise Committee. Topics for guidelines are identified through analysis of Medicare Advantage members. Guidelines may include, but are not be limited to:

- Behavioral health (i.e. depression)
- Adult health (i.e. hypertension, diabetes, cardiovascular disease, cerebrovascular disease and chronic obstructive pulmonary disease)
- Population health (i.e. obesity, tobacco cessation)

Guidelines are promoted to health partners through newsletters, the CareSource health partner website, direct mailings, health partner manual, and through focused meetings with CareSource Health Partner Engagement Representatives.

Information about clinical practice guidelines and health information are made available to Medicare Advantage members via member newsletters, the CareSource member website, or upon request.

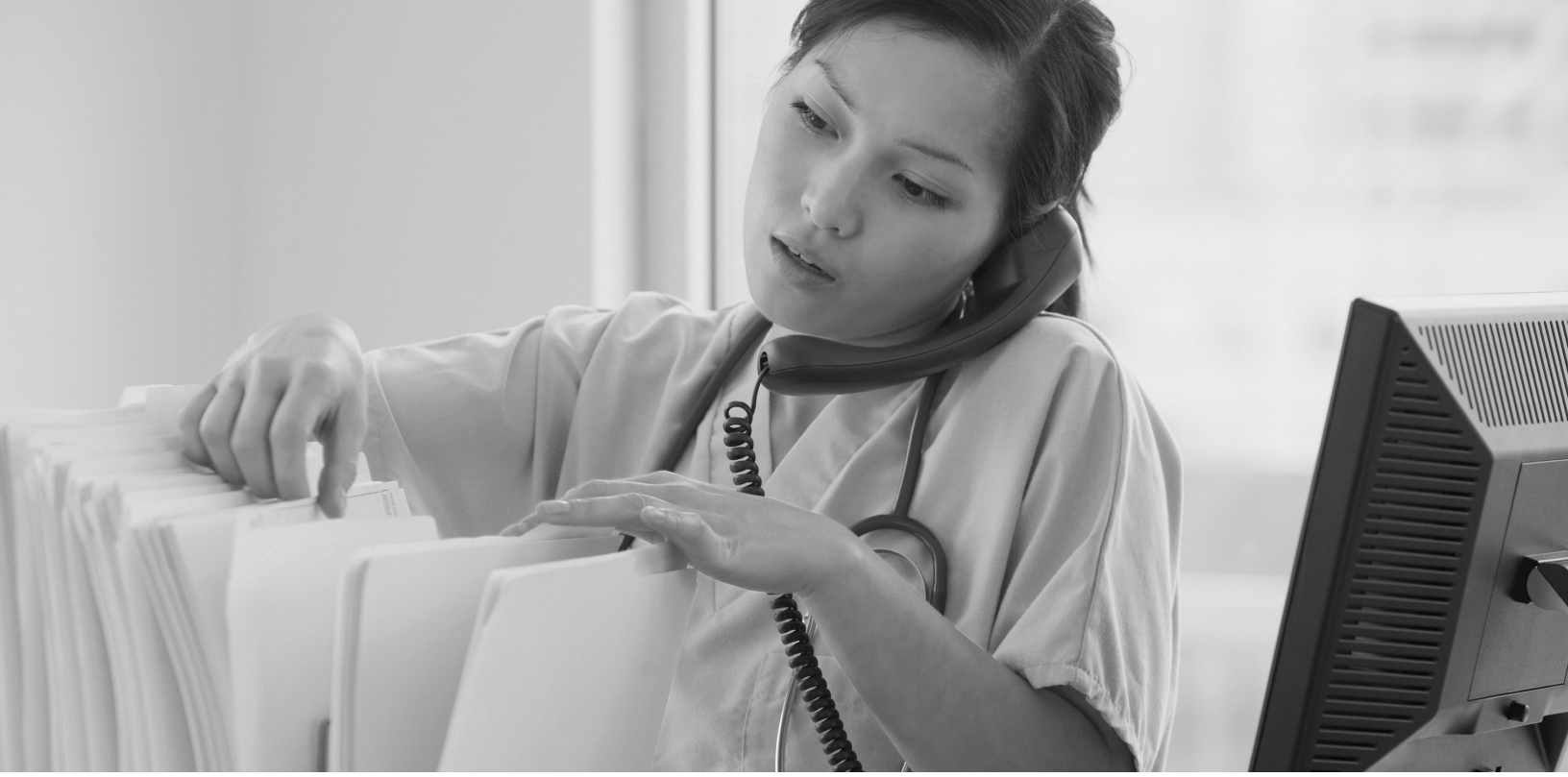
Participation in CMS and HHS Quality Improvement Initiatives

CareSource encourages health partners to participate in CMS and HHS quality improvement initiatives. Information on CMS and HHS quality improvement initiative can be found at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html?redirect=/qualityinitiativesgeninfo/.

If you would like more information on CareSource Quality Improvement, please call Health Partner Services:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).



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 health partners.

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

For certain specialties with higher demand (such as dental, dermatology, orthodontia, endocrinology and orthopedics), patients with routine care needs should be seen within 16 weeks.

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

How to Submit Changes to CareSource:

Email: providermaintenance@caresource.com

Fax: 937-396-3076

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

Health Partner Performance and Profiling

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

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

Referrals and Prior Authorizations

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

If you have questions about referrals and prior authorizations, please call our Medical Management Department:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

Medicare Referral Procedures

Medicare members are not required to obtain referrals from their PCP prior to obtaining services from specialists. However, PCPs are asked to assist members in obtaining specialty services.

If you have difficulty finding a specialist for your CareSource member, please call Health Partner Services and select the option to speak to someone in our Medical Management Department:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

Please note that members may go to non-participating health partners for:

- Emergency care
- Out of area dialysis care
- Out of area urgently needed care

Services Rendered by Out-of-Plan Health Partners

A member may be sent to out-of-plan health partners if the member needs medical care that can only be received from a doctor or other health partner who is not participating with our health plan. PCPs must get prior authorization from our health plan before sending a member to an out-of-plan health partner. You can request prior authorization by calling our Medical Management Department and select the prompt to request prior authorization:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

Second Opinions

A second opinion is not required for surgery or other medical services. However, health partners, or members may request a second opinion at no cost to the member other than applicable copayments, coinsurance and deductibles.

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

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

Prior Authorization Procedures

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

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

Email: MMMA@CareSource.com

Fax:

- Indiana: 855-761-9058
- Kentucky: 855-763-6790
- Ohio: 844-417-6153

The prior authorization form can be found on **CareSource.com.**

Mail: Send prior authorization requests to:
CareSource
P.O. Box 3209
Dayton, OH 45401-3209

Phone: Call Health Partner Services and follow the appropriate menu prompts for the authorization requests, depending on your need:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

When requesting an authorization, please provide the following information:

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

If the request is for inpatient admission (whether it is elective, urgent or emergency), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

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

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received.

When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Health partners must verify eligibility on the date 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 health partner.

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

For standard prior authorization decisions, CareSource provides notice to the health partner and member as expeditiously as the member's health condition requires, but no later than 14 calendar days following receipt of the request for service. Urgent prior authorization decisions are made within 72 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.

Retrospective Review

A retrospective review is a request for an initial review for authorization of care, service or benefit for which an authorization is required, but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. In the event that you fail to obtain prior authorization, you will have 180 days from the date of service, date of discharge, or 90 days from the other carrier's EOB (whichever is later) to request a retrospective review. For retrospective authorization decisions, CareSource provides notice to the health partner and member within 30 days from the date of receipt.

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 up to 90 days to request the appeal from date of service, discharge date or date of the denial if the service is not yet rendered (whichever is later).

A request for retrospective review can be made by contacting the Medical Management Department and following the appropriate menu prompts:

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

You can also fax the request:

- Indiana: 855-761-9058
- Kentucky: 855-763-6790
- Ohio: 844-417-6153

Clinical information supporting the request for services must accompany the request.

Utilization Management (UM)

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The Medical Management Department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities.UM helps maintain the quality and appropriateness of health care services provided to CareSource members.

We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the CareSource case management team are made, if needed. CareSource makes it's UM criteria available in writing by mail, fax or email and via the web.

Mail: CareSource
P.O. Box 3209
Dayton, OH 45401-3209
Fax:

- Indiana: 855-761-9058
- Kentucky: 855-763-6790
- Ohio: 844-417-6153

Email: MMMA@CareSource.com

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

Access to Staff

- Staff members are available from 8 a.m. to 5 p.m. during normal business hours for inbound calls regarding utilization management (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.

Criteria

CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. These criteria are designed to assist health partners in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients. CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. CareSource also has a medical policy developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available to discuss individual cases with attending physicians upon request. 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 partners or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

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

- Indiana: 1-855-202-0557
- Kentucky: 1-855-202-1059
- Ohio: 1-844-679-7865

Health Partner Appeals Procedure

If you are dissatisfied with a determination made by our Medical 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.

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