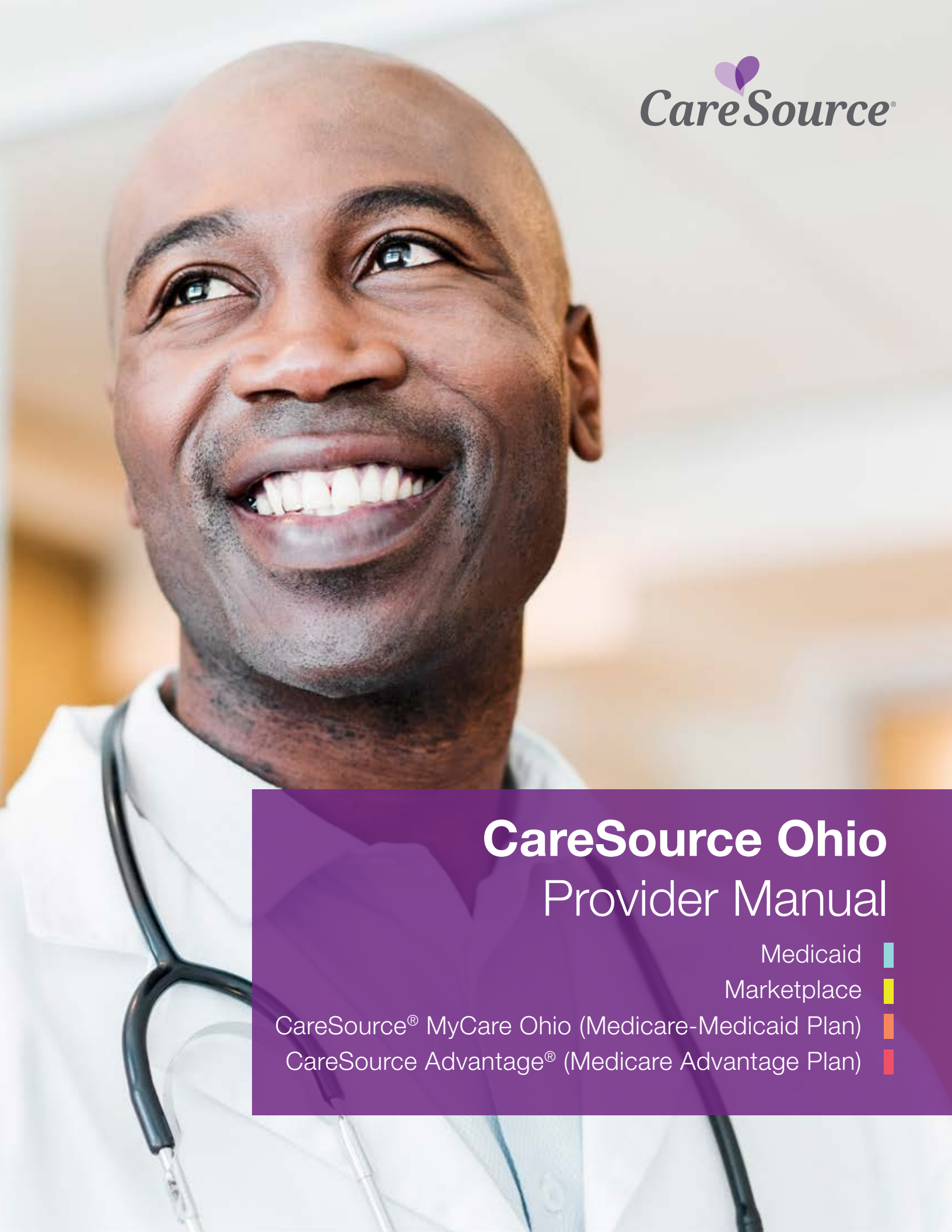

CareSource®

CareSource Ohio
Provider Manual

Medicaid

Marketplace

CareSource® MyCare Ohio (Medicare-Medicaid Plan)

CareSource Advantage® (Medicare Advantage Plan)

This content has been reviewed; however, changes and/or revisions occur frequently. The provider should check the Provider Manual and Updates & Announcements pages on **CareSource.com** for the most up-to-date information

Dear CareSource provider,

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

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

CareSource offers Medicare Advantage plans and Dual-Eligible Special Needs Plans (D-SNP) that offer more coverage than original Medicare. CareSource Advantage members have access to all benefits of Medicare Part A and B, plus prescription drug coverage (Part D). CareSource Dual Advantage members have access to both Medicare and Medicaid benefits in a single plan, plus prescription drug benefits. We also participate in the Ohio duals demonstration program, MyCare Ohio, serving dual-eligible participants in Ohio.

We also offer plans in the Health Insurance Marketplace. Members enrolled in our Marketplace plans pay any premiums and cost-sharing amounts (deductibles, coinsurance, copayments, etc.) that apply to their coverage based on their level of income. Our Marketplace plans help provide members with stability, peace of mind and affordable health care with heart – allowing members to select the plan which best meets their needs.

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

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

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

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

Sincerely,

CareSource®

TABLE OF CONTENTS

ABOUT THIS MANUAL

Format

This manual includes information for all of CareSource's plans/products in Ohio:

- Medicaid
- Medicare Advantage
- Dual Advantage (Dual-Eligible Special Needs plan, or D-SNP)
- Marketplace
- MyCare Ohio

With the exception of information that is universal for all plans, each plan has a dedicated chapter with information pertinent to the operations of that product.

Navigation

In Part One, the following chapters contain all-plan information that is universal to all CareSource Ohio products:

Part One: Introduction to Working with CareSource

- About CareSource
- Communicating with CareSource
- Credentialing and Recredentialing
- Claim Submissions
- Utilization Management

Within these universal chapters, you will also find call-outs that speak to specific plans, designated contact information for each plan, or an "Additional Plan-Specific Details" section at the end of that chapter that provides more information on that topics specific to a plan.

In Part Two, each plan has its own chapter with the following sub-chapters included that speak to that plan only.

Part Two: CareSource Ohio Plans

- Member Enrollment and Eligibility
- Covered Services and Exclusions
- Member Support Services and Benefits
- Member Grievance and Appeals
- Referrals and Prior Authorizations
- Pharmacy
- Provider Appeals Procedures

In Part Three, the following sub-chapters contain all-plan information that is universal to all CareSource Ohio products:

Part Three: Your Role as a CareSource Provider

- CareSource Member Rights and Responsibilities
- Americans with Disabilities Act
- Health Equity Commitment
- Quality Improvement Program
- Primary Care Providers
- Key Contract Provisions
- Fraud, Waste and Abuse

You can easily find which plan chapter you are in by the color-coded header that appears at the top of the page.

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ABOUT CARESOURCE

Welcome

Welcome, and thank you for participating with CareSource.

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

We are a nonprofit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. In Ohio, CareSource currently serves members and consumers of our Medicaid, Medicare Advantage, Dual-Eligible Special Needs (D-SNP), MyCare Ohio, and Marketplace plans.

Our goal is to create an integrated medical home for our members. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy. As a MCO, we improve the health of our members by utilizing a contracted network of high-quality participating providers. Primary care providers within the network provide a range of services to our members, and also coordinate patient care by referring them to specialists when needed, ensuring 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 providers
- Existing providers

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 providers.

Vision and Mission

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

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

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

Our Services

- Provider relations
- Provider 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 with CareSource as well as with our benefit managers:
    - Pharmacy: ExpressScripts Inc. (ESI)
    - Dental: SKYGEN
        - Medicaid – DentaQuest
        - Vision: EyeMed
    - Medicaid: Superior Vision
    - Hearing: TruHearing
    - Fitness: American Specialty Health

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

- Low, medium and complex case management – a "no wrong door" referral intake
- Telephonic case management
- Disease management
- Preventive health and wellness assistance with focused health needs/risk assessment
- Emergency department diversion – high emergency department utilization focus (targeted at members with frequent utilization)
- CareSource24®, Nurse Advice Line
- Maternal and child health
  - Comprehensive prenatal, postpartum and family planning services
  - Outreach programs in partnership with community agencies to target members at greatest risk for preterm birth or complications
- Behavioral health (BH) and substance use disorder (SUD) management
- Collaboration with pharmacy and medication therapy management (MTM)

For more information on these programs across our various plans, see the "Member Support Services and Benefits" chapters for each plan included in this manual.

The CareSource Foundation

CareSource gets actively involved in the communities that we serve, from employees serving on hundreds of nonprofit boards to investing dollars back. We listen, we learn and we are driven to action. As a result, we launched the CareSource Foundation in 2006 to add another component to our professional services: community response. Focus areas of the CareSource Foundation are closely aligned with the greatest needs of our member demographics. Areas of emphasis include: children's health, special populations such as seniors and individuals with disabilities, the uninsured and life issues such as hunger, domestic violence, SUD, and homelessness.

The CareSource Foundation has awarded grants totaling over $16.4 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 CareSource 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.

Compliance and Ethics

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

Our 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 providers, consultants and vendors.

General Compliance and Ethics Expectations of Providers

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

For questions about provider expectations, please call Provider Services at:

- Medicaid: **1-800-488-0134**
- Medicare Advantage: **1-844-679-7865**
- D-SNP: **833-230-2176**
- Marketplace: **1-800-488-0134**
- MyCare: **1-800-488-0134**

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 and Compliance Hotline: 844-784-9583 or http://caresource.ethicspoint.com
- Compliance Officer: 937-487-5110 or CorporateComplianceOfficer@caresource.com

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

The CareSource Corporate Compliance Plan is posted for your reference on **CareSource.com** > About Us > Legal > Corporate Compliance. Please let us know if you have questions regarding the CareSource Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

Personally Identifiable Information

In the day-to-day business of patient treatment, payment and health care operations, CareSource and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices to guide that PII be appropriately protected wherever it is stored, processed and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your sensitive provider data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure protected health information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace, and shred it 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.

Member Consent

When you check eligibility on the Provider Portal, you can also determine if a member has granted consent to share their health information with their past, current and future treating providers. A message displays on the Member Eligibility page if the member has not consented to sharing their health information.

Please encourage CareSource members who have not consented to complete our Member Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located at **CareSource.com** > Provider > Forms.

The Member Consent/HIPAA Authorization Form can also be used to designate a person to speak on the member's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the member specifies.

Accreditation

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

ALL PLANS

COMMUNICATING WITH CARESOURCE

CareSource communicates with our provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSource.com** and network notifications. Please reach out to our Provider Services department with any questions

Provider Services	
Monday to Friday	8 a.m. to 6 p.m. Eastern Standard Time (EST)

Member Services		
CareSource24®, (nurse advice line for all plans)	Seven days a week, 365 days a year	24 hours a day
CareSource Medicaid	Monday to Friday	7 a.m. to 7 p.m. EST
CareSource MyCare	Monday to Friday	8 a.m. to 8 p.m. EST
CareSource Medicare Advantage	Monday to Friday	8 a.m. to 8 p.m. EST
CareSource D-SNP	Monday to Friday	8 a.m. to 8 p.m. EST
CareSource Marketplace	Monday to Friday	7 a.m. to 7 p.m. EST

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

Phone

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

	Medicaid	MyCare	Medicare Advantage	D-SNP	Marketplace
Provider Services	1-800-488-0134	1-800-488-0134	1-844-679-7865	1-833-230-2176	1-800-488-0134
Prior Authorizations	1-800-488-0134	1-800-488-0134	1-844-679-7865	1-833-230-2176	1-800-488-0134
Claim Inquiries	1-800-488-0134	1-800-488-0134	1-844-679-7865	1-833-230-2176	1-800-488-0134
Credentialing	1-800-488-0134	1-800-488-0134	1-844-679-7865	1-833-230-2176	1-800-488-0134
Member Services	1-800-488-0134	1-855-475-3163	1-844-607-2827	1-833-230-2030	1-800-479-9502
CareSource24 – Nurse Advice Line	1-866-206-0554	1-866-206-7861	866-206-0569	1-833-687-7331	1-866-206-4240
Fraud, Waste and Abuse Hotline	1-800-488-0134	1-800-488-0134	1-844-679-7865	1-844-679-7865	1-800-488-0134
TTY for the Hearing Impaired	1-800-750-0750 or 711	1-800-750-0750 or 711	1-800-750-0750 or 711	1-800-750-0750 or 711	1-800-750-0750 or 711

Fax

	Medicaid	MyCare	Medicare Advantage	D-SNP	Marketplace
Credentialing	866-573-0018	866-573-0018	937-396-3632	937-396-3632	866-573-0018
Care Management Referral	877-946-2273	877-946-2273	937-396-3688 866-206-0610	937-396-3688	977-946-2273
Contract Implementation	937-396-3632	937-396-3632	937-396-3632	937-396-3632	937-396-3632
Fraud, Waste and Abuse	800-418-0248	800-418-0248	800-418-0248	800-418-0248	800-418-0248
Medical Prior Authorization Form	888-752-0012	888-752-0012	844-417-6153	1-844-679-7865	888-752-0012
Pharmacy Prior Authorization Form	866-930-0019	877-328-9660	877-328-9660	877-328-9660	866-930-0019

	Medicaid	MyCare	Medicare Advantage	D-SNP	Marketplace
Pharmacy Prior Authorization Specialty Drug Form (Outpatient Drugs Only)	888-399-0271	N/A	N/A	N/A	888-399-0271
Provider Appeals	937-531-2398	937-531-2398	937-531-2398	937-531-2398	937-531-2398
Provider Maintenance	937-396-3076	937-396-3076	937-396-3076	937-396-3076	937-396-3076
Medicare Part D Formulary Exception/Prior Authorization Form	N/A	877-328-9660	877-328-9660	877-328-9660	N/A

Website

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

Provider Portal

URL: https://providerportal.caresource.com/OH

Our secure online Provider Portal allows you instant access at any time to valuable information. You can access the CareSource Provider Portal at CareSource.com > Login > Provider Portal. Simply enter your username and password (if already a registered user), or submit your information to become a registered user. Assisting you is one of our top priorities in order to deliver better health outcomes for our members.

Provider Portal Benefits

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

Provider Portal Tools

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

- **Payment history** – Search for payments by check number or claim number.
- **Claims features**
  - Submit claims – Using online forms, claim submission through the portal is available to traditional providers, community partners, delegates and health homes. For more information about submitting claims online, please visit the "Claim Submissions" section on page 22.
  - Claims status – Search for status of claims and claim appeals.
  - Claims attachments – Submit documentation needed for claims processing.
  - Submit claim – Submit claims using online forms or upload a completed claim. Claim submission through the portal is available to traditional providers, community partners, delegates, and health homes. For more information about submitting claims online, please visit the Claims Submissions section on page 22.
  - Rejected claims – Find claims that may have been rejected so that you can resubmit them.
  - Claim dispute and appeals – Search for the status of claims and claim appeals.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior authorization (PA)** – Submit medical inpatient/outpatient, home health care 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 chiropractic, occupational therapy, physical therapy and speech therapy.
- **Care treatment plans** – Providers can view care treatment plans.
- **Clinical Practice Registry (CPR)** – Filter patient data to identify opportunities for preventive health screenings.
- **Recovery letters** – View and download letters.
- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **Member financial status and information** – View member payment responsibilities (such as deductible, copay and coinsurance) and monthly premium payment status. Also view member's payment history.
- **File grievance**
- **Service plan** – Waiver providers can review, print, respond to and acknowledge approved services.

Portal Registration

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

1. Visit **CareSource.com** > Providers > Ohio and click on "Provider Login."
2. Click on the "Register Now" button and complete the three-step registration process. You will need your Tax ID number and your CareSource Provider Number, located in your welcome letter.
3. Click the "Continue" button.
4. Note the username and password you create so that you can access the portal's many helpful tools.

If you do not remember your username/password, please call Provider Services:

- Medicaid: **1-800-488-0134**
- Medicare Advantage: **1-844-679-7865**
- D-SNP: **833-230-2176**
- Marketplace: **1-800-488-0134**
- MyCare: **1-800-488-0134**

Dental Providers

Please use the **Providers > Dental Provider** Login menu option of the Provider Portal to access capabilities specifically for dental providers.

Mail

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

	Medicaid	MyCare	Medicare Advantage	D-SNP	Marketplace
Provider Appeals	N/A	CareSource P.O. Box 2008 Dayton, OH 45401-2008	CareSource P.O. Box 2008 Dayton, OH 45401-1432	N/A	CareSource P.O. Box 1947 Dayton, OH 45401-1947
Member Appeals & Grievances	CareSource P.O. Box 1947 Dayton, OH 45401-1947	CareSource P.O. Box 1947 Dayton, OH 45401-1947	CareSource P.O. Box 1947 Dayton, OH 45401-1947	CareSource P.O. Box 1947 Dayton, OH 45401-1947	CareSource P.O. Box 1947 Dayton, OH 45401-1947
Medicare Pharmacy Appeals	N/A	Express Scripts PO Box 66588 St. Louis, MO 63166-6588 c/o Medicare Clinical Appeals	Express Scripts PO Box 66588 St. Louis, MO 63166-6588 c/o Medicare Clinical Appeals	N/A	N/A

	Medicaid	MyCare	Medicare Advantage	D-SNP	Marketplace
Medicare Pharmacy Grievances	N/A	CareSource Attn: Member Grievance and Appeals P.O. Box 1947 Dayton, OH 45401-1947	CareSource P.O. Box 1947 Dayton, OH 45401-1947	CareSource P.O. Box 1947 Dayton, OH 45401-1947	N/A
Claims	CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401-8730	CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401-8730	CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401-8730		CareSource P.O. Box 8730 Dayton, OH 45401-8730
Fraud, Waste and Abuse	CareSource Attn: Program Integrity and Investigations P.O. Box 1940 Dayton, OH 45401-1940	CareSource Attn: Program Integrity and Investigations P.O. Box 1940 Dayton, OH 45401-1940	CareSource Attn: Program Integrity and Investigations P.O. Box 1940 Dayton, OH 45401-1940		CareSource Attn: Program Integrity and Investigations P.O. Box 1940 Dayton, OH 45401-1940

Please note: Provider appeals can only be mailed if supporting documentation is above 100 MBs where the Provider Portal will not allow submission.

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

Provider Communications

Newsletters

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

Network Notifications

Network notifications are published for CareSource providers to regularly communicate updates to policies and procedures. Network notifications are found on our website at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements.

Provider Demographic Changes and Updates

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

Online

CareSource.com > Providers > Provider Portal Log-In

Email

ProviderMaintenance@caresource.com

Fax

937-396-3076

Mail

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

ALL PLANS

CREDENTIALING AND RECREDENTIALING

CareSource credentials and recredentials all licensed independent practitioners including physicians, facilities and non-physicians with whom we contract and who fall within our scope of authority and action. Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners.

Credentialing Process

Council for Affordable Quality Healthcare Application

CareSource is a participating organization with the Council for Affordable Quality Healthcare (CAQH). Please make sure that we have access to your provider application prior to submitting your CAQH number:

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

Please also include copies of the following documents:

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

It is essential that all documents are complete and current, or CareSource will discontinue the contracting and credentialing process.

Debarment and Criminal Conviction Attestation

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

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

CareSource conducts credentialing and recredentialing activities according to National Committee for Quality Assurance (NCQA) standards and the appropriate federal and individual state department of insurance requirements.

Providers Credentialed

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

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

Providers Who Do Not Need Credentialed by CareSource

- Providers who practice exclusively within t he inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting
- Providers who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the CareSource Provider Directory
- Providers who do not provide care for members in a treatment setting (e.g. board-certified consultants)
- Waiver independent providers who provide personal care services in members' homes

Provider Selection Criteria

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

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

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

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

Criteria

- Active and unrestricted license in the state issued by the appropriate licensing board.
- Current DEA certificate (if applicable).
- Successful completion of all required education.
- Successful completion of all training programs pertinent to one's practice.
- For MDs and DOs, successful completion of residency training pertinent to the requested practice type
- For dentists and other providers where special training is required or expected for services being requested, successful completion of training.
- Board certification is not required for primary care specialties. Primary Care Providers (PCPs) who are approved by the CareSource Credentialing Committee will appear in CareSource Provider Directories.
- Providers approved by the CareSource Credentialing Committee in non-primary care specialties will be listed in the Provider Directory as specialists if certified by a specialty board, which is recognized by the CareSource Credentialing Committee.
- Education, training, work history and experience are current and appropriate to the scope of practice requested.
- Malpractice insurance at specified limits is established for all practitioners by the credentialing policy.
- Good standing with Medicaid and Medicare.
- Quality of care and practice history as judged by:
  - Medical malpractice history
  - Hospital medical staff performance
  - Licensure or specialty board actions or other disciplinary actions, medical or civil
  - Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
  - Other quality of care measurements/activities

  - Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
  - Lack of issues on HHS-OIG, SAM/ EPLS, or state site for sanctions or terminations (fraud and abuse)
- Signed, accurate credentialing application and contractual documents.
- Participation with care management, quality improvement and credentialing programs.
- Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
- Agreement to comply with plan formulary requirements or acceptance of Plan Drug Formulary as administered through the Pharmacy Benefit Manager (PBM).
- Agreement to access and availability standards established by the health plan.
- Compliance with service requirements outlined in the provider agreement and CareSource Provider Manual.

Organizational Credentialing and Recredentialing

The following organizational providers are credentialed and recredentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting

Additional organizational providers are also credentialed:

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

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

The following elements are assessed for organizational providers:

- Provider is in good standing with state and federal regulatory bodies
- Provider has been reviewed and approved by an accrediting body
- Every three years, provider 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

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

Provider Credentialing Rights

- Providers have the right to review information submitted from outside sources to support their credentialing application upon request to the CareSource credentialing department. CareSource keeps all submitted information locked and confidential.
- Providers have the right to correct incomplete, inaccurate or conflicting information 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 provider will be notified and given the opportunity to correct this information prior to presenting to the credentialing committee.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the credentialing department.

Provider Responsibilities

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

MEDICAID AND MYCARE PROVIDERS

Ohio Department of Medicaid (ODM) requires all providers participating in Ohio Medicaid and MyCare to have an active Medicaid number. Per ODM requirements, MCOs will be unable to pay Medicaid or MyCare provider claims if they do not have an active Medicaid ID number. CareSource will not onboard new providers who do not have an active Medicaid number. Applications without a number will be returned requesting that the provider resubmit their application with an active Medicaid number. Eligible providers, including Waiver non-traditional providers, must have a NPI number.

Recredentialing

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

Board Certification Requirements

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

Effective 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 timeframe specified by their respective board. Failure to become certified may result in termination as a participating provider.

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

To be credentialed as a subspecialist physicians must:

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

Delegation of Credentialing/Recredentialing

CareSource will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is National Committee for Quality Assurance (NCQA)-accredited for these functions, follows NCQA credentialing standards or utilizes an NCQA-accredited credentials verification organization (CVO), and successfully passes a pre-delegation audit demonstrating compliance with NCQA, federal and state requirements.

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

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

Delegates must be in good standing with Medicaid and Centers for Medicare & Medicaid Services (CMS). Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

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

Reconsideration and Appeals of Credentialing/Recredentialing Decisions

CareSource may decide that an applying or participating provider may pose undue risk to our members and should be denied participation or be removed from CareSource's network. If this happens, the applying or participating provider will be notified in writing. Reconsideration and appeal opportunities are available unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan. To submit a request, the following steps apply:

Step 1

Submit to the Vice President/Senior Medical Director a reconsideration 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 reconsideration requests must be received by CareSource within 30 calendar days of the date the provider 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 provider will be notified in writing of the committee's decision.

Step 2

If the committee maintains the original decision, an appeal may be made consistent with provisions of the CareSource Fair Hearing Plan unless an exception applies. Any appeal request must be submitted in writing and received by CareSource within 30 calendar days of the date the provider is notified of the reconsideration decision.

Appeals Should Be Sent To:

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

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

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

Provider Disputes

Provider 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

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

CareSource
Attn: Provider 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 provider who, in the opinion of the CareSource Vice President/Senior Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our members. Any participating provider that is subject to a suspension or termination may dispute the action and request a hearing through the CareSource Fair Hearing Plan unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan.

ALL PLANS

CLAIM SUBMISSIONS

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 update this information on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal or email ProviderMaintenance@caresource.com.

MARKETPLACE PROVIDERS

As with other Marketplace health plans, CareSource's Marketplace plan members are responsible for copays, coinsurance and deductibles. Providers are responsible for collecting the appropriate payments.

Billing Methods

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

Submit Claims Online Through Provider Portal

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

- Improves accuracy by decreasing the opportunities for transcription errors and missing or incorrect data
- Allows tracking and monitoring of claims through a convenient online search tool
- Includes attachments up to 100MB that may be necessary for claim processing
- Allows uploading of a completed claim
- Allows corrections and re-submissions

Who Can Submit Claims Via the Portal?

All CareSource providers, including primary care, specialty and community partners, may submit claims through the Provider Portal.

What Types of Claims Can Be Submitted?

The following claims may be submitted through the Provider Portal:

- Professional medical office claims
- Medical/surgical dental claims
- Institutional claims
- Behavioral health claims

Routine hearing and vision claims must be submitted to TruHearing and EyeMed respectively, through your relationship with the benefits manager. Vision claims for Ohio Medicaid must be submitted to the SuperiorVision vendor.

Dental Providers

Dental claims other than those listed above must be submitted to DentaQuest through their provider web portal www.dentaquest.com.

Electronic Funds Transfer

CareSource offers electronic funds transfer (EFT) as a payment option. We work with ECHO Health Inc. as our claims processing vendor. Visit the Provider Portal for additional information about the program and to enroll in EFT. Providers who elect to receive EFT payment will receive an EDI 835 (electronic remittance advice). Providers 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 providers.
- **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.
- **Enhanced Information** – Receive member specific third party liability (TPL) information.

Please Note: TPL/coordination of benefits (COB) information can be found in loop xxx/segment xxx on the 835 file.

CareSource provides TPL/COB information for EFT. This can be found in segment 2100 Claim Payment Information and loop 2110 Service Payment Information on the 835 file in this format:

- NM1*PR*AETNA US HEALTHCARE
- NM1*GB*1*YARBORO*JUSTIN
- REF*6P*W246632770
- The NM1*PR (COB carrier), NM1* GB (other subscriber information from other payer) and REF*6P (other insurance group number)

To enroll in EFT, complete the enrollment form, available on **CareSource.com** > Providers > Claims, and fax it back to our payment processing vendor, ECHO Health Inc. Providers may also call ECHO support at 1-888-834-3511 for assistance with registration.

Electronic Claim Submission

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

Availity Clearinghouse

CareSource prefers electronic claim submission. To submit electronic claims, you may use the Provider Portal or our Availity clearinghouse.

You can reach Availity at 800-282-4548 or at www.availity.com.

Please provide the clearinghouse with the CareSource payer ID number: **31114**

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 on Oct.1, 2015. The new standard is the HIPAA 5010 format. All trading partners and payers should be 5010 compliant.

Transactions Covered Under the 5010 Requirements

- 837 Health Care Claim/Encounter
- 276/277 Health Care Claim Status Request and Response
- 835 Health Care Claim Payment/Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 278 Health Care Services Review (Prior Authorization Requests)
- 834 Benefit Enrollment and Maintenance
- 820 Group Premium Payment for Insurance Products
- NCPDP Version D.0

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

National Provider Identifier and Tax ID Numbers

Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Please note: On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering Provider's NPI and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating Provider's NPI and (if applicable) Box 49 for the group NPI

Location of Provider Information on Professional Claims

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

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

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

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

Institutional Claims

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

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

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

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

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

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

Claims Payment Processing

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

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

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

To register for claims payment, complete the ECHO enrollment form located on **CareSource.com** > Provider > Claims and fax, email, or mail it back to ECHO. You may call ECHO Customer Support at 1-888-834-3511 for assistance with your enrollment.

Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. For more information on electronic claims, please reference the “Electronic Claims Submission” section of this chapter, on page 24.

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 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.nucc.org
- UB-04 Form Instructions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf

Please note: On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

All claims (EDI and paper) must include:

- Patient (member) name.
- Patient address.
- Insured's ID number – Be sure to provide the complete 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 patient'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 (PA) number, where applicable – A number is needed to match the claim to corresponding PA information. This is only needed if the service provided required prior authorization.
- NPI – Please refer to sections for professional and institutional claim information.
- Federal tax ID number or physician social security number – Every provider practice (e.g., legal business entity) has a different tax ID number.
- Signature of physician or supplier – The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

MEDICARE PROVIDERS

All HCFA claims must have Box 27 completed in order for the claim to pay correctly.

What to Include on Claims That Require National Drug Code

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

Instructions for National Drug Code on Paper Claims

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

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

Do not enter hyphens or spaces with the NDC. Use three spaces between the NDC number and the units on paper forms.

Tips for Submitting Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.

CareSource uses an optical/intelligent character recognition (OCR/ICR) system to capture claims information, which increases efficiency, improves accuracy and results in faster turnaround time.

To ensure optimal claims processing timelines:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current form version as designated by CMS, NUCC and the ADA.
- No handwritten (including printed claims with any handwritten information) claims or Super Bills will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Fonts should be 10 to 14 point (capital letters preferred) with printing in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- It is recommended that you submit your 12-digit CareSource Provider ID, located in your welcome letter, in conjunction with your required NPI number (Please refer to sections for Professional and Institutional claim information).

- Federal Tax ID number or physician SSN is required for all claim submissions.

Please send all paper claim forms to CareSource:

CareSource
Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401

MEDICAID PROVIDERS

Additional Claim Processing Information

- For prenatal or delivery services, the last menstrual date* is required on claims. For delivery services, the birth weight is required.
- NDC code is required when submitting Drug J code.
- NDCs are required for any drug covered by Medicaid and for all professional and outpatient facility claims.
- The specific code may be included in one of the following groups:
  - HCPCs codes in the J series J0120-J9999
  - HCPCS codes in the Q or S series that represent drugs
  - CPT codes in 90281-90399 series

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

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.

For claim denials, providers must adhere to the following timeframes for submitting disputes and appeals:

- If the claim is denied, then providers have 60 days after the receipt of the written determination of the claim to submit a dispute or 365 days from the date of service or discharge to file a claim appeal.
  - **Medicare Advantage, D-SNP and MyCare:** Providers have 60 days after the receipt of the written determination of the claim to submit a dispute or to file a claim appeal.
- If the provider was denied authorization or reimbursement due to not obtaining a required prior authorization, then providers have 180 days from the date of service or discharge to submit an appeal
  - **Medicare Advantage, D-SNP and MyCare:** Providers have 60 days after the receipt of the written determination of the claim to submit a dispute or to file a claim appeal.

Claim Processing Guidelines

- Providers 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.
  - **Medicare Advantage, D-SNP and MyCare:** Providers have 60 days after the receipt of the written determination of the claim to submit a dispute or to file a claim appeal.
- If you do not agree with the decision of the processed claim, you will have 60 days after receipt of the written determination of the claim to submit a dispute or 365 calendar days from the date of service or discharge to file a claim appeal.
- If the provider was denied authorization or reimbursement due to not obtaining a required prior authorization, then providers have 180 calendar days from the date of service or discharge to file a claim appeal.
  - **Medicare Advantage, DSN-P and MyCare:** Providers have 60 days after the receipt of the written determination of the claim to submit a dispute or to file a claim appeal.
- If a member has other insurance and CareSource is secondary, the provider 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 provider must submit the primary payer's explanation of benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.

Please see "Provider Appeals Procedures" sections in each plan-specific chapters for more information on the claims dispute and appeals processes.

MEDICARE PROVIDERS

Appeals filed past the timeframe will be dismissed unless a good cause is documented.

Searching for Claim Information Online

Claim statuses are 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 or patient number.

Additional Claim Enhancements on the Provider Portal

- Claim history available up to 24 months from the date of service
- Submission of claim appeals
- Reasons for payment, denial, or adjustment
- Checking for numbers and dates
- Procedure/diagnostic
- Claim payment date
- Dental claim information
- Submission of attachments for denied claims

- Easy submission for corrected claim when the claim was submitted online via the portal
- Accessibility to claim recovery letters

Procedure and Diagnosis Codes

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

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD- 10- CM). Available from the U.S. Government Printing Office at (202) 512-1800, (202) 512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at www.ama-assn.org/amaone/cpt-current-procedural-terminology.
- 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.
- NDC: available at http://www.fda.gov/.

Procedures That Do Not Have a Corresponding Code

- If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
  - A full, detailed description of the service provided.
  - A report, such as an operative report or a plan of treatment.
  - Any information that would assist in determining the service rendered. For example, 84999 is an unlisted lab code that would require additional explanation.
- Drug injections that do not have specific J code (J3490 thru J3999) and any assigned HCPCS J code that is not listed on the 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.
- 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 provider.

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

CareSource Provider Coding and Reimbursement Guidelines

CareSource strives to be consistent with national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, ICD-10 and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored as would be any aspect of a provider contract. Generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) (also known as CCI) edits as maintained by CMS.

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

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

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

Explanation of Payment

An explanation of payment (EOP) is a statement of the current statuses of 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. Providers who receive EFT payments will receive an electronic remittance (ERA) and can access a "human readable" version on the Provider Portal.

Information Included on Explanation of Payment

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

Checking Claims Status

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

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

Other Coverage

Coordination of Benefits

CareSource collects coordination of benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately.

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

Search coordination of benefits on the Provider Portal By:

- Member ID Number
- CareSource case number
- Medicaid number/MMIS number
- Member name and date of birth

You can also check members' coordination of benefits by calling Provider Services at:

- Medicaid: **1-800-488-0134**
- Medicare: **1-844-679-7865**
- D-SNP: **1-833-230-2176**
- Marketplace: **1-800-488-0134**
- MyCare: **1-800-488-0134**

You can check COB information for members who have been active with CareSource within the last 12 months. For providers enrolled in EFT, member-specific COB information is provided on the 835 remittance advice notification.

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

Coordination of Benefits Overpayment

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

Workers' Compensation

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

Third-Party Liability/Subrogation

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

Additional Plan-Specific Information

MEDICAID AND MYCARE PROVIDERS

Member Billing Policy

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

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

Regulations on Billing Medicaid Members

Federal regulations as well as the Medicaid Addendum, part of your executed contract with CareSource, prohibit providers from billing members except in very limited situations. To bill a member all of the following must have occurred:

- Provider has submitted a prior authorization request to CareSource and CareSource has denied the prior authorization request.
- After receipt of denial and prior to rendering the services the provider has notified the member, in writing, of the financial liability to the member should member elect to proceed with the services.

- The written notification must be specific to the services to be provided and clearly state the member is financially responsible for the specific service. A general patient liability statement signed by all patients at your practice does not meet this requirement.
- The written notification must be signed and date by the member; date must be prior to date of service.

In compliance with federal and state requirements, CareSource Medicaid members cannot be billed for missed appointments. CareSource encourages members to keep scheduled appointments and call to cancel, if needed. CareSource provides transportation for many doctor's visits to help ensure our member make it to needed appointments. Please call our Utilization Management Department at 1-888-882-3614 if you are concerned about CareSource members who miss appointments.

Providers should called Provider Services for guidance to determine if billing members for any services is appropriate. You can reach Provider Services by calling: **1-844-679-7865**.

MARKETPLACE PROVIDERS

Member Financial Liability and Grace Period

Some benefits under a plan may have first dollar coverage while others will require a member to first pay an annual deductible before CareSource contributes payment for the services. In addition to the deductible, copayments or coinsurance are also applicable for many covered services. It is up to the provider to collect these amounts at the time of service. If a member overpays his or her coinsurance, the provider must refund the overpayment to the member. Please refer to the "Involuntary Member Disenrollment" section on page 104 for more information on the grace period.

Explanation of Benefits

CareSource members receive an explanation of benefit (EOB) that informs members of their deductible and out-of-pocket status and shows copays and coinsurance they have paid. The EOB outlines the amount the provider billed, the amount CareSource reimbursed and the remaining amount for which the member is responsible

ALL PLANS

UTILIZATION MANAGEMENT

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The UM department performs utilization management activities such as: prior authorization (PA), concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources.

We also monitor the coordination of medical care to ensure its continuity and refer members to CareSource's case management, if needed. CareSource's UM criteria are available in writing by mail, fax or email and via the web.

	Phone	Fax	Email	Mail
Medicaid	1-800-488-0134	888-752-0012	mmauth@caresource.com	CareSource P.O. Box 1307 Dayton, OH 45401
Medicare Advantage	1-844-679-7865	844-417-6157	MMMA@caresource.com	CareSource P.O. Box 3209 Dayton, OH 45401
D-SNP	1-833-230-2176	844-417-6157	MMMA@caresource.com	CareSource P.O. Box 3209 Dayton, OH 45401
MyCare	1-800-488-0134	844-417-6157	MMMA@caresource.com	CareSource P.O. Box 1307 Dayton, OH 45401
Marketplace	1-800-488-0134	844-676-0372	MMHIX-Just4Me@caresource.com	N/A

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

Criteria

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

CareSource also has a medical policy developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the applicable criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available within five business days of decision to discuss individual cases with attending physicians upon request.

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

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

- Medicaid: **1-800-488-0134**
- Medicare Advantage: **1-844-679-7865**
- D-SNP: **1-833-230-2176**
- Marketplace: **1-800-488-0134**
- MyCare: **1-800-488-0134**

Post Stabilization Services

Post-stabilization care services are covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition. PA is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a participating provider. PA is required for post-stabilization services in an inpatient setting.

To request PA for observation services as a non-participating provider or to request authorization for an inpatient admission, please visit the Provider Portal at **CareSource.com** > Login > Provider Portal.

You can also request a PA by calling our Provider Services and selecting the option to request a PA. During regular business hours, your call will be answered by our UM department. If calling after regular business hours, the call will be answered by CareSource24, our nurse advice line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

If you have questions related to post-stabilization service, please call the Provider Services lines listed above.

Access to Staff

Providers may call Provider Services to contact UM staff with any questions:

- Medicaid: **1-800-488-0134**
- Medicare: **1-844-679-7865**
- D-SNP: **1-833-230-2176**
- Marketplace: **1-800-488-0134**
- MyCare: **1-844-679-7865**

Staff Availability

- Staff members are available via the toll-free telephone line or direct dial telephone number from 8 a.m. to 5 p.m. Eastern Standard Time (EST) Monday through Friday for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours. Providers may leave voice mail messages on these telephone lines after business hours, 24 hours a day, seven days a week. A dedicated fax line, email and Provider Portal for medical necessity determination requests is also available 24 hours a day, seven days a week.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

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

Additional Plan-Specific Information

MEDICAID AND MEDICARE PROVIDERS

Provider Appeals Procedure

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

MEDICAID PROVIDERS

Retrospective Review

A retrospective review is a request for an initial review for authorization of care, service or benefit which an authorization is required, but was not obtained prior to the delivery of the care, service or benefit. PA is required to ensure that services provided to our members are medically necessary and provided appropriately. Upon written request, CareSource shall permit retrospective review where a PA was required but not obtained (retro authorization). To qualify, the service must meet all of the following:

- The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original PA service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

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

All retro-authorization requests must be submitted within 30 calendar days of the date of service or date or date of discharge. No appeal rights are provided if retro request is denied.

Claims not meeting the necessary criteria will be denied.

A request for retrospective review can be made on the Provider Portal at **CareSource.com** > Login > Provider Portal.

You can also call **1-800-488-0134** and allow our IVR to direct you to the UM department or fax the request to 888-527-0016. Clinical information supporting the request for services must accompany the request.

Surgical Procedure Form

CareSource accepts the same certification and consent forms for abortion, hysterectomy and sterilization procedures that the Ohio Department of Medicaid (ODM) accepts. The most current copies of the abortion certification, hysterectomy and sterilization consent forms can be obtained online at: www.medicaid.ohio.gov/resources/publications/medicaidforms.aspx.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Medicaid Plan

MEMBER ENROLLMENT AND ELIGIBILITY

The Ohio Department of Medicaid (ODM) is responsible for determining member eligibility and sending the information to CareSource on a monthly basis. ODM notifies CareSource of some eligibility changes throughout the month. New members are effective on the first day of the month except for babies born to existing members.

Member Eligibility Verification

Except for emergency services, providers are expected to verify member eligibility before providing services:

- Log on to **CareSource.com** and select Provider Portal from the menu options. Using our secure Provider Portal, you can check CareSource member eligibility up to 24 months after the date of service.
- You can search by date of service plus any one of the following: member name and date of birth, case number, Medicaid (MMIS) number, or CareSource member ID number. You can submit multiple member ID numbers in a single request.
- Call Provider Services at **1-800-488-0134** and tell our IVR system you want to verify member eligibility. You will be directed to our automated member-eligibility verification system. The automated system, available 24 hours a day, will prompt you to enter the member ID number and the month of service to check eligibility.

Each month, primary care providers (PCPs) can view a list of eligible members who have chosen them or are assigned to them as of the first day of that month. The list also includes other important information, such as date of birth and indicators for patients who are due for a Healthchek exam (please review the “Member Support Services and Benefits” section on page 48 of this manual). Log onto our secure Provider Portal to view or print your list.

Eligibility changes can occur throughout the month, and the member list does not prove eligibility for benefits or guarantee coverage. Please use one of the above methods to verify member eligibility on date of service.

Member ID Cards

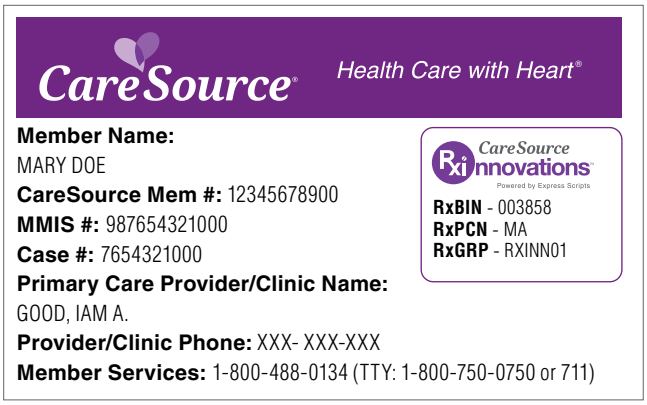
All new CareSource members receive a membership ID card, which replaces the state Medicaid card. New CareSource ID cards are not issued monthly like the state Medicaid ID cards. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card.

The member ID card is used to identify a CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their previous ID card. Likewise, members may lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to each service rendered.

Providers may use our secure Provider Portal to check member eligibility, or call the Provider Services department at **1-800-488-0134** and follow the prompts to check member eligibility.

Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification.

Front of Ohio Medicaid ID Card


CareSource Health Care with Heart®

Member Name:
MARY DOE
CareSource Mem #: 12345678900
MMIS #: 987654321000
Case #: 7654321000
Primary Care Provider/Clinic Name:
GOOD, IAM A.
Provider/Clinic Phone: XXX- XXX-XXX
Member Services: 1-800-488-0134 (TTY: 1-800-750-0750 or 711)

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

ID Card Elements

- **Member's Name**
- **CareSource Member's ID** – *use this number on claims.*
- **MMIS #** – *the member's State Medicaid ID number; please do not use this to bill CareSource.*
- **Member Services phone number** *and TTY for the hearing impaired.*
- **Member's Date of Birth**
- **Case #** – *This number may be valid for multiple household members. It is not the member's ID number.*
- **Primary Care Physician/Clinic Name** – *Members choose a participating provider to be their primary care provider (PCP). IF a choice is not made, a PCP is assigned.*
- **CareSource24, Nurse Advice Line**

Back of Ohio Medicaid ID Card


THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT VERIFY ELIGIBILITY

MEMBER: Show your ID card to medical providers BEFORE you receive care. Never let anyone else use your ID card. In case of emergency, call 911 or go to the nearest emergency room (ER). If you are not sure if you need to go to the ER, call your primary care provider or call our CareSource24® nurse advice line.

HEALTH CARE PROVIDERS: You must verify member eligibility for the date of service. Visit **www.CareSource.com** or call **1-800-488-0134** to access this information. Authorization required for inpatient admission.

PHARMACIST: 1-800-416-3629

MEDICAL CLAIMS: CareSource, P.O. Box 8730, Dayton, OH 45401-8730

PHARMACY CLAIMS: Express Scripts, ATTN: Commercial Claims
P.O. Box 14711 Lexington, KY 40512-4711 OH-MMED-2269

CareSource24® Nurse Advice Line: 1-866-206-0554 (TTY: 711)

ID Card Elements

- **Website** – *Our website contains plan information, as well as special functionality: verify eligibility, check claims prior authorization status, submit a prior authorization, check COB and more.*
- **Send Paper Claims to**
- **Provider Services** – *The toll-free phone number for providers who have questions or wish to verify eligibility over the phone.*
- **Pharmacy Information**

Please note: CareSource may be notified by ODM that a member has lost eligibility retroactively. This occurs occasionally, and in those situations, CareSource will take back payments made for dates when a member lost eligibility. The take-back code will appear on the next explanation of payment (EOP) for any impacted claims.

New Member Welcome Kits

Each household received a new member kit, in addition to a welcome letter and an ID card for each person in the family who has joined CareSource. The new member kits are mailed separately from the ID card and new member welcome letter.

New Member Welcome Kit Elements

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

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

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

Newborn Enrollment

Newborns whose mothers are members of the CareSource Ohio Medicaid plan on the newborn's date of birth, normally are covered by CareSource effective on their date of birth. The newborn will appear on the PCP's member eligibility list after they are added to the CareSource system.

To verify eligibility for a newborn, please use the secure Provider Portal at **CareSource.com** > Provider Overview > Provider Portal. Once you enter the mother's case number, you are able to view all eligible members of the household.

Member Disenrollment

Members may disenroll from CareSource for a number of reasons. If members lose Medicaid eligibility, they lose eligibility for CareSource benefits. Disenrollment may be initiated by the member, CareSource or ODM.

Reasons for Member Disenrollment

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to provide services to the member or others

Please notify the CareSource care management department if any of the situations listed above occur. Review the "Member Support Services and Benefits" section on page 48 for more information. Please see the section below for procedures for dismissing non-compliant members from your practice. We can counsel the member, or in severe cases, initiate a request to ODM for disenrollment. ODM will review each of our requests for member disenrollment and determine if the request should be granted. Disenrollment from CareSource will always occur at the end of the effective month.

Procedures for Dismissing Non-Compliant Members

Participating health care providers can request that a CareSource 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, skipping scheduled appointments or failure to modify behavior as requested. Any time a member misses three or more consecutive appointments, providers are asked to notify our care management department for assistance.

CareSource requires that a provider's 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, providers may initiate the dismissal by following the guidelines listed on page 43.

Medicaid Plan

COVERED SERVICES AND EXCLUSIONS

For the most up-to-date list of CareSource's Ohio plan covered benefits, please visit **CareSource.com** > Ohio > Medicaid > Benefits and Services. You will find 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 on page 61 for more information about referral and prior authorization (PA) 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 Provider Services at **1-800-488-0134**.

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

Medical Necessity Determinations

"Medically reasonable and necessary service" is a covered service that is required for the care of well-being of the member and is provided in accordance with generally accepted standards of medical or professional practice.

Some services require PA. CareSource reviews all service requests for Medicaid members under the age of 21 (through the month of the member's 21st birthday) for medical necessity. If a request for authorization is submitted, CareSource will notify the provider and member in writing of the determination.

If a service cannot be covered, providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Provider Appeals Procedures" section on page 70 of this manual for information on how to file an appeal.

Abortion and Sterilization

CareSource covers abortions, hysterectomies and sterilizations in very limited circumstances. Please review the information below for specific information. Visit the "Forms" section of our website for all appropriate forms to complete for an abortion, hysterectomy or sterilization. For your convenience, CareSource also has tutorials on how to complete these forms on our website. Providers can also submit these forms on the Provider Portal at **CareSource.com** > Providers > Provider Portal Log-In.

Abortion

Abortion services are covered in the following circumstances with PA:

- Instances in which the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a provider, place the woman in danger of death unless an abortion is performed.
- Instances in which the pregnancy was the result of an act of rape and the patient, the patient's legal guardian, or the person who made the report to the law enforcement agency, certifies in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the provider performing the abortion.
- Instances in which the pregnancy was the result of an act of incest and the patient, the patient's legal guardian, or the person who made the report certifies in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or in the case of a minor, with a county children services agency established under Chapter 5153 of the Revised Code, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the provider performing the abortion.

Certification Form for Reimbursement of Abortion

Before reimbursement for an abortion can be made, the provider performing the abortion must certify that one of the three circumstances above has occurred. The certification must be made on the Ohio Department of Job and Family Services (ODJFS) Abortion Certification Form (JFS 03197 Form). The provider's signature must be in the physician's own handwriting. All certifications must contain the name and address of the patient. The certification form must be attached to the claim.

The certification must be as follows:

- I certify that, on the basis of my professional judgment, this service was necessary because:
- The woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a provider, place the woman in danger of death unless an abortion is performed.
- The pregnancy was the result of an act of rape and the patient, the patient's legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction.
- The pregnancy was the result of an act of incest and the patient, the patient's legal guardian, or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or in the case of a minor, with a county children services agency established under Chapter 5153 of the Revised Code.
- The pregnancy was the result of an act of rape or incest, and in my professional opinion the recipient was physically unable to comply with the reporting requirement.

Sterilization

Sterilization procedures are covered if the following requirements are met:

- The member is at least 21 years of age at the time of the informed consent.
- The member is mentally competent and not institutionalized.
- Sterilization is the result of a voluntary request for services by a member legally capable of consenting to such a procedure.
- The member is given a thorough explanation of the procedure. In instances where the individual is blind, deaf or otherwise handicapped or unable to understand the language of the consent, an interpreter must be provided for interpretation.
- Informed consent is obtained on the Consent to Sterilization Form (HHS-687 (5/2010), which is located on our website, with legible signature(s) and submitted to our health plan with the claim.
- Informed consent is not obtained while the individual to be sterilized is in labor or childbirth seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness.
- The procedure is scheduled at least 30 days, but not more than 180 days, after the consent is signed.

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

Immunizations

Providers may administer immunizations obtained through the Vaccines for Children (VFC) program to CareSource members. The vaccines are available free of charge through the VFC program.

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

Please see the "Member Support Services and Benefits" section on page 48 for more details on immunizations. CareSource will not reimburse costs for vaccines obtained outside the VFC program when provided to children under age 19.

Annual Wellness Exams for Adults

All adults are eligible to receive a wellness exam from a primary care provider (PCP) at the earliest opportunity upon enrollment with CareSource. A wellness exam may be performed annually and consists of the following:

- Routine physical exam, including (but not limited to) urinalysis, pap smear, hemoccult, general health screen panel and other lab tests as indicated
- Screening which consists of the following, as appropriate:
  - Mammography performed at intervals recommended by the American Cancer Society and American College of Obstetrics and Gynecology for age and risk factors
  - Prostatic-specific antigen for males
  - Flexible sigmoidoscopy every three years beginning at age 40
  - Colonoscopy as indicated for patients with high risk factors
  - Flu shots, as appropriate
  - Vision exams through a primary care provider or vision vendor
  - Hearing exams

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

Medicaid Plan

MEMBER SUPPORT SERVICES AND BENEFITS

CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

CareSource Member Services

CareSource Medicaid members can access the Member Services department by calling our toll-free number and following the menu prompts at 1-800-488-0134.

Representatives are available by telephone Monday through Friday, except on the following holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

Member Services is available 7 a.m. to 7 p.m. Eastern Standard Time (EST), Monday through Friday. Please visit **CareSource.com** > About Us > Contact Us for more information on the holiday hours.

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. For improved care coordination with PCPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse provided.

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

Care Management/Outreach

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

Direct Access for Medicaid

Direct access for care management referrals and assistance with member needs is available at **1-800-993-6902**.

Care4U: Population Health and Care Management Services

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

The focus of the Care4U model is to provide a dynamic, community based, member-centric model of service delivery. The model, designed as a population health management approach with care coordination for members, is implemented by regional, multi-disciplinary teams responsible for a defined population and sub-populations within a region.

As a population management model, the ultimate goal of the model is to:

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

The program is designed to support the care and treatment you provide and recommend to your patient. We stress the importance of establishment of the medical home, identification of barriers and keeping appointments, and we can assist in arranging transportation to the provider's office. This one-on-one personal interaction with community health workers and licensed, professional care managers helps provide a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional needed community resources, such as assistance with housing and food.

In Care4U, we offer individualized education and support for many conditions and needs, including but not limited to:

- Diabetes
- Asthma
- Congestive heart failure
- Coronary obstructive pulmonary disease (COPD)
- Hypertension
- Depression
- Members with special health care needs
- Members with serious and persistent mental illness (SPMI)

Care Management of High-Risk Members

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

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

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

Perinatal Care Management

CareSource's perinatal and neonatal care management program utilizes a multi-disciplinary team with extensive OB and NICU clinical experience. Specialized nurses are available to help manage high-risk pregnancies and medically complex newborns by working in conjunction with providers and members. The expertise offered by the staff includes a focus on patient education and care coordination and involves direct telephone contact with members and providers.

We encourage our prenatal care providers to notify our care management department at **1-800-993-6902** when a member with a high-risk pregnancy has been identified. Care management staff is notified of medically complex infants at the time of admittance to the neonatal intensive care unit.

Disease Management Program

Our free disease management program helps our members find a path to better health through information, resources and support.

We help our members through:

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

Members with specific disease conditions such as asthma, diabetes, or hypertension are identified by criteria or triggers, such as emergency room visits, hospital admissions, or the health assessment. These members are automatically mailed quarterly condition specific newsletters. The materials are available in English and Spanish. Any member may self-refer or be referred into the disease management program to receive condition-specific information and outreach. If a member does not wish to receive newsletters or outreach, they can call **1-844-438-9498.**

Benefits to Members and Providers

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

Disease Management Referrals

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

Emergency Department Diversion

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

We instruct members to call their primary care provider (PCP) or the CareSource24 nurse advice line if they are unsure if they need to go to an ER. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. We offer enhanced reimbursement to PCP offices for holding evening or weekend hours to help ensure that our members have alternatives other than the ER available to them when they need medical care outside of normal business hours. Please see the "Primary Care Providers" chapter on page 162 of this manual for more information.

Member ER utilization is tracked closely. If there is frequent ER utilization, members are referred to our care management department for analysis or intervention. Members are contacted via phone or mail. Intervention includes education, as well as assistance with removing any identified health care access barriers. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Eyeglass Frames

Members of our health plan can choose from a large selection of eyeglass frames, in addition to those approved by Medicaid, at no cost to them. These frames must be ordered through one of CareSource's contracted optical labs. Please refer to **CareSource.com** > Medicaid > Benefits and Services > Additional Services for more information about vision services.

Interpreter Services

CareSource offers onsite sign and language interpreters as well as over-the phone (OPI) and video remote interpreting (VRI) when appropriate, for medical appointments outside of the surgical, hospital or emergency room setting*. These services are available to CareSource members who are hearing impaired, do not speak English, or have limited English-speaking proficiency. These services are available at no cost to the member or provider. As a provider, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately.

To arrange services, please contact our Provider Services department at **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711). 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.

**CareSource requires hospitals, emergency rooms and skilled nursing facilities, at their own expense, to offer sign and other language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking proficiency. This includes providers that perform in-office surgeries. These services should be available at no cost to the member.*

Transportation

Transportation can be provided for covered appointments, Women, Infants and Children (WIC) appointments and Medicaid redetermination appointments with the County Department of Job and Family Services (DFJS). If a member must travel 30 miles or more to a covered appointment, CareSource will provide transportation. The enhanced transportation benefit is limited to 15 round-trip visits (30 one-way trips) annually per member for Medicaid. Members who have exhausted their transportation benefit are referred to their county's non-emergency transportation (NET) program for future trip needs. Transportation is provided at no cost to the member. Members can arrange transportation by calling the Member Services phone number on their ID card and requesting transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

Healthchek

Healthchek is the state of Ohio's name for Early Periodic Screening Diagnosis and Treatment (EPSDT) services. This is a federally mandated program developed for babies, kids and young adults younger than age 21 who are enrolled in Ohio Medicaid. All CareSource members under the age of 21 should receive Healthchek exams. The purpose of the program is to discover and treat health problems early. If a potential health problem is found, further diagnosis and treatments are covered by Medicaid.

Healthchek Exam Components

The Healthchek exam is a general health assessment and is composed of the following required screening components:

- Medical history
- Complete unclothed exam (with parent approval)
- Developmental screening (to assess if a child's physical and mental abilities are age appropriate)
- Vision screening
- Dental screening
- Hearing assessment
- Immunization assessment (making sure child received them on time)
- Lead screening; and
- Other services or screenings as needed

Healthchek Exam Frequency

The recommended schedule for Healthchek exams is as follows:

- Birth
- 3-5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- after 30 months, one exam per year until age 21

Providers can access a list of eligible CareSource members who have been chosen or assigned to the provider via the portal.The list also includes indicators for patients who are due for a Healthchek exam. If there is a "Y" in the Exam Due column, that member is due to receive a Healthchek exam in the following month. You can find this list on our website at **CareSource.com** > Medicaid > Benefits and Services > EPSDT.

Healthchek Form

Please document all required components of the Healthchek exam in the member's medical record. We encourage you to use a form to ensure that you capture all of the needed data. Please use the Healthchek form at http://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM03518.pdf.

Healthchek Codes

In order to receive proper payment for EPSDT/Healthchek services, you must use the appropriate preventive medicine CPT codes, diagnosis codes and EPSDT referral indicators. CareSource requires the appropriate referral field indicators to be populated on EPSDT claims. **Claims missing this information, or submitted with invalid combinations of this information, may be rejected or denied.**

Healthchek Electronic Claims

Completion of CR02 and CR03 are required for electronic claims. Select the response in Loop 2300 Segment CRC02, 'Was an EPSDT referral given to the patient?" as follows:

- Enter "Y" in Loop 2300 Segment CRC02 if the service was an EPSDT, follow up is required and a referral is made.
- Enter "N" in Loop 2300 Segment CRC02 if the service is an EPSDT and no follow-up services were required.

Select the condition indicators in Loop 2300 Segment CRC03. If response to CRC02 is "N", use NU (Not Used). If response to CRC02 is "Y", use one of the following:

- AV (Available – not used)
- S2 (Under treatment)
- ST (New services requested)

In addition, completion of SV111 is required for electronic claims to indicate the service rendered was the result of an EPSDT referral.

- Enter "Y" in each Loop 2400 Segment SV111 if the service was rendered as the result of an EPSDT referral.
- Enter "N" in each Loop 2400 Segment SV111 if the service was not rendered as the result EPSDT referral.

Healthchek Paper Claims

Report the referral field indicator in field 24h for EPSDT services as follows:

Lower, Unshaded Area:

- Enter "Y" if the service was related to EPSDT.
- Enter "N" if the service was not related to EPSDT

Upper, Shaded Area:

If "Y" is entered in the lower, unshaded area, add the appropriate condition indicator in the upper, shaded area using one of the following:

- NU (No EPSDT referral was given)
- AV (Referral was offered, but the individual refused it)
- ST (New services requested)
- S2 (Under treatment)

No value in the upper shaded area is needed if the value in the lower shaded area is "N."

Sick and Well Visit Billing

If it is the first time a patient is seen in a provider office, only one of the two billed visits can be billed a new patient visit. For example, if a new patient is seen for both a well visit and a sick visit, only one service is a new patient visit while the other is considered an established visit. As long as the provider's documentation supports services for a well visit and sick visit (no overlapping documentation components), then separate reimbursement is warranted and supported.

When billing a "sick visit" on the same day as a "well visit," ensure the appropriate Evaluation & Management code with modifier and preventive code is used:

- Codes: 99201-99215
- Modifier: -25
- Preventive codes: 99381-99397

Healthchek Exam Referrals

If the PCP is unable to provide all of the components of the Healthchek exam, or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating provider within CareSource's provider network in accordance with CareSource's referral procedures. The member's medical record must indicate where the member was referred.

Blood Lead Level Testing

The Ohio Medicaid program requires that children receive a blood lead level test at one and two years of age. This is a required part of the Healthchek exam provided at these ages. Filter paper testing is an accepted method for obtaining blood lead levels and is approved by the Ohio Department of Health (ODH).

The filter paper method offers fast, quantitative results from two drops of blood obtained through a finger stick capillary puncture. Lead levels that exceed 5 ug/dL with this sampling method must be confirmed with venous draw according to ODH guidelines.

For more information, please contact The Ohio Department of Health, Ohio Healthy Homes and Lead Poisoning Prevention Program at 1-877-LEADSAFE (532-3723).

Immunizations

Immunizations are an important part of preventive care for children and should be administered during Healthchek exams as needed. CareSource endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. The recommended schedule is included in this section of the manual. This schedule is updated annually and the most current updates are located on www.aap.org.

Immunization Codes

Effective Oct. 1, 2015, CareSource requires providers to use ICD-10-CM Codes and CPT Codes on claims. Please refer to the Code Tables located on the CMS website at www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html.

You can also get CMS Coding Guidelines at www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf.

Vaccines for Children Program

The federal Vaccines for Children (VFC) program makes designated vaccines available at no cost to VFC participating health care providers to administer to children under the age of 19 who are eligible for Medicaid. CareSource members under the age of 19 are eligible for these vaccines. This program in Ohio is administered by ODH.

CareSource encourages providers to participate with the VFC program. Vaccines administered to children under the age of 19 must be obtained through the VFC program, which supplies vaccines to program participating providers at no cost.

Providers will be reimbursed to administer vaccines to enrollees under the age of 19. CareSource will not reimburse costs for vaccines obtained outside the VFC when provided to children under age 19.

Please bill CareSource with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. CareSource will pay for the administration of the vaccine only. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

For more information about the Ohio VFC program and how to enroll and obtain vaccines, please contact:

Immunization Program

Ohio Department of Health 246 N. High Street Columbus, OH 43215

Email

immunize@odh.ohio.gov

Phone

1-800-282-0546 or 1-614-466-4643 (ask to speak with the VFC representative for your county)

Statewide Web-Based Immunization Registry

CareSource encourages all participating providers to take advantage of the statewide web-based immunization registry called IMPACT SIIS, found at https://odhgateway.odh.ohio.gov/impact/.

The registry consolidates immunizations from multiple providers into one central record and provides reliable immunization history that is electronically accessible from multiple health care practice sites. It also facilitates the introduction of new vaccine protocols and sends immunization reminder/recall notices automatically. The system is designed to save time and money, reduce paperwork and provide quick and efficient tracking of immunizations. It also streamlines inventory reporting required by the VFC program.

Babies First Program

Babies First is a free program offered to pregnant members and parents or guardians of babies less than 18 months of age. Through this program, members can earn up to $150 on a MyCareSource Rewards® card. The program focuses on encouraging pregnant members to visit their doctor for prenatal care early in their pregnancies, and then as often as their doctor recommends, including a postpartum visit. Additionally, the program encourages well-baby visits as recommended, to help ensure mom and baby will be as healthy as possible.

The MyCareSource Rewards card is a restricted spend card, accepted at several local merchants. The card can be used to purchase healthy items and baby toys, but cannot be used to purchase unhealthy items such as tobacco, alcohol or candy.

For more information, members can visit **CareSource.com** > Ohio > Benefits and Services > Additional Services > Babies First or call Member Services at 1-800-488-0134. Members must re-enroll in the Babies First program with each pregnancy to earn rewards.

Kids First Program

Kids First is a free program offered to members ages 18 months to 18 years. Through this program, members can earn up to $100 on a MyCareSource Rewards® card. The program focuses on encouraging children and teenagers to get regular well-child visits, dental exams, and age-appropriate vaccinations.

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

Members can enroll in Kids First by completing the form at **CareSource.com** > Benefits and Services > Additional Services > Rewards or call Member Services at **1-800-488-0134**.

Women First Program

CareSource offers a program to reward adult females for completing preventive screenings. Women ages 19 years and up can earn rewards $70 or more each year by completing mammograms, pap exams, and more. Members can redeem rewards for gift cards to retailers including T.J. Maxx, Marshalls, Home Goods, Panera Bread, iTunes and more.

Members can enroll in the program online at **CareSource.com** > Medicaid > Benefits and Services > Additional Services > Rewards. Or, call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711).

Health Education

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

Online Health Engagement

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

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

All of the tools are accessible via web or mobile.

Medicaid Plan

MEMBER GRIEVANCE AND APPEALS PROCEDURE

As a CareSource provider, we may contact you to obtain additional documentation when a member has filed a grievance or appeal or has requested a State Hearing or State and federal agencies require CareSource to comply with all requirements, which include aggressive resolution timeframes.

Members or providers, when designated as the authorized representative by the member, may file a grievance or appeal with CareSource. Detailed grievance and appeal procedures are explained in the member handbook. Members or providers can contact CareSource at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) to learn more about these procedures.

Member Grievances

Any time a member informs us that they are dissatisfied with CareSource, or one of our providers, it is a grievance. CareSource investigates all grievances. If the grievance is about a provider, CareSource calls the provider's office to gather information for resolution.

- If a member's grievance is about not being able to get medical care, CareSource responds within two business days.
- For grievances about getting a bill for care the member received, CareSource responds within 60 calendar days.
- CareSource responds to all other grievances within 30 calendar days.

If members are not satisfied with our response to a grievance, they can ask us to reconsider it by sending us a letter within 15 calendar days.

Member Appeals

CareSource notifies members in writing when the following decisions are made:

- Deny or limit authorization of a requested service, including the type or level of service
- Reduction, suspension or termination of services prior to the member receiving the services previously authorized
- Denial, in whole or part, of payment for a service
- Failure to provide services in a timely manner
- Failure to act within the resolution time frame
- If an appeal is dismissed or approved

Members have the right to appeal the actions listed in the letter if they contact CareSource within 60 calendar days. CareSource will respond to the appeal in writing within 15 calendar days of when it was received.

Expedited Appeals

An expedited appeal should be considered if the member's life or health is at risk, if a decision about care is not made in a timely manner. Providers may submit a verbal request to the Grievance and Appeals department by calling **1-800-488-0134**.

CareSource will make a determination within one working day of the expedited appeal request whether to expedite the appeal resolution. CareSource will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal resolution. This attempt will be made by phone. If the member is in a facility, the provider or facility will be notified on the same business day of the decision. The member will be informed of the limited time available for presentation of evidence and allegations of fact or law in person or in writing.

The member and provider will be notified in writing of the determination to process as a standard appeal within two calendar days of receipt of the appeal, including information that the member can appeal the decision. In the event that CareSource denies the request for an expedited appeal, the appeal will be resolved within 15 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

Expedited appeals will be resolved and verbal notification will be made within 72 hours of receipt of the appeal or as expeditiously as the medical condition requires, unless the resolution timeframe is extended.

State Hearings

CareSource members can request a state hearing through the Ohio Department of Job and Family Services (ODJFS) if CareSource makes a decision to deny, reduce, suspend or stop care for a member. CareSource members can also request a state hearing if they receive a bill from a provider as a result of CareSource's denial of payment. CareSource members are required to exhaust CareSource's grievance or appeal process before requesting a state hearing.

If a member would like a state hearing, they are asked to sign and return a state hearing form within 120 calendar days of the appeal decision. CareSource will assist the member with filing this action, if needed. If CareSource proposes to reduce, suspend or terminate a service already approved, members may request continuation of benefits until a state hearing is held; however, the member may be liable for the cost. Providers have the right to participate in the state hearing process if the member has authorized them to act as their authorized representative or requested that provider attends as a witness. A hearing officer will consider the case and render a determination based upon information presented and whether state regulations were followed.

Medicaid Plan

REFERRALS AND PRIOR AUTHORIZATIONS

CareSource uses a select network of hospitals, physicians and ancillary providers. Typically, CareSource does not pay for non-network, non-emergent services; however, these may be provided with prior authorization (PA) from CareSource's Utilization Management (UM) team. There are specific criteria for obtaining PA. Please visit the Provider Portal at **CareSource.com** for the most current information on PA and referral requirements.

Please note: PA does not guarantee payment.

Referral Information

Generally, CareSource does not require referrals or PA before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, PAs are needed before CareSource will pay for services from out-of-network providers, except in cases of emergency.

Referral Procedures

Any treating doctor can refer CareSource members to specialists. Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists require PA for any services rendered to CareSource members.

You can also submit a request on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal. You can request a PA by calling Provider Services and telling our interactive voice response system (IVR), that you want to request a PA.

If you have difficulty finding a specialist for your CareSource member, please use our online Find a Doctor/ Provider tool at **CareSource.com** > Members > Tools & Resources > Find a Doctor or call Provider Services at: **1-800-488-0134**.

Services That Do Not Require a Referral

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

- Certified nurse midwife services
- Certified nurse practitioner services
- Chiropractic care (within benefit limits)
- Dental care (excluding oral surgery and orthodontics)
- Services to treat an emergency
- Family planning services (e.g., Planned Parenthood)
- Laboratory services, including genetic testing (must be ordered by a participating provider)
- Podiatric care
- Psychiatric care at Community Behavioral Health Centers (CBHCs) only
- Psychological care (from private providers or at CBHCs)
- Care at public health clinics
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Most radiology services (must be ordered by a participating provider)
- Routine eye exams (at participating vision centers, within benefit limits)
- Speech and hearing services
- Care from obstetricians (OBs) and gynecologists (GYNs)
- Care at urgent care centers after hours
- Services for children with medical handicaps

Please visit **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization for the most up to date list of services requiring prior authorization.

Members May Go to Nonparticipating Providers For:

- Emergency care
- Care at CBHCs
- Family planning services provided at qualified family planning providers (e.g., Planned Parenthood)
- Care at CBHCs and RHCs
- Care at Ohio Department of Mental Health and Addiction Service (ODMHAS) facilities that are Medicaid providers

Referral Procedures

A referral is required for specialty services not listed above and for plan members to be evaluated or treated by most specialists. Any treating provider can refer CareSource members to specialists. Please refer to our website for more information on services that require a referral. Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists must request PA for any services rendered to CareSource patients.

You can submit a PA request on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

You can also request a PA by calling Provider Services and selecting the option to request a PA.

If you have difficulty finding a specialist for your CareSource member, please use our online Find a Doctor/ Provider tool at **CareSource.com** > Members > Tools & Resources > Find a Doctor or call Provider Services at: **1-800-488-0134**.

How to Make a Referral to a Specialist

Referring Doctor – Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

Specialist – Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure.

Standing Referrals – A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral. Members who meet the definition of Children with Special Health Care Needs (CSHCN) may access specialty care providers directly through the use of a standing referral.

Referrals to Out-of-Plan Providers – A member may be referred to out-of-plan providers if the member needs medical care that can only be received from a doctor or other provider who is not participating with our health plan. Treating providers must get PA from our health plan before sending a member to an out-of-plan provider

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. However, providers or members may request a second opinion at no additional cost to the member if the service was obtained in network.

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

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

Prior Authorization Information

Prior Authorization Procedures

The Provider Portal is the preferred method to request prior authorizations for health care services. You get immediate approval or pend status, and can also check pending claim status. Email us at CiteAutoAssistance@caresource.com for portal login assistance.

Online

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

Alternate Submission Methods

Phone

1-800-488-0134

Fax

888-752-0012

E-mail

mmauth@caresource.com

Mail

CareSource
P.O. Box 1307
Dayton, OH 45401

Copies of prior authorization forms can be found on **CareSource.com** > Providers > Forms.

When requesting an authorization, please provide the following information:

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

If the provider fails to obtain PA for non-emergency services, neither the plan nor a covered person will be required to pay for those non-emergency services.

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

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

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

PA is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When PA is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date of service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request PA as soon as it is known that the service is needed.

All services that require PA from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which PA is required, but not obtained by the provider. CareSource will notify you of PA determinations by a letter mailed to the provider's address on file. Lack of appropriate notification will result in a provider denial.

For all PA decisions (standard or urgent), CareSource provides notice to the provider and member as expeditiously as the member's health condition requires. 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.

Services that Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. Please visit **CareSource.com** > Providers > Provider Portal > Prior Authorization and select your plan for the most up-to-date information of services that require PA.

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

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

These services require a PA from NIA Magellan. Providers can obtain PA from NIA Magellan for an imaging procedure in the following ways:

- Online – www.radmd.com
- By Phone – 1-800-424-5660 (follow the options to obtain a prior authorization and select the option for advanced radiology prior authorization), Monday through Friday, from 8 a.m. to 8 p.m. EST.

Authorization requests are approved at intake in most cases. If an approval cannot be issued during the initial intake, more information may be required.

Please note: All MyCare Waiver services require prior authorization. All durable medical equipment, personal care items and specialized medical equipment requests must follow proper payer sequencing, submitting claims to the member's Medicare coverage for primary coverage. DME items and other services only covered by Medicaid will be reviewed for medical necessity. Waiver coverage for services is considered the payer of last resort.

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

Synagis Prior Authorization

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

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

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

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

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. To avoid claim denials providers need to submit supporting clinical documentation with the claim submission.

Please Note: There are no authorizations required for J codes for Medicare.

Determination Timeframes

CareSource's timeframes to make authorization determinations vary depending upon the member's health condition, completeness of submission information and state requirements.

Review Type	Time for plan to respond when all information is present	Time for plan to request additional information	Provider response time to submit additional information	Plan response time after receiving additional
Inpatient Notification (DEMO)	N/A	1 day	1 day	1 day
Inpatient Initial	1 day	1 day	1 day	1 day
Inpatient Continued Stay Review (CSR)	1 day	1 day	1 day	1 day
Outpatient/Elective Non-Urgent	within 10 calendar days	N/A	N/A	N/A
Outpatient/Elective/ URGENT	within 48 hrs	N/A	N/A	N/A
Retrospective	within 30 days	N/A	N/A	N/A

Medicaid Plan

PHARMACY

Prescription Drug Coverage

CareSource partners with Express Scripts, Inc. to process medication claims. Express Scripts, Inc. processes medication claims for all Ohio plans to provide continuity for provider offices and CareSource members.

CareSource covers all medically necessary Medicaid-covered prescription drugs and medical supplies. This applies to everyone who gets health care through an Ohio Medicaid MCO. Effective January 1, 2020 CareSource has implemented the Ohio Medicaid Unified Preferred Drug List (UPDL). This UPDL is shared across all Medicaid managed care plans and fee for service.

Other Medical Supplies and Durable Medical Equipment

To support member access and convenience, select medical supplies, such as wound care supplies, can continue to be filled by the CareSource pharmacy benefit manager (PBM) through the retail pharmacy for a limited period of time until a durable medical equipment (DME) provider can be contacted.

Medications Administered in the Provider Setting

Medications that are administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center will be billed to the MCP. Prior authorization (PA) requirements exist for many injectables.

Transition Period

A 90-day transition period applies for members moving from fee-for-service to MCOs. After the 90-day transition period has ended, PA may be applicable depending on the member's medication. Check **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization to determine if medications require prior authorization (PA).

For a complete list of drugs available, visit **CareSource.com** > Providers > Tools & Resources > Drug Formulary. Members may also confirm coverage and costs of a specific drug using the CareSource Find My Prescriptions tool at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions.

Drug Formulary

CareSource uses a list of covered drugs, called a drug formulary. The drug formulary contains information about drugs covered, their cost share tiers and limitations of coverage (such as PAs, quantity limits and step therapy protocols). Drugs are listed by therapeutic class and by alphabetical index so that therapeutic interchanges for most drug classes are easier to compare. To learn more about how to use our pharmaceutical management procedures, please visit our website's Pharmacy page at **CareSource.com** > Provider Overview > Education > Patient Care > Pharmacy.

CareSource updates the drug formulary regularly and communicates any updates online on the Drug Formulary Changes pages. The most up-to-date formulary may be found online at **CareSource.com** > Providers > Tools & Resources > Drug Formulary. Drugs not listed on the Drug Formulary are not covered without prior approval.

Quantity, Supply, Duration and Benefit Limits

Quantity limits and dosing limits are based on several factors such as the manufacturer's recommended dosing frequencies, long-term considerations, diagnosis and best practices, and/or Food & Drug Administration (FDA) recommendations. Limits on opioids or other substances of abuse are based upon maximal morphine equivalent dosing limits or applicable law. Additionally benefit limitations may pertain to preventive coverage or as defined by applicable rights to coverage for our members.

Step Therapy

Certain medications on the drug formulary are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a first step formulary medication used to treat the same condition be tried and failed prior to the approval of a step two formulary medication.

Generic Substitution & Therapeutic Exchange

Generic substitution occurs when a pharmacy dispenses a generic drug that is equivalent to the prescribed brand-name drug. Generally, generic drugs are priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Members and providers can expect the generic to produce the same effect and have the same safety profile as the brand-name drug.

The formulary document is subject to state-specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness, and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drugs.
- Manufactured in the same strength and dosage form as the brand-name drugs.

Prior Authorization

To submit prior authorization requests please fax all documents to 866-930-0019, or to submit by phone, call the following number and use the prompts: **1-800-488-0134**.

CareSource processes Medicaid PA requests in accordance with Ohio Medicaid regulations. PA requires that a drug be preapproved in order for it to be covered under a health benefit. The PA staff will adhere to the Ohio Administrative Code (OAC) and determine medical necessity for formulary exception requests that will be reviewed based in drug-specific prior authorization criteria or standard non-formulary prescription request criteria. Providers will be required to submit pertinent medical or drug history, prior treatment history and any other necessary supporting clinical information with the request.

Medical Reasons for Exceptions

Providers may be asked to provide written clinical documentation as to why a member needs an exception. In determining whether an exception will be given, CareSource will consider whether the requested drug is clinically appropriate.

Medication Therapy Management Program

CareSource offers a medication therapy management (MTM) program for all members. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs and provide health care to patients in a cost-effective manner. You may be contacted by a pharmacist to discuss your patients' medications. We also encourage members to talk with their pharmacist about their medications, as we want to make sure they are getting the best results from the medications they are taking.

Network Pharmacies

Our pharmacy directory gives members a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website for a complete list of network pharmacies at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions > Find A Pharmacy.

Medicaid Plan

PROVIDER APPEALS PROCEDURES

If in your capacity as a member's provider you file an appeal on behalf of a member, please refer to the procedures set forth in this manual. Please refer to the applicable plan's "Member Grievances and Appeals Procedures" sections for additional details.

Please note: If time frames in this manual differ from those in the provider agreement, the agreement has ruling authority.

Claim Dispute Process

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

Claim Dispute Process for Participating and Non-Participating Providers

- Claim disputes must be submitted in writing or by using the CareSource Provider Portal.
- The dispute must be submitted within 90 days after the provider's receipt of the written determination of the claim.
- If CareSource fails to render a determination for the dispute within 30 days after receipt, an appeal may be submitted.

Appeals of Claims Denials or Adverse Decisions

If you do not agree with the decision of a processed claim or dispute, 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 timeframe, the claim will not be considered and the appeal will be denied. If the appeal is denied, providers will be notified in writing. If the appeal is approved, payment will show on the provider's Explanation of Payment (EOP). MyCare providers have 120 days from the date of service or discharge to file an appeal.

How to Submit Claim Appeals

Providers can submit claims online.

Online

CareSource.com > Login > Provider Portal

From the **Providers** menu, select Claims Appeals.

All provider appeals requested must be submitted electronically. Mail submissions will no longer be accepted and will not be processed. The only exception is an appeal that has a medical record submission that is over 100 MB. These submissions must be submitted on disc to the CareSource Appeals department at the following address:

CareSource Provider Appeals Department
P.O. Box 2008
Dayton, OH 45401

Use the Claim Appeal Request Form located on our website. Please include:

- The member's name and CareSource member ID number
- The provider'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

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

Provider Appeals/Clinical Appeals

Provider or Provider Appealing on Behalf of a Member Standard Medical Necessity Appeals of Non-Certification Determinations

An appeal is defined as a formal request by a member or provider, including facilities or other health care entities on behalf of a member or provider for a review of a determination or action.

Timeline for Clinical Appeals

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

- Provider – within 180 days from the date of denial issued by a Utilization Management or Pharmacy, date of discharge or date of service (MyCare providers have 120 days from date of service).
- Provider on behalf of a member with written authorization from the member – within 90 days of receipt (MyCare providers have 60 days from the date of receipt).
- Member– within 90 days of receipt (MyCare members have 120 days from date of service).

Additional Details about Clinical Appeals

Timing for Medical Necessity Appeals

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days from the date of denial, date of discharge or date of service.

Appeals Filed on Behalf of the Member

Medical necessity appeals filed by members or providers on behalf of a member must be submitted to CareSource within 90 days and will be resolved within 10 calendar days of receipt or as expeditiously as the member's condition warrants. Appeals on behalf of the member must include written authorization to appeal on their behalf for the specific service that is being appealed. All other medical necessity appeals will be resolved within 30 calendar days of receipt. MyCare providers have 60 days to submit the appeal and15 days to resolve pre-service with 30 days to post.

Expedited Appeals

An expedited appeal should be considered if the provider feels that the patient's life or health is at risk if a decision about care is not made in a timely manner.

Requests may be a verbal request and should be submitted to the Grievance and Appeals department by calling **1-800-488-0134**.

CareSource will make a determination within one working day of the expedited appeal request whether to expedite the appeal resolution. CareSource will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal resolution. This attempt will be made by phone. If the member is in a facility, the provider or facility will be notified on the same business day of the decision. The member will be informed of the limited time available for presentation of evidence and allegations of fact or law in person or in writing.

The member and provider will be notified in writing of the determination to process as a standard appeal within two calendar days of receipt of the appeal, including information that the member can appeal the decision. In the event that CareSource denies the request for an expedited appeal, the appeal will be resolved within 10 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

Expedited appeals will be resolved and verbal notification will be made within 72 hours of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution timeframe is extended.

Notification of Resolution

CareSource will verbally notify the provider or facility of the appeals resolution if the member is in an inpatient setting and will send written notification to both the provider and member on the same business day of the decision.

Extending an Appeal

A member can verbally request that CareSource extend the timeframe to resolve a standard or expedited appeal up to 14 calendar days. CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days. CareSource must submit documentation that the extension is in the member's best interest to the Ohio Department of Medicaid (ODM) for prior approval. If ODM approves the extension, CareSource must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

Dissatisfaction of Medical Necessity Appeals – One Level of Appeal

If you are dissatisfied with any medical necessity decision made by CareSource, we offer one level of appeal as mandated by ODM. Members have the right to a state hearing as a first or second level of appeal (See "State Hearings" in the "Member Support Services and Benefits" section on page page 48 of this manual for more information).

You may use the Appeal Request Form on our website to submit your appeal. Visit **CareSource.com** > Provider Overview > Tools & Resources > Forms to access the Appeal Request Form.

Appeal Request Elements

- The member's name, CareSource member ID number and date of birth
- The provider's name and CareSource provider billing number
- The place, date and type of service that had a non-certification determination for clinical appeals
- The reason why the determination should be reconsidered
- Any additional available medical information to support your reasons for reversing the determination

The Appeals department may request additional information from you to document medical necessity. All appeal requests and associated information are reviewed by clinicians previously uninvolved with the case. You will be notified in writing of the outcome of your appeal request.

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days from the date of denial, date of discharge or date of service.

How to Submit Appeals

Appeals may be submitted online, by fax, or by mail.

Online

Visit **CareSource.com** > Login > Provider Portal

Fax

937-531-2398

Mail

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

Medicare Plans

Medicare Advantage and Dual-Eligible Special Needs Plans (D-SNP)

MEMBER ENROLLMENT AND ELIGIBILITY

CareSource Medicare plans, Medicare Advantage and Dual-Eligible Special Needs Plans (D-SNP), are health care plans committed to helping members get the care they need.

Medicare Advantage is a Medicare plan 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 verified a member's eligibility Medicare Part A, and enrollment in Medicare Part B, before the applicant can be enrolled in a plan. New members are effective on the first day of the month.

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

- Be entitled to Medicare Part A and enrolled in Part B
- 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

Medicare Dual Advantage (D-SNP) is offered to members who are eligible for Medicare Parts A and B and who live in our service area. The D-SNP plan offers full Medicaid benefits.

TO be eligible to receive services through D-SNP, a person must:

- Be entitled to Medicare Part A and enrolled in Part B with full Medicaid benefits
- Not have end-stage renal disease (ESRD)
- Live in our CareSource D-SNP service area
- Choose CareSource D-SNP during a valid election period
- Agree to the rules of the CareSource D-SNP plan

Member Eligibility Verification

Providers are expected to verify member eligibility each time a service is rendered. 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 Provider Services and follow the appropriate menu options to reach our automated member eligibility verification system 24 hours a day. The automated system will prompt you to enter the member ID number and the month of service to check eligibility.
  - Medicare Advantage: **1-844-679-7865**
  - D-SNP: **1-833-230-2176**

Primary Care Providers (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 providers should always verify member eligibility before rendering services except in an emergency. This helps prevent unpaid claims.

Member ID Cards

Each new Medicare member receives a member ID card. An ID card for CareSource Medicare plans is issued when a member joins CareSource. Members can continuously use the same CareSource 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, providers must verify a member's eligibility on each date of service.

You can use our secure Provider Portal or call Provider Services and follow the prompt to check member eligibility.

- Medicare Advantage: **1-844-679-7865**
- D-SNP: **1-833-230-2176**

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

Billing CareSource

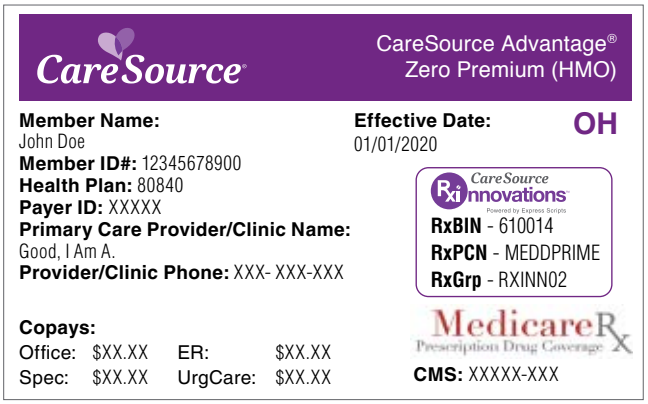
CareSource members should not present their red, white and blue card for Original Medicare. If a CareSource member uses their red, white and blue Medicare card instead of their CareSource card and you bill the Medicare program instead of CareSource, the Medicare program will not pay for these services.

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 Program Integrity and Investigations department at **1-844-679-7865** and follow the appropriate menu options to report fraud.

Billing Ohio Medicaid for D-SNP

After receiving payment from CareSource for services provided to a CareSource D-SNP member, any remaining amount is not the responsibility of the CareSource member and he/she should not be billed by the provider. Instead, the provider should bill the Ohio Medicaid program for the amount owed using the member's MMIS number obtained from the member's CareSource member ID card.

Front of Ohio Medicare Advantage Member ID Card


CareSource

CareSource Advantage®
Zero Premium (HMO)

Member Name:
John Doe
Member ID#: 12345678900
Health Plan: 80840
Payer ID: XXXXX
Primary Care Provider/Clinic Name:
Good, I Am A.
Provider/Clinic Phone: XXX- XXX-XXX

Effective Date:
01/01/2020

OH

CareSource Innovations
Powered by Express Scripts
RxBIN - 610014
RxPCN - MEDDPRIME
RxGrp - RXINN02

MedicareRx
Prescription Drug Coverage

CMS: XXXXX-XXX

Copays:
Office: $XX.XX ER: $XX.XX
Spec: $XX.XX UrgCare: $XX.XX

Back of Ohio Medicare Advantage Member ID Card

CareSource.com/Medicare
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, use the website or call:

MEMBERS: 1-844-607-2827 TTY: 1-800-750-0750

24/7 Nurse Advice Line:
1-866-206-0569

Providers:
1-844-679-7865

Vision Benefits:
EyeMed 1-866-248-2011

Dental Network:
DenteMax

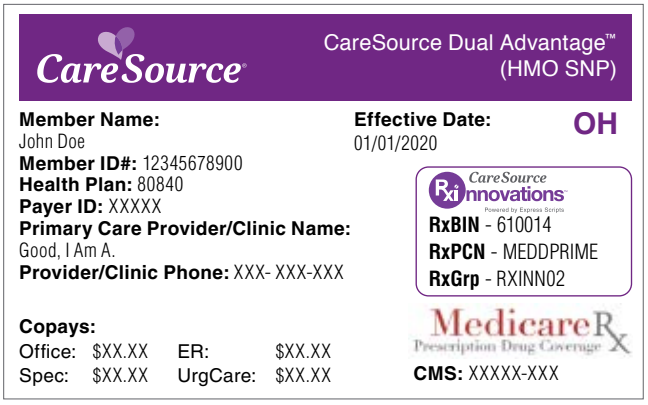
Hearing Benefits:
TruHearing 1-855-205-6219

Pharmacy:
1-800-416-1673

Medical Claims:
CareSource
P.O. Box 8730
Dayton, OH 45401-8730

Pharmacy Claims:
Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

Front of Ohio D-SNP Member ID Care


CareSource

CareSource Dual Advantage™
(HMO SNP)

Member Name:
John Doe
Member ID#: 12345678900
Health Plan: 80840
Payer ID: XXXXX
Primary Care Provider/Clinic Name:
Good, I Am A.
Provider/Clinic Phone: XXX- XXX-XXX

Effective Date:
01/01/2020

OH

CareSource Innovations
Powered by Express Scripts
RxBIN - 610014
RxPCN - MEDDPRIME
RxGrp - RXINN02

MedicareRx
Prescription Drug Coverage

CMS: XXXXX-XXX

Copays:
Office: $XX.XX ER: $XX.XX
Spec: $XX.XX UrgCare: $XX.XX

Back of Ohio D-SNP Member ID Care

CareSource.com/Medicare
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, use the website or call:

MEMBERS: 1-833-230-2020 TTY: 1-800-750-0750

24/7 Nurse Advice Line:
1-833-687-7331

Providers:
1-833-230-2176

Vision Benefits:
EyeMed 1-866-299-1425

Dental Network:
DenteMax

Hearing Benefits:
TruHearing 1-833-759-6826

Pharmacy:
1-800-416-1673

Medical Claims:
CareSource
P.O. Box 8730
Dayton, OH 45401-8730

Pharmacy Claims:
Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

ID Card Elements

- **Member's Name**
- **CareSource Member's ID** – *use this number on claims.*
- **MMIS #** – *the member's State Medicaid ID number; please do not use this to bill CareSource.*
- **Member Services phone number** *and TTY for the hearing impaired.*
- **Member's Date of Birth**
- **Primary Care Physician/Clinic Name** – *Members choose a participating provider to be their primary care provider (PCP). IF a choice is not made, a PCP is assigned.*
- **CareSource24, Nurse Advice Line**

New Member Welcome Kits

Each household received a new member kit, a welcome letter, and an ID card for each person who has joined CareSource. The new member kits are mailed separately from the ID card and new member welcome letter.

New Member Kit Elements

- 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 directories
- Health risk assessment

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

- Acknowledgement/confirmation letter
- Identification card

Member Disenrollment

A member may end their membership with CareSource 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 (AEP) and during the annual 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 service area.

Please note: All CareSource D-SNP members can move from plan to plan every three months while they are Medicaid-eligible.

Medicare Annual Enrollment Period

October 15-December 7

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

- Medicare Advantage: **1-844-607-2827**
- D-SNP: **1-833-230-2020**

Members are advised to continue to use their CareSource 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, and validating eligibility with CareSource 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. The plan cannot and will not terminate a member because of the amount or cost of services.

CareSource can terminate members with CMS' 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, but members have the right to appeal the cancellation of coverage.

Procedures for Dismissing Non-Compliant Members

Participating providers can request that a CareSource 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, providers 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, providers may initiate the dismissal by following the guidelines below.

- The provider 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 the 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 Provider Services if you have questions about disenrollment reasons or procedures.

- Medicare Advantage: **1-844-679-7865**
- D-SNP: **1-833-230-2176**

Member Enrollment and Provider Marketing

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

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

Provider Marketing

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers 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 providers 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 provider
- 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

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

Providers 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 provider affiliation materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials from all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials. Rather, if a provider 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, providers 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 provider 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

Please Note: The "Medicare and You" Handbook or "Medicare Options Compare" (from www.medicare.gov) may be distributed by providers 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 providers 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 providers of the provisions of these rules.

Please Note: Per guidance from CMS, a provider 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 provider.

Medicare Plans

Medicare Advantage and Dual-Eligible Special Needs Plans (D-SNP)

COVERED SERVICES AND EXCLUSIONS

For the most up-to-date list of CareSource's Medicare Advantage plan covered benefits, please visit **CareSource.com** > Ohio Medicare Advantage > Benefits & Services.

For the most up-to-date list of CareSource's D-SNP plan covered benefits, please visit **CareSource.com** > Ohio D-SNP > Benefits & Services.

You will find 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 on page 90 of this manual for more information about referral and prior authorization (PA) 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 Provider Services.

- Medicare Advantage: **1-844-679-7865**
- D-SNP: **1-833-230-2176**

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

Medical Necessity Standards and Practices

"Medically reasonable and necessary service" is a covered service that is required for the care of well-being of the member and is provided in accordance with generally accepted standards of medical or professional practice.

Some services require PA. CareSource reviews all service requests for Medicare members under the age of 21 (through the month of the member's 21st birthday) for medical necessity. If a request for authorization is submitted, CareSource will notify the provider and member in writing of the determination.

If a service cannot be covered, providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Provider Appeals Procedures" section on page 96 of this manual for information on how to file an appeal.

Covered services and exclusions for CareSource members can be found at **CareSource.com** > Benefits and Services (Filter the drop-down by state and plan).

Covered services and exclusions for CareSource Medicare Advantage plans are listed in the Evidence of Coverage (EOC). The EOC is located on our website at **CareSource.com** > Medicare Advantage > Plan Documents.

Covered services and exclusions for CareSource D-SNP plans are also listed in the Evidence of Coverage (EOC). The EOC is located on our website at **CareSource.com** > D-SNP > Plan Documents.

Medicare Plans

Medicare Advantage and Dual-Eligible Special Needs Plans (D-SNP)

MEMBER SUPPORT SERVICES AND BENEFITS

CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

CareSource Member Services

CareSource Medicare members can access the Member Services department by calling our toll-free number and following the menu prompts: 1-844-607-2827 (TTY: 1-800-750-0750).

Representatives are available by telephone Monday through Friday, except on the following holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

Members Services is available 8 a.m. to 8 p.m. Eastern Standard Time (EST) Monday through Friday and from Oct. 1 – Mar. 31 we are open the same hours 7 days a week. Please visit **CareSource.com** > About Us > Contact Us for more information on the holiday hours.

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. For improved care coordination with PCPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse gave.

Key features of this service include nurses who:

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

Members may 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. The 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, but not limited to:

- Diabetes
- Asthma
- Congestive heart failure

- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Members with special health care needs
- Behavioral health needs

If you would like to contact one of our case managers please call us on our confidential voice mail line at **1-844-679-7867** or email us at MAcasemanagement@Caresource.com.

Care Management of 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 (CSMA) Standards of Practice utilizing "Community Health Workers" to help patients overcome health care access barriers. It also strengthens our provider and community resource partnerships through collaboration.

Our services include face-to-face meetings with our most at-risk members. Ideally, these are conducted at the point of care to ensure development of a treatment plan that is comprehensive and collaborative. Typical 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.

D-SNP Provider Model of Care Training

The Centers for Medicare & Medicaid Services (CMS) requires Ohio D-SNP plans to provide initial and annual Model of Care (MOC) training to all network providers contracted to see dual-eligible members and all out-of-network providers seen by dual-eligible members routinely.

Providers are required by CMS to attest to completing the annual model of care training. To view and attest that you have completed the training and receive credit, please log on to the Provider Portal (link to this), which will prompt you to review and attest to completing the model of care training.

Disease Management Program

Our free disease management program helps our members find a path to better health through information, resources and support.

We help our members through:

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

Members with specific disease conditions such as asthma, diabetes, or hypertension are identified by criteria or triggers, such as emergency room visits, hospital admissions, or the health assessment. These members are automatically mailed quarterly condition specific newsletters. The materials are available in English and Spanish. Any member may self-refer or be referred into the disease management program to receive condition-specific information and outreach. If a member does not wish to receive newsletters or outreach, they can call the Disease Management department:

- Medicare Advantage: **1-844-438-8498**
- D-SNP: **1-866-415-0584**

Benefits to Members and Providers

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

Disease Management Referrals

If you have a CareSource patient with asthma, diabetes, or hypertension who you believe would benefit from this program and is not currently enrolled, call the Disease Management department at:

- Medicare Advantage: **1-844-438-9498**
- D-SNP: **1-866-415-0584**

CareSource Rewards Programs

CareSource offers MyHealth Rewards for members over the age of 18 to take health assessments, set goals and track activities. Members can take online health training based on their needs. Members can also earn rewards, if applicable. Members can redeem rewards in MyHealth for gift cards to retailers including T.J. Maxx, Marshalls, Home Goods, Panera Bread, iTunes and more. Members can get started by signing on to their My.CareSource.com account and click on the MyHealth icon under My Plan.

Transportation

Medicare Advantage Members

Transportation may be available for CareSource members with hypertension and/or diabetes (Chronically ill) for 24 one-way trips to covered appointments in addition to post-discharge 7-day and 14-day follow-up appointments following an in-patient stay. Transportation is provided at no cost to the member. Transportation must be arranged via the member's care manager initially to ensure eligibility. Transportation can be arranged by calling the Member Services phone number on the member's ID card and requesting transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

D-SNP Members

Transportation can be provided for CareSource members to covered appointments, Women, Infants and Children (WIC) appointments and Medicaid redetermination appointments with the County Department of Job and Family Services. The CareSource transportation benefit is limited to 30 round-trip visits (60 one-way trips) annually per member. Transportation is provided at no cost to the member. Members can arrange transportation by calling the Member Services phone number on their ID card and requesting transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

MEMBER GRIEVANCE AND APPEALS PROCEDURES

Any time a member informs us that they are dissatisfied with CareSource, or a provider, 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, grievance, or reconsideration timeframe. 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 provider, CareSource calls the provider's office to gather information and attempt a possible resolution. CareSource responds to member grievances in accordance with CMS timeframes.

Member, Provider or Provider Appealing on Behalf of a Member

For appeals on behalf of the member, please refer to the CareSource Medicare Advantage member's Evidence of Coverage (EOC).

The Medicare Advantage EOC is located at **CareSource.com** > OH Medicare Advantage > Plan Documents.

The D-SNP EOC is located at **CareSource.com** > D-SNP > Plan Documents.

Providers who are not physicians and are submitting appeals on behalf of members must have a valid Authorization of Representative (AOR) on file.

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. The representative must have a valid Authorization of Representative (AOR) form or other corresponding document on file with CareSource for the appeal to be processed.

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 you of our decision. We will also automatically send the member's appeal to the Independent Review Entity (IRE) 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 the CareSource Grievance and Appeals department. 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

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 IRO reviews the decision made when we said no to the first appeal. This organization decides whether the decision we made should be changed.

The IRO 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 IRO. 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 IRO additional information to support their appeal. Reviewers at the IRO 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 IRO 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

The notice received from the IRO 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 (ALJ) 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 (IRO), 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 ALJ 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 (IRO), 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.

Medicare Plans

Medicare Advantage and Dual-Eligible Special Needs Plans (D-SNP)

REFERRALS AND PRIOR AUTHORIZATIONS

CareSource uses a select network of hospitals, physicians and ancillary providers. Typically, CareSource does not pay for non-network, non-emergent services; however, these may be provided with prior authorization from CareSource's Utilization Management (UM) team. There are specific criteria for obtaining prior authorization. Please visit the Provider Portal at **CareSource.com** for the most current information on prior authorization and referral requirements.

Please note: Prior Authorization does not guarantee payment.

Referral Information

Generally, CareSource does not require referrals or PA before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, prior authorizations are needed before CareSource will pay for services from out-of-network providers, except in cases of emergency.

Referral Procedures

Any treating doctor can refer CareSource members to specialists. Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists require PA for any services rendered to CareSource members.

You can also submit a request on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal. You can request a PA by calling Provider Services and telling our interactive voice response system (IVR),that you want to request a PA.

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

- Medicare Advantage: **1-844-679-7865**
- D-SNP: **1-844-679-7865**

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 Provider Services at **1-844-679-7865** and select the option to speak to someone in the UM Department.

Please note: Medicare members may go to non-participating providers for: emergency care, out of area dialysis care, and out-of-area urgently needed care.

Prior Authorization Information

Prior Authorization Procedures

The Provider Portal is the preferred method to request prior authorizations for health care services. You get immediate approval or pend status, and can also check pending claim status. Email us at CiteAutoAssistance@caresource.com for portal login assistance.

Online

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

Alternate Submission Methods

Phone

1-844-679-7865

Fax

844-417-6157

E-mail

MMMA@caresource.com

Mail

CareSource
P.O. Box 1307
Dayton, OH 45401

Copies of prior authorization forms can be found on **CareSource.com** > Providers > Forms.

When requesting an authorization, please provide the following information:

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

If the provider fails to obtain PA for non-emergency services, neither the plan nor a covered person will be required to pay for those non-emergency services.

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

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

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

PA is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When PA is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date of service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request PA as soon as it is known that the service is needed.

All services that require PA from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which PA is required, but not obtained by the provider. CareSource will notify you of PA determinations by a letter mailed to the provider's address on file. Lack of appropriate notification will result in a provider denial.

For all PA decisions (standard or urgent), CareSource provides notice to the provider and member as expeditiously as the member's health condition requires. 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.

Services that Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. Please visit **CareSource.com** > Providers > Provider Portal > Prior Authorization and select your plan for the most up-to-date information of services that require PA.

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

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

These services require a PA from NIA Magellan. Providers can obtain PA from NIA Magellan for an imaging procedure in the following ways:

- Online – www.radmd.com
- By Phone – 1-800-424-5660 (follow the options to obtain a prior authorization and select the option for advanced radiology prior authorization), Monday through Friday, from 8 a.m. to 8 p.m. EST.

Authorization requests are approved at intake in most cases. If an approval cannot be issued during the initial intake, more information may be required.

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

Synagis Prior Authorization

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

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

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

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

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. To avoid claim denials providers need to submit supporting clinical documentation with the claim submission.

Please Note: There are no authorizations required for J codes for Medicare.

Determination Timeframes

CareSource's timeframes to make authorization determinations vary depending upon the member's health condition, completeness of submission information and state requirements.

Review Type	Time for plan to respond when all information is present	Time for plan to request additional information	Provider response time to submit additional information	Plan response time after receiving additional
Inpatient Notification (DEMO)	1 day	24 hrs	N/A	N/A
Inpatient Initial	1 day	24 hrs	N/A	N/A
Inpatient Continued Stay Review (CSR)	1 day	24 hrs	N/A	N/A
Outpatient/Elective Non-Urgent	within 14 calendar days	24 hrs	N/A	N/A
Outpatient/Elective/ URGENT	within 48 hrs	24 hrs	N/A	N/A
Retrospective	within 30 days	24 hrs	N/A	N/A

Medicare Plans

Medicare Advantage and Dual-Eligible Special Needs Plans (D-SNP)

PHARMACY

Prescription Drug Coverage

CareSource partners with Express Scripts, Inc. to process medication claims. Express Scripts, Inc. processes medication claims for all Ohio plans to provide continuity for provider offices and CareSource members.

Tiered Medications

Every drug covered on the CareSource Medicare Advantage drug formulary is in one of five cost-sharing tiers listed below. 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. (May include select brand drugs).

Cost-Sharing Tier 2: Includes non-preferred generic drugs. (May include select brand drugs).

Cost-Sharing Tier 3: Includes preferred brand drugs. (May include select generic drugs).

Cost-Sharing Tier 4: Non-preferred brand drugs (May include select generic 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 at **CareSource.com** > Providers > Tools & Resources > Drug Formulary.

Tiered Cost-Sharing Exceptions

In certain circumstances, a member may request a reduction in the copayment or co-insurance 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 (PBM) will verify, through the provider's supporting statement(s) and/or standards documented in clinical guidelines adopted by the plan, that all drugs in the lower preferred tiers:

- Would not be as effective for the member as the requested drug
- Would have adverse effects for the member, or both. Tiered cost-sharing exception requests will be processed through CareSource's PBM's prior authorization (PA) review process.

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

CareSource currently uses a pharmacy partner to handle PA requests. All requests for pharmaceutical PAs should be directed to: **1-800-416-1673**. Please follow the prompts for Medicare PA.

For written requests, please send via fax: 877-328-9660 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 PA review process. PA requires a drug to be "pre-approved" in order for it to be covered under a benefit plan.

The PA staff will adhere to the Centers for Medicare & Medicaid Services (CMS) approved criteria. The PBM's National Pharmacy and Therapeutics Committee established clinical guidelines, and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines.

Providers can submit PA requests by phone or fax. Providers 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.

Drug Formulary

CareSource uses a list of covered drugs, called a drug formulary. The drug formulary contains information about drugs covered, their cost share tiers and limitations of coverage (such as PAs, quantity limits and step therapy protocols). Drugs are listed by therapeutic class and by alphabetical index so that therapeutic interchanges for most drug classes are easier to compare. To learn more about how to use our pharmaceutical management procedures, please visit our website's Pharmacy page at **CareSource.com** > Provider Overview > Education > Patient Care > Pharmacy.

CareSource updates the drug formulary regularly and communicates any updates online on the Drug Formulary Changes pages. The most up-to-date formulary may be found online at **CareSource.com** > Providers > Tools & Resources > Drug Formulary. Drugs not listed on the Drug Formulary are not covered without prior approval.

The CareSource Medicare Advantage formulary was selected in consultation with a team of providers, 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.

Quantity, Supply, Duration and Benefit Limits

Quantity limits and dosing limits are based on several factors such as the manufacturer's recommended dosing frequencies, long-term considerations, diagnosis and best practices, and/or Food & Drug Administration (FDA) recommendations. Limits on opioids or other substances of abuse are based upon maximal morphine equivalent dosing limits or applicable law. Additionally benefit limitations may pertain to preventive coverage or as defined by applicable rights to coverage for our members.

Step Therapy

Certain medications on the drug formulary are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a first step formulary medication used to treat the same condition be tried and failed prior to the approval of a step two formulary medication.

Generic Substitution & Therapeutic Exchange

Generic substitution occurs when a pharmacy dispenses a generic drug that is equivalent to the prescribed brand-name drug. Generally, generic drugs are priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Members and providers can expect the generic to produce the same effect and have the same safety profile as the brand-name drug.

The formulary document is subject to state-specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness, and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drugs.
- Manufactured in the same strength and dosage form as the brand-name drugs.

Prior Authorization

To submit prior authorization requests please fax all documents to 877-328-9660, or to submit by phone, call the following number and use the prompts: **1-800-416-1673**.

CareSource processes Medicaid PA requests in accordance with Ohio Medicaid regulations. PA requires that a drug be preapproved in order for it to be covered under a health benefit. The PA staff will adhere to the Ohio Administrative Code (OAC) and determine medical necessity for formulary exception requests that will be reviewed based in drug-specific prior authorization criteria or standard non-formulary prescription request criteria. Providers will be required to submit pertinent medical or drug history, prior treatment history and any other necessary supporting clinical information with the request.

Medical Reasons for Exceptions

Providers may be asked to provide written clinical documentation as to why a member needs an exception. In determining whether an exception will be given, CareSource will consider whether the requested drug is clinically appropriate.

Medication Therapy Management Program

CareSource offers a medication therapy management (MTM) program for all members. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs and provide health care to patients in a cost-effective manner. You may be contacted by a pharmacist to discuss your patients' medications. We also encourage members to talk with their pharmacist about their medications, as we want to make sure they are getting the best results from the medications they are taking.

Network Pharmacies

Our pharmacy directory gives members a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website for a complete list of network pharmacies at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions > Find A Pharmacy.

PROVIDER APPEALS PROCEDURES

If in your capacity as a member's provider you file an appeal on behalf of a member, please refer to the procedures set forth in this manual. Please refer to the applicable plan's "Member Grievances and Appeals Procedures" sections for additional details.

Please note: If time frames in this manual differ from those in the provider agreement, the agreement has ruling authority.

Claim Dispute Process

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

Claim Dispute Process for Participating and Non-Participating Providers

- Claim disputes must be submitted in writing or by using the CareSource Provider Portal.
- The dispute must be submitted within 90 days after the provider's receipt of the written determination of the claim.
- If CareSource fails to render a determination for the dispute within 30 days after receipt, an appeal may be submitted.

Appeals of Claims Denials or Adverse Decisions

If you do not agree with the decision of a processed claim or dispute, you will have 120 days from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required timeframe, the claim will not be considered and the appeal will be denied. If the appeal is denied, providers will be notified in writing. If the appeal is approved, payment will show on the provider's Explanation of Payment (EOP).

How to Submit Claim Appeals

Providers can submit claims online.

Online

CareSource.com > Login > Provider Portal

From the Providers menu, select Claims Appeals.

All provider appeals requested must be submitted electronically. Mail submissions will no longer be accepted and will not be processed. The only exception is an appeal that has a medical record submission that is over 100 MB. These submissions must be submitted on disc to the CareSource Appeals department at the following address:

CareSource Provider Appeals Department
P.O. Box 2008
Dayton, OH 45401

Use the Claim Appeal Request Form located on our website. Please include:

- The member's name and CareSource member ID number
- The provider'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

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

Provider Appeals/Clinical Appeals

Provider or Provider Appealing on Behalf of a Member Standard Medical Necessity Appeals of Non-Certification Determinations

An appeal is defined as a formal request by a member or provider, including facilities or other health care entities on behalf of a member or provider for a review of a determination or action.

Timeline for Clinical Appeals

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

- Provider – within 120 days from the date of service
- Provider on behalf of a member with written authorization from the member – within 60 days of receipt
- Member – within 120 days of receipt

Additional Details about Clinical Appeals

Timing for Medical Necessity Appeals

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days from the date of denial, date of discharge or date of service.

Appeals Filed on Behalf of the Member

Medical necessity appeals filed by members or providers on behalf of a member must be submitted to CareSource within 60 days and will be resolved within 10 calendar days of receipt or as expeditiously as the member's condition warrants. Appeals on behalf of the member must include written authorization to appeal on their behalf for the specific service that is being appealed. All other medical necessity appeals will be resolved within 30 calendar days of receipt. Medicare providers have 30 days to resolve pre-service.

Expedited Appeals

An expedited appeal should be considered if the provider feels that the patient's life or health is at risk if a decision about care is not made in a timely manner.

Requests may be a verbal request and should be submitted to the Grievance and Appeals department by calling **1-800-488-0134**.

CareSource will make a determination within one working day of the expedited appeal request whether to expedite the appeal resolution. CareSource will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal resolution. This attempt will be made by phone. If the member is in a facility, the provider or facility will be notified on the same business day of the decision. The member will be informed of the limited time available for presentation of evidence and allegations of fact or law in person or in writing.

The member and provider will be notified in writing of the determination to process as a standard appeal within two calendar days of receipt of the appeal, including information that the member can appeal the decision. In the event that CareSource denies the request for an expedited appeal, the appeal will be resolved within 10 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

Expedited appeals will be resolved and verbal notification will be made within 72 hours of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution timeframe is extended.

Notification of Resolution

CareSource will verbally notify the provider or facility of the appeals resolution if the member is in an inpatient setting and will send written notification to both the provider and member on the same business day of the decision.

Extending an Appeal

A member can verbally request that CareSource extend the timeframe to resolve a standard or expedited appeal up to 14 calendar days. CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days. CareSource must submit documentation that the extension is in the member's best interest to the Ohio Department of Medicaid (ODM) for prior approval. If ODM approves the extension, CareSource must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

Dissatisfaction of Medical Necessity Appeals – One Level of Appeal

If you are dissatisfied with any medical necessity decision made by CareSource, we offer one level of appeal as mandated by ODM. Members have the right to a state hearing as a first or second level of appeal (See "State Hearings" in the "Member Support Services and Benefits" section on page 83 of this manual for more information).

You may use the Appeal Request Form on our website to submit your appeal. Visit **CareSource.com** > Provider Overview > Tools & Resources > Forms to access the Appeal Request Form.

Appeal Request Elements

- The member's name, CareSource member ID number and date of birth
- The provider's name and CareSource provider billing number
- The place, date and type of service that had a non-certification determination for clinical appeals
- The reason why the determination should be reconsidered
- Any additional available medical information to support your reasons for reversing the determination

The Appeals department may request additional information from you to document medical necessity. All appeal requests and associated information are reviewed by clinicians previously uninvolved with the case. You will be notified in writing of the outcome of your appeal request.

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days from the date of denial, date of discharge or date of service.

How to Submit Appeals

Appeals may be submitted online, by fax, or by mail.

Online

Visit **CareSource.com** > Login > Provider Portal

Fax

937-531-2398

Mail

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

Marketplace Plan

MEMBER ENROLLMENT AND ELIGIBILITY

The Health Insurance Marketplace is responsible for determining whether applicants are eligible for benefits under the plan, the application and enrollment processes and any subsidy level that may apply. Applicants must be citizens of the United States and reside in the plan's service area.

Members must enroll in the Marketplace every year. They must inform the Marketplace if they become pregnant, have a baby, change address or phone number, have a change in income or marital status or become eligible for other health care coverage.

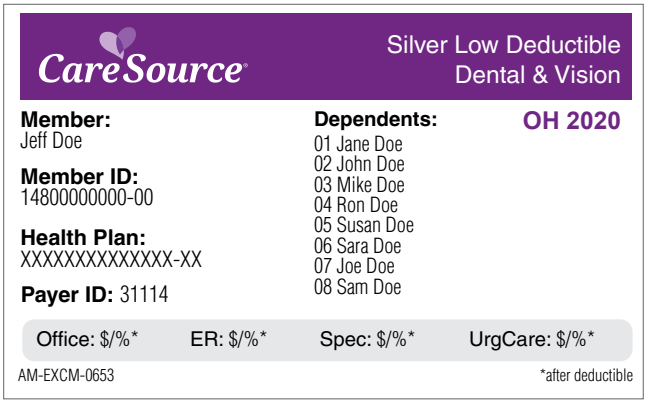
Member ID Cards

The member ID card is used to identify a CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their previous ID card. Therefore, it is important to verify member eligibility prior to each service rendered.

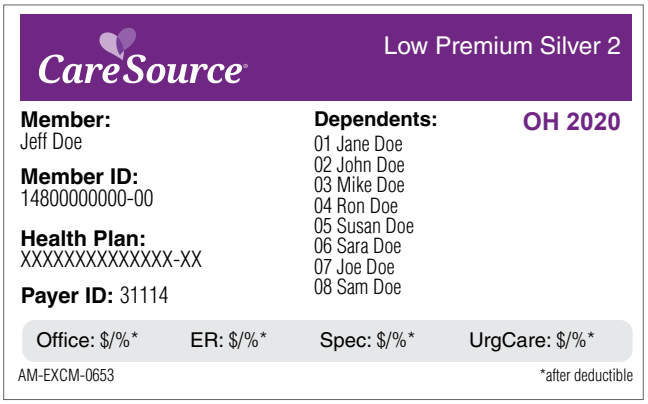
You can use our secure Provider Portal or call Provider Services at **1-800-488-0134** and follow the prompt to check member eligibility. Click on "Member Eligibility" on the left, which is the first tab. Make sure to enter the full 11-digit member ID for the person, and if a dependent, include the dependent suffix.

Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification.

Front & Back of Ohio Marketplace Member ID Card – Low Deductible Silver Plan



Front & Back of Ohio Marketplace Member ID Card – Low Premium Silver 2



ID Card Elements

- The CareSource member ID card contains the following:
- Member plan – Member's plan choice will be included in this area, including with dental and vision coverage in applicable.
- Member – This is the name of the plan holder.
- Member ID – This is the ID number + suffix for the plan holder.
- Health plan number.
- Payer ID number.
- Copay amounts for office, emergency room, specialist and urgent care visits.
- Dependents – When checking eligibility and/or submitting claims for dependents, please ensure you replace the subscriber suffix (last 2 digits, usually 00) of the Member ID number with the dependent suffix from the ID card.
- Member Services phone number.
- CareSource24. Nurse Advice Line.
- Provider Services phone numbers.
- Benefit Manager Information – CareSource partners with several benefit managers to provide our members with the best service possible in specific benefit categories. This section identifies the benefit category, company name and contact number.
- Address to submit medical claims.
- Pharmacy numbers.

New Member Welcome Kits

Once a member has paid to effectuate their coverage, each household receives a new member kit and two or more ID cards that include each family member who has joined CareSource. The new member kits are mailed separately from the ID card.

New Member Kit Elements

- A welcome letter
- A Member Handbook and an Evidence of Individual Coverage and Health Insurance Contract, which explain plan services and benefits and how to access them
- Schedule of Benefits which explains deductibles, copays, coinsurance and out-of-pocket limits for essential health benefits
- A postcard with which the member can request a Provider Directory
- A flier describing supplemental benefits

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

Member Disenrollment

Members may disenroll from CareSource for a number of reasons. Disenrollment may be initiated by the member, CareSource or the Health Insurance Marketplace.

Involuntary Member Disenrollment

CareSource is required to provide a 90 calendar day grace period to members for non-payment of their premium. During those 90 days, CareSource will continue to process medical claims and pay providers accordingly.

If the member is terminated for non-payment of premium, CareSource will retro-terminate the member and all monies paid on claims for months two and three of delinquency will be recovered.

Pharmacy benefits are eliminated when the member has reached 30-day delinquency. Pharmacy benefits will be reinstated if the member becomes current with their premiums within the 90-day grace period.

Marketplace Plan

COVERED SERVICES AND EXCLUSIONS

CareSource's Marketplace product is compliant with the Affordable Care Act (ACA) in terms of benefit offerings and cost share applications. Please refer to **CareSource.com** > Plans > Marketplace > Benefits and Services and the "Referrals and Prior Authorizations" section of this manual on page 123 for more information about referral and prior authorization (PA) 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 Provider Services at **1-800-488-0134**.

This section describes some of the services and exclusions to benefits that are provided to our CareSource members. CareSource covers all medically necessary covered services for members. Covered services may require PA. Please visit **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization for the most up-to-date list of services that require PA.

Medical Necessity Determinations

Some services require PA. When request for authorization is submitted, CareSource will notify the provider and member in writing of the determination. If a service cannot be covered, the letter from CareSource will include the reason that the service cannot be covered and how to request an appeal if necessary.

If a service cannot be covered, providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Provider Appeals Procedures" section on page 130 of this manual for information on how to file an appeal.

Pediatric Dental and Vision

All CareSource pediatric members have access to dental and vision benefits. Pediatric dental provides coverage for the majority of dental services from dental exams and preventive services to major/comprehensive services. Pediatric vision services are provided exclusively through our Vision Benefits Manager, EyeMed, and the benefit covers eye exams (no cost), eyewear including glasses or contact lenses, as well as other value add services through the relationship such as low vision exams/aids and discounts on a wide array of materials and services.

Routine Hearing Exams and Hearing Aids

All CareSource members have access to no cost routine hearing exams through our vendor, TruHearing. Members must contact TruHearing's member services to establish a relationship with a hearing specialist who will guide them through finding a provider, setting up an appointment, as well as supporting them through any follow up processes to ensure satisfaction.

Optional Adult Dental, Vision and Fitness

CareSource's Dental, Vision, & Fitness plans provide adult members (19 years and older, except as stated below) the ability to access the following benefits:

Dental – Adult dental benefits include services such as preventive and diagnostic (cleanings and exams), basic restorative (fillings) and major restorative (extractions, dentures and crowns). Two preventive visits are allowed each year for cleanings and oral examination. Services may be subject to a benefit limit and are subject to an $800 allowance each calendar year.

Vision – Adult routine vision benefits are available exclusively through our Vision Benefits Manager, EyeMed, and include eye exams (cost share may apply), eyewear including contact lenses, as well as other value add services through the relationship such as low vision exams/aids and discounts on a wide array of materials and services. Eyewear (glasses and contacts) are subject to a $250 allowance each calendar year with no copay/deductible.

Fitness – Available for members age 18 and above, CareSource is proud to offer our adult members access to the Active&Fit® program with no member cost share. The Active&Fit program provides your patient with a no cost access to their network of participating fitness centers and select YMCAs along with access to up to two home fitness kits per benefit year, online tools such as fitness center search, a quarterly online newsletter, online classes and more. *The Active&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit is a trademark of ASH and used with permission herein.*

Marketplace Plan

MEMBER SUPPORT SERVICES AND BENEFITS

CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

CareSource Member Services

CareSource Marketplace members can access the Member Services department by calling our toll-free number and following the menu prompts at 1-800-479-9502.

Representatives are available by telephone Monday through Friday, except on the following holidays:

- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

Member Services is available 7 a.m. to 7 p.m. Eastern Standard Time (EST), Monday through Friday. Please visit **CareSource.com** > About Us > Contact Us for more information on the holiday hours.

Benefit Manager Member Services

Members access our Benefit Manager member services by calling the toll free numbers listed below. Benefit Managers are able to provide answers to questions on overall services, coverages, claims, in-network providers, and more.

- Active&Fit (American Specialty Health): 1-877-771-2746
- Routine Vision Services and Glasses/Contacts (EyeMed): 1-833-337-3129
- Routine Hearing Services and Hearing Aids (TruHearing):

CareSource24, Nurse Advice Line

Members can call our nurse advice line 24 hours a day, 7 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. For improved care coordination with PCPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse provided.

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

Care Management/Outreach

CareSource provides the services of care management physical and behavioral health nurses, social workers and outreach specialists to provide one-on-one, personal interaction with patients. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team. Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging non-compliant patients, reinforcing medical instructions and assessing social needs, as well as educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many chronic diseases. You can refer a member to Care Management by calling **1-844-280-5463**.

Care Management Services

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

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

- Asthma
- Diabetes
- Heart disease
- Depression
- High blood pressure and cholesterol
- Low back pain
- Pregnancy
- Weight loss
- Smoking cessation

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

Perinatal Care Management

CareSource's perinatal and neonatal care management program utilizes a multi-disciplinary team with extensive OB and NICU clinical experience. Specialized nurses are available to help manage high-risk pregnancies and medically complex newborns by working in conjunction with providers and members. The expertise offered by the staff includes a focus on patient education and care coordination and involves direct telephone contact with members and providers.

We encourage our prenatal care providers to notify our Care Management department at **1-844-280-5463** when a member with a high-risk pregnancy has been identified. Care Management is notified of medically complex infants at the time of admittance to the neonatal intensive care unit.

Our perinatal education packets are mailed out to all members identified as pregnant to stress the importance of early screening, diagnostic, and treatment. Members with high-risk pregnancy are offered additional detailed pregnancy education materials.

Disease Management Program

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

We help our members through:

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

Members with specific disease conditions such as asthma, diabetes, or hypertension are identified by criteria or triggers, such as emergency room visits, hospital admissions, or the health assessment. These members are automatically mailed quarterly condition specific newsletters. The materials are available in English and Spanish. Any member may self-refer or be referred into the Disease Management Program to receive condition-specific information and outreach. If a member does not wish to receive newsletters or outreach, they can call 1-844-438-9498.

Benefits to Members and Providers

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

Disease Management Referrals

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

Emergency Department Diversion

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

We instruct members to call their primary care provider (PCP) or the CareSource24 nurse advice line if they are unsure if they need to go to an ER. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. We offer enhanced reimbursement to PCP offices for holding evening or weekend hours to help ensure that our members have alternatives other than the ER available to them when they need medical care outside of normal business hours. Please see the “Primary Care Providers” chapter on page 162 of this manual for more information.

Member ER utilization is tracked closely. If there is frequent ER utilization, members are referred to our Care Management department for analysis or intervention. Members are contacted via phone or mail. Intervention includes education, as well as assistance with removing any identified health care access barriers. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Interpreter Services

CareSource offers over-the phone (OPI) language interpreters for members who need assistance to communicate with CareSource. These services are available at no cost to the member.

CareSource requires providers, at their own expense, to offer sign and other language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking proficiency. These services should be available at no cost to the member. You are also required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. We can provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed.

For any questions, please contact our Provider Services department at **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711). 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.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during Healthchek exams as needed. CareSource endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices. The recommended schedule is included in this section of the manual. This schedule is updated annually and the most current updates are located on www.aap.org.

Immunization Codes

Effective Oct. 1, 2015, CareSource requires providers to use ICD-10-CM Codes and CPT Codes on claims. Please refer to the Code Tables located on the CMS website at www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html.

You can also get CMS Coding Guidelines at www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf.

Health Education

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

Marketplace Plan

MEMBER GRIEVANCE AND APPEALS PROCEDURE

Marketplace members may contact Member Services at 1-800-479-9502 with any questions they have about benefits, including any questions about coverage and benefit levels; annual deductibles, coinsurance copayment, and annual out-of-pocket maximum amounts; specific claims or services they have received; our network; and our authorization requirements.

We have implemented the Complaint Process and the Internal and External Appeals procedures to provide fair, reasonable, and timely solutions to complaints that members may have concerning the Plan, benefit determinations, coverage and eligibility issues, or the quality of care rendered by network providers.

Complaint Process

Pursuant to Ohio Revised Code 1751.19, we have put in place a Complaint Process for the quick resolution of Complaints members submit to us that are unrelated to benefits or benefit denials. For purposes of this Complaint Process, we define a complaint as an expression of unhappiness or dissatisfaction, orally or in writing, concerning any matter relating to any aspect of the Plan's operation. If members have a complaint concerning the Plan, they may contact us by sending a letter to the following address:

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

They may also submit a complaint by calling us at **1-800-479-9502**. They may arrange to meet with us in-person to discuss the Complaint.

Within 30 calendar days of our receipt of a complaint, we will investigate, resolve, and respond to the complaint and send a letter explaining the Plan's resolution of the complaint. Please note that the Adverse Benefit Determination Appeal Process below addresses issues related to benefits, benefits denials, or other adverse benefit determinations.

CareSource Managed Care

In processing claims, CareSource reviews requests for prior authorization (PA), Predetermination and Medical Review for purposes of determining whether requested Health Care Services are Covered Services. This managed care process is described below. Members with questions regarding the information contained in this section may call Member Services at **1-800-479-9502**.

Definitions

- ***Prior Authorization*** – A required review of a service, treatment or admission for a benefit coverage determination, which must be obtained prior to the service, treatment or admission start date, pursuant to the terms of this Plan.
- ***Predetermination*** – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. We will review the EOC to determine if there is an Exclusion for the Health Care Service. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the Health Care Service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.
- ***Medical Review*** – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a Health Care Service that did not require Prior Authorization and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which we have a related clinical coverage guideline, and are typically initiated by us.

Most network providers know which services require Prior Authorization and will obtain any required Prior Authorization or request a Predetermination if they feel it is necessary. The ordering network providers will contact us to request Prior Authorization or a Predetermination review. We will work directly with network providers regarding such Prior Authorization request. However, they may designate an Authorized Representative to act on their behalf for a specific request.

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

Members are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact Member Services.

Categories of Prior Authorization, Predetermination and Medical Requests:

- **Urgent Review Request** – A request for Prior Authorization or Predetermination that in the opinion of the treating provider with knowledge of the Covered Person's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function or subject the Covered Person to severe pain that cannot be adequately managed without such care or treatment. If an urgent care review request is not approved, the Covered Person may proceed with an Expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.
- **Prospective Review Request** – A request for Prior Authorization or Predetermination that is conducted prior to the service, treatment or admission.

- **Concurrent Review Request** – A request for Prior Authorization or Predetermination that is conducted during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.
- **Retrospective Review Request** – A request for Prior Authorization that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Timing of Decisions and Notifications

We will issue our benefit decisions and related notifications within the timeframes set forth below. Please call Member Services at **1-800-479-9502** with any questions.

Review Request Category	Timeframe for Making Decision
Urgent Care Claims*	As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours from the receipt of request.
Prospective Care Claims**	Within two (2) Business Days after receiving all necessary information, or fifteen (15) calendar days from the receipt of the request, whichever is less.
Concurrent Urgent Care Claims when request is received at least twenty-four (24) hours before the expiration of the previous authorization or no previous authorization exists	Within twenty-four (24) hours from the receipt of the request, taking into account the medical exigencies.
Concurrent Urgent Care Claims when request is received less than twenty-four (24) hours before the expiration of the previous authorization or no previous authorization exists	As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours from the receipt of request, whichever is less.
Concurrent Care Claim	Within one (1) Business Day after receiving all necessary information.
Retrospective***	Ninety (90) calendar days from the receipt of the request.

*** Urgent Care Claims**. The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan. If the Plan needs more information before we can make a decision, we will notify you of the information we need within twenty-four (24) hours of our receipt of your request. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Plan will notify you of our final decision as soon as possible, but in no case later than forty-eight (48) hours after the earlier of: (a) our receipt of the specified information, or (b) the end of time period afforded to you to provide the specified additional information.

**** Prospective Care Claims**. The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the

date by which the we expect to render a decision.

*** **Retrospective Care Claims.** The timeline above does not apply if the Plan does not receive sufficient information to determine whether, or to what extent, Health Care Services are covered by the Plan or due to matters beyond the Plan's control. If the Plan needs more information before we can make a decision, then the Plan will notify of you. The notice will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

This period may also be extended one time by the Plan, for up to fifteen (15) days, if the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notify you, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- Verbal: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.
- Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Covered Person or his or her Authorized Representative.

If we do not approve the Benefits, we will provide members with a Notice of an Adverse Benefit Determination. The Notice of an Adverse Benefit Determination will include the specific reason or reasons for the Adverse Benefit Determination; the reference to the specific Plan provisions on which the Adverse Benefit Determination is based; a description of any additional material or information necessary for the member or provider to perfect the claim for Benefits; and a description of our review procedures and the time limits applicable to such procedures.

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

Adverse Benefit Determination Appeals

If we make an Adverse Benefit Determination, we will provide the member or Authorized Representative with a Notice of an Adverse Benefit Determination, as described above.

Providers must have member written consent to file pre-service appeals.

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

If a member wishes to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, the member or his/her Authorized Representative must submit an appeal in writing within one hundred eighty (180) calendar days of receiving the Adverse Benefit Determination. They do not need to submit Urgent Care appeals in writing. This communication should include:

- The Covered Person's name and identification number as shown on the ID card;
- The provider's name;
- The date of the medical service;
- The reason the member or their Authorized Representative disagrees with the denial; and
- Any documentation or other written information to support the request.

The member or their Authorized Representative may send a written request for an appeal to:

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

For Urgent Care requests for Benefits that have been denied, members or their Authorized Representative can call the Plan at **1-800-479-9502** to request an appeal.

The Plan offers one (1) level of appeal. The Plan must notify the members of the Expedited appeal determination involving a Pre-Service denial within forty-eight (48) hours and within ten (10) calendar days after receiving the completed appeal for a pre-service denial and thirty (30) completed days after receiving the completed post-service appeal.

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

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

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

Within five business days after we receive an appeal of an Adverse Benefit Determination, we will send to the appealing party a letter acknowledging the date the Plan received the appeal and a list of documents the appealing party must submit if additional information is needed. If the appeal was oral, the Plan will enclose a one-page appeal form clearly stating that the form must be returned to CareSource for prompt resolution. The appeal will be reviewed by an individual not involved in the initial decision. For clinical related appeals, the appeal will be reviewed by a provider who is in the same or similar specialty that typically manages the medical or dental condition, procedure, or treatment under review.

Notice of our Final Internal Adverse Benefit Decision on the appeal will include the dental, medical, and contractual reasons for the resolution; clinical basis for the decision and the specialization of provider consulted. A denial will also include notice of the member's right to have an External Review of the denial and the procedures to obtain that review.

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

- **Urgent Care Services Requests for Benefits** – A request for Benefits provided in connection with Urgent Care Services, as defined in Section 13 "Glossary" in the member's Evidence of Individual Coverage and Health Insurance Contract (EOC).
- **Prospective Service Requests for Benefits or Pre-Service Requests** – A request for Benefits which the Plan must approve or in which you must notify us before non-Urgent Care Services are provided; and
- **Retrospective Post-Service** – A claim for reimbursement of the cost of non-Urgent Care Services that have already been provided.
- **Concurrent Service Requests for Benefits** – A request for Benefits during the course of treatment or admission. If a Concurrent review request is not approved, a Covered Person who is receiving an ongoing course of treatment may proceed with an expedited External Review while simultaneously pursuing an internal appeal, the procedures for which are described below.
- The time frames which the member or the member's Authorized Representative and CareSource are required to follow are provided below.

Urgent Care Request for Benefits

If we deny the member's request for Urgent Care Services, we must notify the member or his/her Authorized Representative of our benefit determination as soon as possible, taking into account the medical exigencies, but not later than 48 hours after receiving the request for the appeal.

Urgent Care appeals do not need to be submitted in writing. The member or his/her Authorized Representative should call CareSource as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits

The member or his/her Authorized Representative must appeal an Adverse Benefit Determination related to Pre-Service Requests for Benefits no later than 180 calendar days after receiving the Adverse Benefit Determination. We must notify the member or his/her Authorized Representative of our benefit determination within 10 calendar days after receiving the request for the appeal. We may require a one-time extension of no more than 10 calendar days only if more time is needed due to circumstances beyond CareSource's control.

Post-Service Claims

The member or his/her Authorized Representative must appeal an Adverse Benefit Determination related to Post-Service Requests for Benefits no later than 180 calendar days after receiving the Adverse Benefit Determination. We must notify the member or his/her Authorized Representative of our benefit determination within 30 calendar days after receiving the request for the appeal. We may be entitled to a one-time extension of no more than 15 calendar days only if more time is needed due to circumstances beyond CareSource's control.

Concurrent Services Requests

Appeals relating to ongoing emergencies or denials of continued hospital stays are referred directly to an expedited appeal process for investigation and resolution. They will be concluded in accordance with the medical or dental immediacy of the case but in no event will exceed one working day from the date all information necessary to complete the appeal is received. Initial notice of the decision may be delivered orally if followed by written notice of the decision within three business days.

The appeal will be reviewed by a health care partner not involved in the initial decision, which is in the same or similar specialty that typically manages the medical or dental condition, procedure, or treatment under review. The Physician or provider reviewing the appeal may interview the patient or patient's designated representative.

Expedited Review of Internal Appeal

Expedited Review of an internal appeal may be started orally, in writing, or by other reasonable means available to the member. We will complete expedited review of an appeal as soon as possible given the medical needs but no later than 48 hours after our receipt of the request and will communicate our decision by telephone to the member's attending Physician or the ordering provider. We will also provide written notice of our determination to the member, attending Physician or ordering provider, and the Facility rendering the service.

Members may request an expedited review for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
  - Could seriously jeopardize the member's life or health or the member's ability to regain maximum function, or,
- In the opinion of a Physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Except as provided above, a claim involving Urgent Care Services is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of the member's medical condition determines is a claim involving urgent care.

Exhaustion of Internal Appeals Process

The internal appeal process must be exhausted prior to initiating an External Review except in the following instances:

- We agree to waive the exhaustion requirement;
- The member did not receive a written decision of our internal appeal within the required time frame;
- We failed to meet all requirements of the internal appeal process unless the failure:
  - Was minor;
  - Does not cause or is not likely to cause prejudice or harm to the member;
  - Was for good cause and beyond our control;
  - Is not reflective of a pattern or practice of non-compliance; or
  - An Expedited External Review is sought simultaneously with an expedited internal review.

External Reviews

Under Chapter 3922 of the Ohio Revised Code, CareSource, as a health plan, must provide a process that allows the members the right to request an independent External Review of an Adverse Benefit Determination. An Adverse Benefit Determination is a decision by us to deny Benefits because services are not covered, are excluded, or limited under the Plan, or because the member is not eligible to receive the Benefit. The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An External Review may be conducted by an IRO or by the Ohio Department of Insurance. The member will not pay for the External Review. There is no minimum cost of Health Care Services denied in order to qualify for an External Review; however, the member must generally exhaust CareSource's internal appeal process before seeking an External Review. Any exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

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

- The Adverse Benefit Determination involves a medical judgment or is based on any medical information.
- The Adverse Benefit Determination indicates the requested service is Experimental or Investigational, the requested Health Care Service is not explicitly excluded from the Plan and the member's treating Physician certifies at least one of the following:
  - Standard Health Care Services have not been effective in improving the member's condition.
  - Standard Health Care Services are not medically appropriate for the member.
  - No available standard Health Care Service covered by us is more beneficial than the requested Health Care Service.

Standard reviews are normally completed within thirty (30) calendar days. An expedited review for urgent medical situations is normally completed within forty-eight (48) hours and can be requested if any of the following applies:

- The member's treating Physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the member's life or health or would jeopardize the member's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The member's treating Physician certifies that the Final Internal Adverse Benefit Determination involves a medical condition that could seriously jeopardize the member's life or health or would jeopardize the member's ability to regain maximum function if treatment is delayed until after the time frame of a standard External Review.
- The Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or Health Care Service for which the member received Emergency Health Services, but has not yet been discharged from a Facility.
- An expedited internal appeal may be requested concurrently with a request for an expedited External Review request for an Adverse Benefit Determination and the member's treating Physician certifies in writing that the recommended Health Care Service or treatment would be significantly less effective if not promptly initiated.

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

Please Note:

- An expedited External Review is not available for retrospective Final Internal Adverse Benefit Determinations (meaning the Health Care Service has already been provided to the member.
- Upon receipt of new information from the IRO, we may reconsider our Adverse Benefit Determination and provide coverage. If we make such reconsideration, we will notify the member, the IRO, and the Ohio Department of Insurance of our decision within one (1) Business Day.

External Review by the Ohio Department of Insurance

The member is entitled to an External Review by the Department in either of the following instances:

- The Adverse Benefit Determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The Adverse Benefit Determination for an Emergency indicates that the medical condition did not meet the definition of Emergency AND our decision has already been upheld through an External Review by an IRO.

Request for External Review

Regardless of whether the External Review case is to be reviewed by an IRO or the Department of Insurance, the member or his/her Authorized Representative must request an External Review through us within one hundred eighty (180) calendar days of the date of the notice of Final Internal Adverse Benefit Determination issued by us. All requests must be in writing, except for a request for an expedited External Review. Expedited External Reviews may be requested electronically or orally.

If the member's request is complete, we will initiate the External Review and notify the member in writing, or immediately in the case of an expedited review, that the request is complete and eligible for External Review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the member that, within ten (10) Business Days after receipt of the notice, the member may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review.

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

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

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

Independent Review Organization Assignment

When we initiate an External Review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of Health Care Service. An IRO that has a conflict of interest with us, the member, the member's provider, or the Facility will not be selected to conduct the review.

Independent Review Organization Review and Decision

The IRO must consider all documents and information considered by us in making the Adverse Benefit Determination, any information submitted by the member and other information such as: medical records, attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Plan, the most appropriate practice guidelines, clinical review criteria used by the Plan or our utilization review organization, and the opinions of the IRO's clinical reviewers. The IRO is not bound by any previous decision reached by us.

The IRO will provide a written notice of its decision within thirty (30) calendar days of receipt by us of a request for a standard review or within forty-eight (48) hours of receipt by us of a request for an expedited review. This notice will be sent to the member, us and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for External Review.The date the IRO was assigned by the Ohio Department of Insurance to conduct the External Review.
- The dates over which the External Review was conducted.
- The date on which the IRO's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards that were used or considered in reaching its decision.

Note: Written decisions of an IRO concerning an Adverse Benefit Determination that involves a health care treatment or service that is stated to be Experimental or Investigational also include the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation. In the event the Department of Insurance determines that, due to facts and circumstances, a second External Review is required, we will pay the costs of such second External Review.

Binding Nature of External Review Decision

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

Member Questions

Members may contact us by mail, fax, or phone. Please call Member Services.

Members may also contact the Ohio Department of Insurance at:

Ohio Department of Insurance
Attn: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

To file a Consumer Complaint, members may go to:

http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Definitions

For purposes of this section, the following definitions apply:

Adverse Benefit Determination means an adverse benefit determination as defined in 29 CFR 2560.503-1, as well as any rescission of coverage, as described in § 147.128 (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time). An Adverse Benefit Determination is a decision by CareSource to deny, reduce, or terminate a requested Health Care Service or Benefit in whole or in part, including all of the following:

- A determination that the Health Care Service does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
- A determination of a member's eligibility for Benefits under the Plan;
- A determination that a Health Care Service is not a Covered Service;
- The imposition of an Exclusion or other limitation on Benefits that would otherwise be covered;
- A determination not to issue coverage to a member, if applicable to this Plan; or
- A determination to rescind coverage under the Plan regardless of whether there is an adverse effect on any particular Benefit at that time.

Appeal (or internal appeal) means the review by the Plan of an Adverse Benefit Determination, as required in this section.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to state or federal law.

Final Internal Adverse Benefit Determination means an adverse benefit determination that has been upheld by the Plan at the completion of the internal appeals process described in this Section.

Independent review organization (or IRO) means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to this Section.

Marketplace Plan

REFERRALS AND PRIOR AUTHORIZATIONS

CareSource uses a select network of hospitals, physicians and ancillary providers. Typically, CareSource does not pay for non-network, non-emergent services; however, these may be provided with prior authorization from CareSource's Utilization Management (UM) team. There are specific criteria for obtaining prior authorization. Please visit the Provider Portal at **CareSource.com** for the most current information on prior authorization and referral requirements.

Please note: Prior Authorization does not guarantee payment.

Referral Information

Generally, CareSource does not require referrals or PA before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, prior authorizations are needed before CareSource will pay for services from out-of-network providers, except in cases of emergency.

Referral Procedures

Any treating doctor can refer CareSource members to specialists. Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists require PA for any services rendered to CareSource members.

You can also submit a request on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal. You can request a PA by calling Provider Services and telling our interactive voice response system (IVR),that you want to request a PA.

If you have difficulty finding a specialist for your CareSource member, please use our online Find a Doctor/ Provider tool at **CareSource.com** > Members > Tools & Resources > Find a Doctor or call Provider Services at: **1-800-488-0134**.

Prior Authorization Information

Prior Authorization Procedures

The Provider Portal is the preferred method to request prior authorizations for health care services. You get immediate approval or pend status, and can also check pending claim status. Email us at CiteAutoAssistance@caresource.com for portal login assistance.

Online

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

Alternate Submission Methods

Phone

1-800-488-0134

Fax

888-752-0012

E-mail

MMHIX-Just4Me@caresource.com

Mail

CareSource
P.O. Box 1307
Dayton, OH 45401

Copies of prior authorization forms can be found on **CareSource.com** > Providers > Forms.

When requesting an authorization, please provide the following information:

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

If the provider fails to obtain PA for non-emergency services, neither the plan nor a covered person will be required to pay for those non-emergency services.

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

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

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

PA is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When PA is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date of service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request PA as soon as it is known that the service is needed.

All services that require PA from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which PA is required, but not obtained by the provider. CareSource will notify you of PA determinations by a letter mailed to the provider's address on file. Lack of appropriate notification will result in a provider denial.

For all PA decisions (standard or urgent), CareSource provides notice to the provider and member as expeditiously as the member's health condition requires. 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.

Please note: Any participating facility/provider requesting prior authorization for an elective admission must obtain PA for the use of any out of network RAPHL (radiologist, pathology, hospitalist and laboratory) provider.

Determination Timeframes

CareSource's timeframes to make authorization determinations vary depending upon the member's health condition, completeness of submission information and state requirements.

Review Type	Time for plan to respond when all information is present	Time for plan to request additional information	Provider response time to submit additional information	Plan response time after receiving additional
Inpatient Notification (DEMO)	N/A	24 hrs	48 hrs	24 hrs
Inpatient Initial	24 hrs	24 hrs	48 hrs	24 hrs
Inpatient Continued Stay Review (CSR)	24 hrs	24 hrs	48 hrs	24 hrs
Outpatient/Elective Non-Urgent	2 business days	24 hrs	45 days	2 business days
Outpatient/Elective/ URGENT	72hrs	24 hrs	48 hrs	48 hrs
Retrospective	within 30 days	30 days	45 days	30 Calendar days

Marketplace Plan

PHARMACY

Prescription Drug Coverage

CareSource partners with Express Scripts, Inc. to process medication claims. Express Scripts, Inc. processes medication claims for all Ohio plans to provide continuity for provider offices and CareSource members.

Qualified health plans in the Health Insurance Marketplace provide prescription drug coverage. This benefit will provide coverage for prescriptions obtained from a retail pharmacy, mail-order pharmacy or specialty pharmacy. This also includes those drugs that are administered in the patient's home and/or administered through a home health agency.

Copayment/Coinsurance Requirements

Members may be required to pay a copayment or coinsurance for covered prescription drugs. Our plans offer lower cost shares for less costly drugs. For example, there may be a lower charge for a generic drug, a higher copay for a preferred brand-name drug and a still higher copay for a non-preferred drug.

For specialty pharmacy, a coinsurance is applied. Coinsurance is a percent of the drug's cost. When members pay a percentage, their cost may be high for many reasons:

- The cost of the drug may be high. Let's assume the coinsurance is 30 percent. In this case, a $250 drug will be more costly than a $25 drug.
- The drug may not be on a preferred tier on the formulary, so the member pays at a higher tier.
- The member may be buying a more expensive brand-name drug when there is a generic equivalent available for less money, if authorized.

Prescribing providers for CareSource's Marketplace plan members must contact the plan for medication prior authorizations (PAs).

For a complete list of drugs available, visit CareSource.com > Providers > Tools & Resources > Drug Formulary. Members may also confirm coverage and costs of a specific drug using the CareSource Find My Prescriptions tool at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions.

Tiered Medications

Every drug covered on the CareSource Marketplace drug formulary is in one of the tiers below. In general, the higher the cost-sharing tier number, the higher the cost for the drug:

Tier 0: Prescription drugs include preventive medications. These medications are available without a copayment or coinsurance.

Tier 1: Prescription drugs in this tier contain low cost generic drugs.

Tier 2: Prescription drugs have a higher coinsurance or copayment than those in Tier 1. This tier will contain preferred medications that may be single or multi source brand-name drugs.

Tier 3: Prescription drugs have a higher coinsurance or copayment than those in Tier 2. This tier will contain non-preferred medications. This will include medications considered single- or multi-source brand-name drugs.

Tier 4: Prescription drugs have a higher coinsurance or copayment than those in Tier 3. Medications generally classified as specialty* preferred medications fall into this category.

Tier 5: Prescription drugs have a higher coinsurance than those in Tier 4. Medications generally classified as specialty* non-preferred medications fall into this category.

* Accredo, a full-service specialty pharmacy, will be the preferred in-network specialty pharmacy for many of your patients with CareSource health benefits. Many CareSource patients may need to use Accredo to take full advantage of their specialty drug coverage options. Please send specialty pharmacy prescriptions to Accredo.

Drug Formulary

CareSource uses a list of covered drugs, called a drug formulary. The drug formulary contains information about drugs covered, their cost share tiers and limitations of coverage (such as PAs, quantity limits and step therapy protocols). Drugs are listed by therapeutic class and by alphabetical index so that therapeutic interchanges for most drug classes are easier to compare. To learn more about how to use our pharmaceutical management procedures, please visit our website's Pharmacy page at **CareSource.com** > Provider Overview > Education > Patient Care > Pharmacy.

CareSource updates the drug formulary regularly and communicates any updates online on the Drug Formulary Changes pages. The most up-to-date formulary may be found online at **CareSource.com** > Providers > Tools & Resources > Drug Formulary. Drugs not listed on the Drug Formulary are not covered without prior approval.

Quantity, Supply, Duration and Benefit Limits

Quantity limits and dosing limits are based on several factors such as the manufacturer's recommended dosing frequencies, long-term considerations, diagnosis and best practices, and/or Food & Drug Administration (FDA) recommendations. Limits on opioids or other substances of abuse are based upon maximal morphine equivalent dosing limits or applicable law. Additionally benefit limitations may pertain to preventive coverage or as defined by applicable rights to coverage for our members.

Step Therapy

Certain medications on the drug formulary are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a first step formulary medication used to treat the same condition be tried and failed prior to the approval of a step two formulary medication.

Generic Substitution & Therapeutic Exchange

Generic substitution occurs when a pharmacy dispenses a generic drug that is equivalent to the prescribed brand-name drug. Generally, generic drugs are priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Members and providers can expect the generic to produce the same effect and have the same safety profile as the brand-name drug.

The formulary document is subject to state-specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness, and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drugs.
- Manufactured in the same strength and dosage form as the brand-name drugs.

A reasonable clinical trial of the step one drug is defined to include appropriate use for labeled or compendia-supported indications, titration of the step one drug (where appropriate), and supporting evidence (such as provider notes or lab results) to show the step one drug has failed. Step two drugs are formulary medications which may require the member to pay higher cost share and also may be more costly to the plan. Step therapy is designed to preserve best practice and protect our member's financial medication burden.

If a non-formulary brand drug is requested instead of the generic equivalent, a PA request would be required. Our Medical Necessity for Non-Formulary drugs policy requires submission of clinical documentation including clinical notes, proper MedWatch form submissions, etc., as explained in the policy. A determination of medical necessity will be made as explained in the Prior Authorizations section below. If approved, members will pay higher copayments and be subject to additional costs which will not apply to their maximum out of pocket costs. This can be significant for our members.

A list of covered drugs is available on **CareSource.com** > Providers > Tools & Resources > Drug Formulary. This site also includes other information about the CareSource pharmacy program.

Prior Authorization

To submit prior authorization requests please fax all documents to 866-930-0019, or to submit by phone, call the following number and use the prompts: **1-800-488-0134**.

Pharmacy PAs are reviewed and determinations are made within 72 hours of receipt. If your request is urgent, please mark it as "expedited" and a decision will be rendered within 24 hours of receipt. If you experience technical difficulties or have an urgent need where fax may not be sufficient, you may call in your request. Please note that requests for exceptions or PAs without clinical documentation supplied as required may experience a higher rate of denial and/or appeals because of incomplete policy requirements. Therefore, we encourage all requests to be submitted with complete clinical documentation in order to achieve the best outcomes for our members.

Medical Reasons for Exceptions

Typically, our drug formulary 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 or considered a treatment standard of care equal to or better than the drug you are requesting, we generally will not approve your request for an exception.

Medically necessary reasons for approving an exception could include lack of available alternatives on our formulary to treat the member's condition, a severe intolerance or allergy to all of our formulary drugs causing hospitalization or submission of a MedWatch notice to the Federal Drug Administration (FDA), or the member has failed all available formulary options.

As mentioned previously, drugs that are on the formulary may have utilization management (UM) applied for reasons of cost, safety, allowances by state laws and more. All documentation to request an exception must establish medical necessity of the requested drug over the available drugs covered by the plan as per each policy.

CareSource has an exception process that allows the member, the member's representative or the prescribing physician to make a request for a formulary coverage exception, or an exception to UM. The member, member's representative or prescribing physician may initiate the request by calling Member Services. CareSource then reaches out to the provider to obtain the appropriate documentation.

CareSource will provide a decision no later than 72 hours after the request is received, or within 24 hours if the request is expedited.

If the initial exception request is denied, providers have the right to request an external review by an Independent Review Organization (IRO). The external review process is outlined in the "Member Grievances and Appeals" section on page 112 of this manual for the Marketplace plan.

Medication Therapy Management Program

CareSource offers a medication therapy management (MTM) program for all members. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs and provide health care to patients in a cost-effective manner. You may be contacted by a pharmacist to discuss your patients' medications. We also encourage members to talk with their pharmacist about their medications, as we want to make sure they are getting the best results from the medications they are taking.

Network Pharmacies

Our pharmacy directory gives members a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website for a complete list of network pharmacies at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions > Find A Pharmacy.

Marketplace Plan

PROVIDER APPEALS PROCEDURES

If in your capacity as a member's provider you file an appeal on behalf of a member, please refer to the procedures set forth in this manual. Please refer to the applicable plan's "Member Grievances and Appeals Procedures" sections for additional details.

Please note: If time frames in this manual differ from those in the provider agreement, the agreement has ruling authority.

Claim Dispute Process

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

Claim Dispute Process for Participating and Non-Participating Providers

- Claim disputes must be submitted in writing or by using the CareSource Provider Portal.
- The dispute must be submitted within 90 days after the provider's receipt of the written determination of the claim.
- If CareSource fails to render a determination for the dispute within 30 days after receipt, an appeal may be submitted.

Appeals of Claims Denials or Adverse Decisions

If you do not agree with the decision of a processed claim or dispute, 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 timeframe, the claim will not be considered and the appeal will be denied. If the appeal is denied, providers will be notified in writing. If the appeal is approved, payment will show on the provider's Explanation of Payment (EOP).

How to Submit Claim Appeals

Providers can submit claims online.

Online

CareSource.com > Login > Provider Portal

From the **Providers** menu, select Claims Appeals.

All provider appeals requested must be submitted electronically. Mail submissions will no longer be accepted and will not be processed. The only exception is an appeal that has a medical record submission that is over 100 MB. These submissions must be submitted on disc to the CareSource Appeals department at the following address:

CareSource Provider Appeals Department
P.O. Box 2008
Dayton, OH 45401

Use the Claim Appeal Request Form located on our website. Please include:

- The member's name and CareSource member ID number
- The provider'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

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

Provider Appeals/Clinical Appeals

Provider or Provider Appealing on Behalf of a Member Standard Medical Necessity Appeals of Non-Certification Determinations

An appeal is defined as a formal request by a member or provider, including facilities or other health care entities on behalf of a member or provider for a review of a determination or action.

Timeline for Clinical Appeals

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

- Provider – within 180 days from the date of denial issued by a Utilization Management or Pharmacy, date of discharge or date of service
- Provider on behalf of a member with written authorization from the member – within 90 days of receipt
- Member– within 90 days of receipt

Additional Details about Clinical Appeals

Timing for Medical Necessity Appeals

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days from the date of denial, date of discharge or date of service.

Appeals Filed on Behalf of the Member

Medical necessity appeals filed by members or providers on behalf of a member must be submitted to CareSource within 90 days and will be resolved within 10 calendar days of receipt or as expeditiously as the member's condition warrants. Appeals on behalf of the member must include written authorization to appeal on their behalf for the specific service that is being appealed. All other medical necessity appeals will be resolved within 30 calendar days of receipt. MyCare has 15 days to resolve pre-service and 30 days to post.

Expedited Appeals

An expedited appeal should be considered if the provider feels that the patient's life or health is at risk if a decision about care is not made in a timely manner.

Requests may be a verbal request and should be submitted to the Grievance and Appeals department by calling **1-800-488-0134**.

CareSource will make a determination within one working day of the expedited appeal request whether to expedite the appeal resolution. CareSource will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal resolution. This attempt will be made by phone. If the member is in a facility, the provider or facility will be notified on the same business day of the decision. The member will be informed of the limited time available for presentation of evidence and allegations of fact or law in person or in writing.

The member and provider will be notified in writing of the determination to process as a standard appeal within two calendar days of receipt of the appeal, including information that the member can appeal the decision. In the event that CareSource denies the request for an expedited appeal, the appeal will be resolved within 10 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

Expedited appeals will be resolved and verbal notification will be made within 72 hours of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution timeframe is extended.

Notification of Resolution

CareSource will verbally notify the provider or facility of the appeals resolution if the member is in an inpatient setting and will send written notification to both the provider and member on the same business day of the decision.

Extending an Appeal

A member can verbally request that CareSource extend the timeframe to resolve a standard or expedited appeal up to 14 calendar days. CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days. CareSource must submit documentation that the extension is in the member's best interest to the Ohio Department of Medicaid (ODM) for prior approval. If ODM approves the extension, CareSource must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

Dissatisfaction of Medical Necessity Appeals – One Level of Appeal

If you are dissatisfied with any medical necessity decision made by CareSource, we offer one level of appeal as mandated by ODM. Members have the right to a state hearing as a first or second level of appeal (See "State Hearings" in the "Member Support Services and Benefits" section on page 107 of this manual for more information).

You may use the Appeal Request Form on our website to submit your appeal. Visit **CareSource.com** > Provider Overview > Tools & Resources > Forms to access the Appeal Request Form.

Appeal Request Elements

- The member's name, CareSource member ID number and date of birth
- The provider's name and CareSource provider billing number
- The place, date and type of service that had a non-certification determination for clinical appeals
- The reason why the determination should be reconsidered
- Any additional available medical information to support your reasons for reversing the determination

The Appeals department may request additional information from you to document medical necessity. All appeal requests and associated information are reviewed by clinicians previously uninvolved with the case. You will be notified in writing of the outcome of your appeal request.

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days from the date of denial, date of discharge or date of service.

How to Submit Appeals

Appeals may be submitted online, by fax, or by mail.

Online

Visit **CareSource.com** > Login > Provider Portal

Fax

937-531-2398

Mail

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

Appeal of Claim Denials

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 a claim appeal. Providers have 180 days from the date of service or the date of discharge, whichever is later, to request a medical necessity appeal. If the 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, providers will be notified in writing. If the appeal is approved, payment will show on the provider'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. Providers have 365 calendar days from the date of service or discharge to submit a corrected claim.

How to Submit Appeals

Providers can submit claims through our secure Provider Portal, phone, fax, or by mail.

Online

Visit **CareSource.com** > Login > Provider Portal

From the **Providers** menu, select Claims Appeals. This is the preferred method of appeal submission.

Provider Claim Submission Fax

855-795-0088

Provider Claim Appeals Fax

937-531-2398

Mail

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

Use the **"Provider Claim Appeal Request Form"** located on our website. Please include:

- The member's name, CareSource member ID number.
- The provider's name and ID number, located in your provider welcome 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.

Provider Medical Necessity Appeals

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

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

Timeline for Medical Necessity Appeals

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

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

Appeals Filed on Behalf of the Member

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

Expedited Appeals

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

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

Requests may be a verbal request and should be submitted to the Grievance and Appeals department by calling **1-800-488-0134**.

Expedited review of an internal appeal may be started orally, in writing, or by other reasonable means available. We will complete expedited review of an appeal as soon as possible given the medical needs but no later than 72 hours after our receipt of the request or as expeditiously as the medical condition requires unless the resolution time frame is extended.

Notification of Resolution

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

Extending an Appeal

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

Dissatisfaction of Medical Necessity Appeals – Member External Reviews

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

Opportunity for External Review

You may use the Provider Appeal Request Form on **CareSource.com** > Providers > Tools & Resources > Forms to submit your appeal, but this form is not required.

Appeal requests should include:

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

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

All appeal requests and associated information are reviewed by clinicians previously uninvolved with the case. You will be notified in writing of the outcome of your appeal request.

How to Submit Medical Necessity Appeals

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

Online

Visit **CareSource.com** > Login > Provider Portal

Fax

937-531-2398

Writing

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

Dispute Resolution and Governing Law

Dispute is defined as any dispute or controversy arising under, out of, or in connection with or in relation to the Agreement or the breach of the Agreement ("Dispute"). The Agreement means the agreement entered into between CareSource and Provider to provide Covered Services to Covered Persons.

Good Faith. The parties shall work together in good faith to resolve any Dispute in a timely manner.

First-Level Dispute Resolution. Upon written notice of a Dispute setting forth the issues and the reasons to support such Dispute from the disputing party to the other party ("Dispute Notice"), the parties shall meet in good faith to resolve such Dispute. Unless otherwise agreed upon by the parties, such meeting shall take place within thirty (30) days of the date of the Dispute Notice.

Second-Level Dispute Resolution. If the Dispute is not resolved or settled within sixty (60) days of the date of the Dispute Notice, each party shall select a vice president and two other individuals to represent each party, and such representatives shall meet in good faith to settle the Dispute. If the Dispute is not satisfactorily resolved within ninety (90) days of the Dispute Notice, then either party can refer the matter to binding arbitration as described below. In no event may arbitration be initiated by a party more than one (1) year following the date of the Dispute Notice.

Binding Arbitration. Any Dispute not resolved after the parties have exhausted the First-Level and Second-Level Dispute resolution process described above shall be (a) conducted in accordance with the American Arbitration Association Alternative Commercial Arbitration Rules and Mediation Procedures (the "AAA Rules"); and (b) determined and settled by a panel of three (3) arbitrators selected in accordance with the AAA Rules. Venue shall be determined in accordance with the Agreement. The arbitrators may construe or interpret, but shall not vary or ignore, the terms of the Agreement. The arbitrators shall have no authority to award any Consequential Damages as defined in the Agreement. Any award rendered by the arbitration shall be final and binding upon each of the parties, and judgment thereof may be entered in any court having jurisdiction thereof. The costs of the arbitration shall be borne equally by both parties, provided that each party shall bear the fees and costs of attorneys or other persons representing the interests of such party. During the pendency of any such arbitration proceeding and until final judgment hereon has been entered, the Agreement between the parties shall remain in full force and effect unless otherwise terminated as provided in the Agreement. The parties agree that if the Dispute pertains to a matter which is generally administered by certain Policies or Protocols (including but not limited to the Fair Hearing Plan, quality improvement plans, and billing audits), the procedures set forth in such Policies or Protocols must be fully exhausted by a party before such party may invoke its right to arbitration under this section.

Exceptions: Notwithstanding the foregoing, either party may seek equitable remedies in any court of competent jurisdiction to protect its intellectual property or confidential information. The parties further agree to exclude the following matters from the operation of this arbitration clause: any counterclaim, cross-claim or third-party claim for indemnity or contribution between CareSource and Provider in any Covered Person's suit against CareSource or Provider, unless a court requires the parties to submit the Covered Person's entire claim to arbitration.

Governing Law and Venue. CareSource and Provider agree to the governing law and venue provisions set forth in the Agreement. In the event there is a dispute as to the governing law it shall default to the State of Ohio as governing law and venue shall default to Montgomery County, Ohio as the sole, proper venue of any arbitration, proceeding or special proceeding between the parties that arises out of or is in connection with any right, duty or obligation under the Agreement.

MyCare Ohio Plan (Medicare-Medicaid Coverage)

Please Note: The information provided within this section of the Ohio Provider Manual is to address information specific to the CareSource MyCare Ohio plan. This information should be used in tandem with the information provided elsewhere throughout this manual. Please refer to the rest of this manual for standards procedures and practices of working with CareSource on Medicaid and Medicare plans.

What is MyCare Ohio?

MyCare Ohio is the state of Ohio's dual demonstration. MyCare Ohio is a system of managed care plans selected to coordinate the physical, behavioral and long-term care services for individuals over the age of 18 who are dually eligible for both Medicaid and Medicare. This includes people with disabilities, older adults and individuals who receive behavioral health services.

The MyCare Ohio program coordinates Medicare and Medicaid benefits for Medicare-Medicaid enrollees. The goal of MyCare Ohio program is to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees, including long-term services and supports.

Providers of MyCare Ohio provide personal care, long-term support, home modifications, home care and other similar services apart from physicians, physician assistants, hospitals and similar health care services.

MyCare Ohio stresses a team approach to health care. **Every enrollee gets a care manager assigned to help coordinate care**. The care team includes the individual, the individual's family and/or caregiver, the CareSource care manager, the waiver service coordinator (if appropriate) the primary care provider (PCP), specialists and other providers as appropriate to support and coordinate the member's care.

CareSource MyCare Ohio is serving people in these 12 Ohio counties:

Columbiana	Lorain	Stark
Cuyahoga	Mahoning	Summit
Geauga	Medina	Trumbull
Lake	Portage	Wayne

Member Eligibility Verification

Opting Out of CareSource MyCare Medicare Coverage

MyCare Ohio allows for individuals to opt out of Medicare coverage from the plan managing their MyCare benefits. Individuals will have the option to have CareSource provide their Medicare benefits or to opt out of the Medicare portion of the program and stay with their current Medicare Advantage plan or traditional Medicare.

Providers need to confirm the MyCare Ohio member's option for Medicare coverage. If a member chooses a different plan for their Medicare benefits, CareSource will only manage Medicaid benefits and will only reimburse claims for Medicaid services. Claims for Medicare must be submitted to the plan managing their Medicare benefits.

Therefore, it is important to verify member eligibility prior to each service rendered. Providers have two options for verifying member eligibility.

- Log on to **CareSource.com** and select Provider Portal from the menu options. Using our secure Provider Portal, you can check CareSource member eligibility up to 24 months after the date of service.
- Call Customer Care Services at **1-800-488-0134** and tell our IVR system you want to verify member eligibility. You will be directed to our automated member-eligibility verification system. The automated system, available 24 hours a day, will prompt you to enter the member ID number and the month of service to check eligibility.

Member ID Card

All new CareSource MyCare Ohio members receive a membership ID card, which replaces the state Medicaid card. If the member has selected CareSource to provide both their Medicare and Medicaid benefits, they will have a single ID card replacing both their state Medicaid and their Medicare Card. These members will require only one card for both plans.

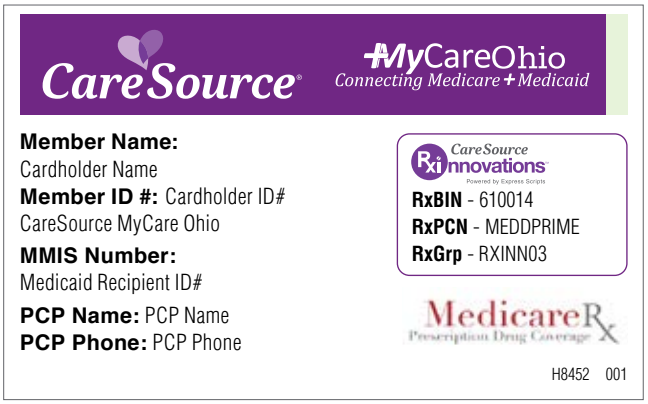
However, if a member does not select CareSource to provide their Medicare benefits, they will continue to use the card for their selected Medicare plan.

Providers need to confirm the MyCare Ohio member's option for Medicare coverage. If a member chooses a different plan for their Medicare benefits, CareSource will only manage Medicaid benefits and will only reimburse claims for Medicaid services. Claims for Medicare must be submitted to the plan managing their Medicare benefits. Therefore, it is important to verify member eligibility prior to each service rendered.

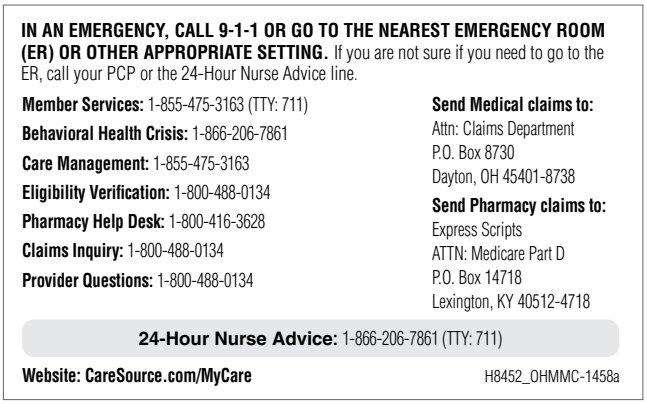
Providers may use our secure Provider Portal to check member eligibility, or call the Provider Services department at **1-800-488-0134** and follow the prompts to check member eligibility.

Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification.

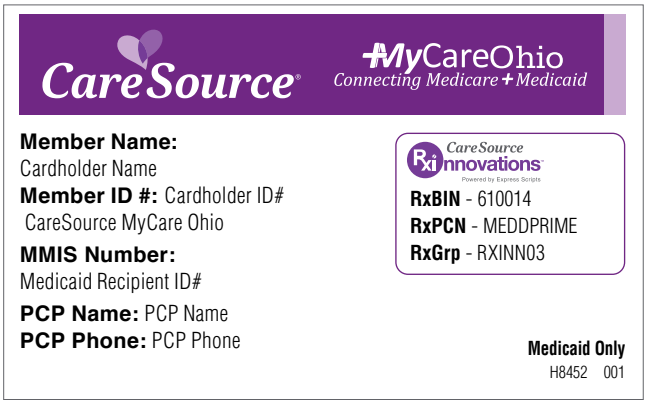
Front of CareSource MyCare Ohio Medicare-Medicaid Member ID Card



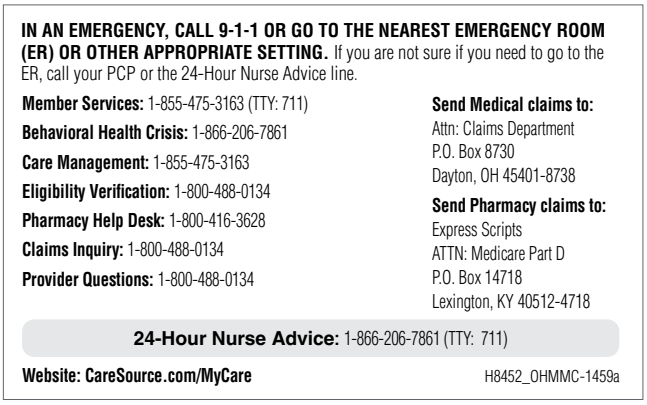
Back of MyCare Ohio Medicare-Medicaid Member ID Card



Front of CareSource MyCare Ohio Medicaid-Only Member ID Card



Back of MyCare Ohio Medicaid-Only Member ID Card



Certifications and Provider Sanctions

Credentialing Process for Network Facilities/Services

It is the policy of CareSource to ensure the quality and qualifications of professionally licensed practitioners and organizational providers through a credentialing and recredentialing process which complies with regulatory and accreditation standards. Please see the "Credentialing and Re-Credentialing" chapter on page 14 of this manual for full details.

The ultimate goal of the credentialing program is to ensure the highest quality of care for our members. CareSource embraces the Institute of Medicine's definition as *"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."*

Prohibited Affiliations

Revocation of licensure will result in immediate termination of the contract between the provider and CareSource. The Credentialing department will monitor the provider attestations upon recredentialing. Should an adverse determination be made against a provider either during the time of recredentialing, or between credentialing cycles, for quality of care and/or service, the provider is given the determination in writing and provided with the appeal process. Depending on the reason for the determination, CareSource notifies the appropriate authorities.

Any providers found to be noncompliant with CareSource credentialing requirements will be given the opportunity to provide explanation for the noncompliant area. The information will then be presented to the Credentialing Committee for review and determination of network status. Action may be taken based on the data collected. Examples of action taken include continuation in the program, required participation in continuing education, required supervision, a clear plan for improvement with the practitioner, evidence of changes in the scope of practice, or termination of the practitioner from the program.

Confidentiality

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

Home and Community-Based Services (HCBS) Waiver Programs

The Ohio Department of Aging (ODA) is responsible for the certification of providers who provide services for Medicaid waiver programs administered through the Community Long-Term Care Division. In addition to holding a Medicaid Provider Agreement, providers of services must meet Ohio Administrative Code 173-39-02 Conditions of participation.

Provider sanctions are specifically addressed in the Ohio Administrative Code 173-39-05, Disciplinary Actions.

Ohio Administrative Code Waiver Rules

Providers are obligated to abide by the regulations and policies of the state. They must read and understand all Ohio Administrative Code (OAC) rules that pertain to their provider type and the services they deliver.

The following OAC chapters can be used as reference for providers.

- State plan home health and private duty nursing services
  - Chapter 5160:3-12, Ohio Home Care Program
- Waiver providers and services
  - Chapter 5160: 3-45, Administered Waiver Service providers
  - Chapter 5160:3-46, Ohio Home Care Waiver
  - Chapter 5160:3-50, Transitions Carve-out Waiver
- There are multiple additional state websites that will be helpful to providers. They include the following:
  - Ohio Department of Job and Family Services (ODJFS) main website: http://jfs.ohio.gov
  - ODJFS consumer website: http://medicaid.ohio.gov/
  - ODJFS provider website: http://medicaid.ohio.gov/providers.aspx
  - MITS (Medicaid Information Technology System) website: http://medicaid.ohio.gov/PROVIDERS/MITS/MITSInformationReleases.aspx
  - MITS eTutorial website: http://medicaid.ohio.gov/PROVIDERS/Training/MITSOnlineTutorialsforProviders.aspx
  - eManuals: http://emanuals.odjfs.state.oh.us/emanuals

Providers need to be aware the pursuant to section 173.391 of the Revised Code, ODA (or ODA's designee) may take disciplinary action against a provider for good cause, including misfeasance, malfeasance, nonfeasance, confirmed abuse or neglect, financial irresponsibility or any conduct ODA determines in injurious or poses a threat, to the health, safety, or welfare of the consumers of the provider's services.

Providers are encouraged to review and be familiar with Chapter 173-39-05, "Disciplinary Actions" for the definitions including and not limited to Level-one disciplinary action, Level-two disciplinary action, Level-three disciplinary action and appeals.

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 (PA) is required to ensure that services provided to our members are medically necessary and provided appropriately. Providers have 30 calendar to submit a retrospective review from the date of service or date of discharge.

In the event that you fail to obtain PA, and your claim denies, you must file a claim appeal (once a claim is submitted providers cannot file for a retro-authorization request). Providers have 120 days from the date of service, date of discharge, or 90 days from the other carrier's Explanation of Benefits (EOB) (whichever is later) to file a claim appeal.

A request for retrospective review can be made by calling **1-800-488-0134** and allowing our interactive voice response (IVR) system, to direct you to the Medical Management department, or by faxing the request to **888-527-0016**. Clinical information supporting the request for services must accompany the request.

Please note: If you are appealing on our member's behalf with their written consent, you have up to 60 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).

MyHealth Rewards Program

CareSource offers MyHealth for members over the age of 18. Members use MyHealth to take health assessments, set goals and track activities. Members can take online health training based on their needs. Members can also earn rewards, if applicable. Members can redeem rewards in MyHealth for gift cards to retailers including T.J. Maxx, Marshalls, Home Goods, Panera Bread, iTunes and more. Members can get started by signing on to their **My.CareSource.com** account and click on the MyHealth icon under My Plan.

Disease Management Program

Our free disease management program helps our members find a path to better health through information, resources and support.

We help our members through:

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

Members with specific disease conditions such as asthma, diabetes, or hypertension are identified by criteria or triggers, such as emergency room visits, hospital admissions, or the health assessment. These members are automatically mailed quarterly condition specific newsletters. The materials are available in English and Spanish. Any member may self-refer or be referred into the disease management program to receive condition-specific information and outreach. If a member does not wish to receive newsletters or outreach, they can call 1-844-438-9498.

Benefits to Members and Providers

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

Disease Management Referrals

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

Transportation

Transportation can be provided for covered appointments, Women, Infants and Children (WIC) appointments and Medicaid redetermination appointments with the County Department of Job and Family Services. If a member must travel 30 miles or more to a covered appointment, CareSource will provide transportation. The enhanced transportation benefit is limited to 30 round-trip visits (60 one-way trips) annually per member for MyCare Opt-In. For MyCare Opt-Out members, CareSource provides the base Medicaid transportation benefit. Members who have exhausted the CareSource benefit are referred to their county's NET program for future trip needs. Transportation is provided at no cost to the member. Members can arrange transportation by calling the Member Services phone number on their ID card and requesting transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

MyCare Model of Care Training

The Centers for Medicare & Medicaid Services (CMS) requires MyCare Ohio plans to provide initial and annual Model of Care (MOC) training to all network providers contracted to see dual-eligible members and all out-of-network providers seen by dual-eligible members routinely.

Providers are required by CMS to attest to completing the annual model of care training. To view and attest that you have completed the training and receive credit, please log on to the Provider Portal (link to this), which will prompt you to review and attest to completing the model of care training.

ALL PLANS

CARESOURCE MEMBER RIGHTS AND RESPONSIBILITIES

As a CareSource provider, you are required to respect the rights of our members. CareSource members are informed of their rights and responsibilities via their Member Handbook. The list of our members' rights and responsibilities are listed below. All members are encouraged to take an active and participatory role in their own health and the health of their family.

Member rights and responsibilities, as stated in the Member Handbook, are as follows:

- Receive information about CareSource, our services, our network providers and member rights and responsibilities.
- Be treated with respect and dignity by CareSource personnel, network providers and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive.
- Participate with your doctor in making decisions about your health care.
- Candidly discuss with your doctor the appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about the plan or the care it provides.
- Make recommendations regarding the plan's member rights and responsibilities policy.
- Choose an advance directive to designate the kind of care you wish to receive should you be unable to express your wishes.
- Be able to get a second opinion from a qualified provider. If a qualified network provider is not able to see you, CareSource will set up a visit with a provider not in our network.

Members of CareSource are also informed of the following responsibilities:

- Supply information needed, to the extent possible, that the organization and its doctors need in order to provide care.
- Follow the plans and instructions for care that you have agreed to with doctors.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- FBe enrolled and pay any required premiums.
- Pay an annual deductible, copayments and coinsurance.
- Pay the cost of limited and excluded services.
- Choose network providers and network pharmacies.
- Show your ID card to make sure you receive full benefits under the plan.

HIPAA Notice of Privacy Practices

Members are notified of CareSource's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CareSource's Notice of Privacy Practices includes a description of how and when member information is used and disclosed within and outside of the CareSource organization. The notice also informs members on how they may obtain a statement of disclosures or request their medical claim information and how they may file a complaint with the U.S. Dept. of Health and Human Services (HHS) Office for Civil Rights (OCR) related to their privacy. CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members.

As a provider, please remember to follow the HIPAA regulations as required for all covered entities and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Please remember that disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the HIPAA regulation 45 CFR 164. For example, providers 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.

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

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

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

Additional Plan-Specific Information

MEDICAID PROVIDERS

Member rights and responsibilities, as stated in the Member Handbook, are as follows:

- As a CareSource Medicare Advantage provider, 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 providers 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.

Members of CareSource are also informed of the following about protection of their 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 who has 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 providers 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 providers, including our network pharmacies.
- You have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- For a list of the providers 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 providers 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.
- We must support your right to make decisions about your care.
  - 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 providers 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 providers when you go for medical care. Your providers 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 provider 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.

Members of CareSource are also informed of actions they can take if they feel they are being treated unfairly or that their 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.

Members of CareSource are also informed of how to get more information:

- 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.

Members of CareSource are also informed of the following responsibilities:

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 providers 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 providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors, other providers 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 providers 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 providers 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/providers.
- 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.

AMERICANS WITH DISABILITIES ACT

Providers are required to comply with Americans with Disabilities Act (ADA) standards, including but not limited to:

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

The ADA prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, providers may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities and follow ADA accessibility standards for new construction and alteration projects. Furthermore, providers' diagnostic equipment must accommodate individuals with disabilities.

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

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

ALL PLANS

CARESOURCE HEALTH EQUITY COMMITMENT

CareSource has a long-standing commitment to addressing the need for culturally competent care in our member populations, as well as looking at those non-clinical needs, or social determinants, that impact member health outcomes. We have maintained a Cultural Competency Commitment for several years, as part of our desire to serve the community and to meet regulatory requirements. We have enhanced and expanded Commitment to Cultural Competency, via our CareSource Commitment to Health Equity or CHEC program. The CHEC seeks to focus on the social determinants of health and to influence and identify health disparities and inequities that impact our members.

Health equity enables everyone to achieve their full health potential. This requires addressing historical and contemporary injustices and removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care (The Health Policy Institute of Ohio (HPIO), 2018). Health inequities are directly related to the existence of historical and current discrimination and social injustice. CareSource recognizes that many of our members experience health disparities and come from cultural and ethnic backgrounds that may impede their ability to achieve positive health outcomes. We have, and continue to, develop and enhance programs to address disparities and promote understanding of how cultural beliefs impact member health decisions.

CareSource considers providing equitable and culturally competent care and services a core value of our organization. We recognize language and cultural differences have a significant impact on member health care experience and outcomes. According to the US Department of Health and Human Services, Office of Minority Health, the lack of culturally and linguistically appropriate services is one of the most modifiable factors in improving health care.

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

CareSource prohibits its providers or partners from refusing to treat, serve or otherwise discriminate against an individual because of race, color, religion, national origin, sex, age, gender orientation (i.e. intersex, transgendered and transsexual) or disability. In consideration of cultural differences, including religious beliefs and ethical principles, CareSource will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the U.S. Department of Health and Human Services (HHS).

CLAS Standards: National Culturally & Linguistically Appropriate Standards

CareSource adheres to the National Culturally & Linguistically Appropriate Standards (CLAS), which serve as a blueprint for health care providers and organizations to implement culturally and linguistically appropriate services. CLAS consists of 15 standards that encompass the following topic areas:

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

Network providers must ensure that:

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

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

ALL PLANS

QUALITY IMPROVEMENT PROGRAM

CareSource is committed to providing evidence-based care in a safe, member-centered, timely, efficient and equitable manner. The scope of our CareSource quality improvement (QI) program is comprehensive and includes both clinical and non-clinical services. CareSource monitors and evaluates the quality of care, encompassing the safety and service delivered to our members with an emphasis on accessibility to care, availability of services and physical and behavioral health care delivered by network practitioners and providers. CareSource also monitors the quality and safety of member services through review of practitioners, provider, hospital, utilization management, care management and pharmacy program results. Member satisfaction and health outcomes are monitored through routine health plan reporting, annual Health Effectiveness Data and Information Set (HEDIS)®, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Qualified Health Plan (QHP) Enrollee Experience Survey scores, assessment of provider and member satisfaction and review of accessibility and availability standards, utilization trends and quality improvement activities. Performance is assessed against goals and objectives that are in keeping with industry standards. Annually, CareSource completes an evaluation of our QI program.

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our Ohio Medicaid and Marketplace plans.

Program Scope

CareSource supports an active, ongoing and comprehensive quality improvement program across the enterprise. The scope of the QI program is to:

- Advocate for members across settings
- Meet member access and availability needs for physical and behavioral health care
- Determine interventions to positively impact HEDIS overall improvement rates that increase utilization of preventive care services and facilitate support for members with acute and chronic health conditions and other complex health, welfare or safety needs
- Determine interventions for improvement that enrich member and provider experience and satisfaction with our CareSource products and services
- Demonstrate enhanced care coordination and continuity across settings

- Meet members' cultural and linguistic needs, encompassing the social determinants of health
- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings
- Determine practitioner adherence to clinical practice guidelines
- Support the development of member self-management skills
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies
- Ensure regulatory and accrediting agency compliance

Quality Strategy

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

Institute for Healthcare Improvement Triple Aim for Populations

CareSource aligns with the Institute for Healthcare Improvement Triple Aim (IHI) framework to:

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

Centers for Medicare & Medicaid Services' National Quality Strategy

CareSource aligns with CMS' National Quality Strategy to optimized health outcomes by leading clinical quality improvement and health system transformation. The goals are:

- Making care safer by reducing harm caused in the delivery of care by eliminating racial and ethnic disparities
- Strengthening person and family engagement as partners in care by enabling local innovations
- Promoting effective communication and coordination of care by enabling local innovations
- Promoting effective prevention and treatment of chronic disease by strengthening infrastructure and data systems
- Working with communities to promote best practices of healthy living by fostering learning organizations
- Making care affordable by fostering learning organizations

Quality Measures

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

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

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer and chlamydia)
  - Well-child care
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure
- Prenatal/Postpartum Care
  - Maternal health outcomes
  - Infant health outcomes
- Behavioral health
  - Follow-up after hospitalization for mental illness
  - Antidepressant medication management
  - Follow-up for children prescribed attention deficit/hyperactivity disorder (ADHD) medication
- Safety
  - Use of imaging studies for low back pain

CareSource uses CAHPS surveys to capture member perspectives on health care quality for Medicaid and Medicare plans. CAHPS is a program overseen by the United States Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ). Potential CAHPS measures include:

- Customer service
- Getting care quickly
- Getting needed care
- How well doctors communicate
- Ratings of all health care, health plan, personal doctor or specialists

Preventive Guidelines and Clinical Practice Guidelines

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

The use of these guidelines allows CareSource to measure their impact on member health outcomes. Review and approval of the guidelines are completed by the Market CareSource Physician Advisory Committee every two years or more often as appropriate. The guidelines are then presented to the Enterprise Physician Advisory Committee for acceptance. Topics for guidelines are identified through analysis of member population demographics and national or state priorities. Guidelines may include, but are not be limited to:

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

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

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

- Medicaid: **1-800-488-0134**
- Medicare: **1-844-679-7865**
- D-SNP: **1-833-230-2176**
- Marketplace: **1-800-488-0134**
- MyCare: **1-800-488-0134**

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 providers

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

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

Primary Care Providers

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 6 weeks

Specialists

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine	Not to exceed 12 weeks

Behavioral Health

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

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

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

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

How to Submit Changes to CareSource

Online

Visit **CareSource.com** > Login > Provider Portal

Email

ProviderMaintenance@caresource.com

Fax

937-396-3076

Mail

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

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

Additional Plan-Specific Information

MARKETPLACE PROVIDERS

Consumer Surveys

CareSource uses the annual member survey, QHP Enrollee Survey, to capture member perspectives on health care quality for our Marketplace plan. The QHP Enrollee Survey is a consumer experience survey that assesses enrollee experience with QHPs offered through Marketplace plans. The survey includes a set of core questions that address key areas of care and service provided to members

Confidentiality

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

Provider Performance and Profiling

CareSource monitors over and underutilization of medical services. Provider profiling is done periodically to measure utilization of common inpatient and outpatient services such as preventive services. Healthcare Effectiveness Data and Information Set (HEDIS®) clinical performance measures and pharmacy utilization*. Summary reports for these measures are available to individual providers upon request, and routine periodic reporting is under development.

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

ALL PLANS

PRIMARY CARE PROVIDERS

Primary Care Provider Concept

All CareSource members may choose a primary care provider (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 online Provider Directory available at **CareSource.com** > Members > Tools & Resources > Find a Doctor. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling Member Services.

Primary Care Provider Roles and Responsibilities

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

- Assisting with coordination of the member's overall care, as appropriate for the member.
- Serving as the ongoing source of primary and preventive care.
- Recommending referrals to specialists, as required.
- Triaging members.
- Participating in the development of case management care treatment plans and notifying CareSource of members who may benefit from case management. Please see the "Member Support Services and Benefits" sections for each plan included in this manual on how to refer members for case management.

Primary Care Providers are responsible for:

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

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

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered as needed. CareSource endorses the same recommended childhood immunization schedule that is recommended by the Center for Disease Control and approved by the Advisory Committee on Immunization Practices (ACIP), the AAP and the American Academy of Family Physicians (AAFP). This schedule is updated annually, and the most current updates can be found at www.aap.org.

Clinical Practice Registry and Member Profile

Quick and easy to access on our secure Provider Portal, the CareSource Clinical Practice Registry helps PCPs improve patient health outcomes efficiently. The primary use of the Registry is to help PCPs manage their patient population.

PCPs can quickly sort their CareSource membership into actionable groups. The CareSource Clinical Practice Registry is a proactive approach to patient care and helps place emphasis on preventive care.

Key Benefits of the Registry

- The registry is color-coded, which provides easy identification of members in need of tests and/or screenings.
- The information can be downloaded as a PDF or in an Excel spreadsheet format (the Excel spreadsheet contains patient contact information).
- It provides direct access to the CareSource Member Profile feature for individual members of interest.

Information Included on the Registry

- Well-baby visits (zero to 15 months)
- Well-care (two to 21 months)
- Asthma
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening
- Lead screening
- Diabetes (e.g. cholesterol, eye exam, hematology, kidney)
- Emergency room visits

The CareSource Clinical Practice Registry is located on our secure Provider Portal.

Member Profile

With its comprehensive view of patient medical and pharmacy data, our Member Profile can help you improve health outcomes for your CareSource patients. The Member Profile can also help you determine an accurate diagnosis more efficiently, reduce unnecessary diagnostic tests and minimize emergency room visits.

Key Benefits of the Member Profile

- Provides medical history
- Identifies potential prescription non-adherence or abuse
- Identifies duplication of services
- Introduces disease or care management options

Please Note: The Member Profile tool can be found on the Eligibility and Prior Authorization screens of the Provider Portal.

After-Hours Care

Telephone Arrangements

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

- A provider's office phone must be answered during normal business hours.
- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments needed by a member.
- Identify and reschedule broken and no-show appointments.
- Identify special member needs while scheduling an appointment (e.g. wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments).
- Schedule continuous availability and accessibility of professional, allied and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provided coverage in the event of a provider's absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other

method and then transferred to a member's medical record.

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

Enhanced Reimbursement

CareSource can help you identify members from your primary care practice who are utilizing the emergency room frequently. We offer this service to help you manage your patients more easily, direct them to the appropriate setting for care and decrease inappropriate emergency room visits. We also offer enhanced reimbursement to primary care offices holding evening or weekend hours.

CPT Code	Days/Hours	Reimbursement
99050	Monday to Friday 5 p.m. to 10 p.m. Weekends and holidays: 8 a.m. to 10 p.m.	$16.50, plus office visit rate
99051	Seven days per week 10 p.m. to 8 a.m.	$22, plus office visit rate

Additional Plan-Specific Information

MEDICAID PROVIDERS

Prenatal and Postpartum Care

Documentation

To ensure accurate documentation of prenatal and postpartum care, please be sure to document the following in patient records:

- Evidence of prenatal teaching – This includes education on infant feeding; Women, Infants and Children (WIC); birth control; prenatal risk factors; dietary/nutrition information and childbirth procedures.
- Components of the postpartum checkup – This includes documenting the pelvic exam, blood pressure, weight, breast exam and abdominal exam.

Prenatal Risk Assessment Forms

CareSource is committed to helping providers manage the high-risk pregnancies of our members. We ask prenatal care providers to use Prenatal Risk Assessment Forms, located on our website to communicate critical information to us about our pregnant members. In turn, participating providers receive payment for submission of each Prenatal Risk Assessment Form. Payment is made according to the Ohio Medicaid fee schedule and your provider agreement with CareSource.

Guidelines When Submitting Prenatal Risk Assessment Forms to CareSource

You may use any form designed for prenatal risk assessment documentation, such as ODJFS Form 3535, the American College of Obstetricians and Gynecologists (ACOG) Form, the Hollister Form, or forms provided by CareSource. If you don't already have a supply of the CareSource forms, please visit our website. You may also use your own office's assessment form if you have one that captures the same information. We must receive the forms, filled out completely, no later than one week after the member's first prenatal visit. Please be sure to include the member's estimated delivery date on the form.

We accept copies or originals by fax or by mail.

Fax

937-487-1157

Mail

CareSource
Attn: Maternal Child Department
P.O. Box 8730
Dayton, OH 45401-8730

Email

MaternalChildHealth@CareSource.com

We accept up to three assessment forms per pregnancy in case additional forms are needed for changes noted at subsequent visits as the pregnancy progresses. Please use code H1000 on the associated claim to indicate that an assessment form was submitted. This will help ensure that you are reimbursed appropriately.

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

Well-child/Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a child health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. All children of these ages who are CareSource members must receive a well-child/EPSDT exam. It supports two goals: to ensure access to necessary health resources, and to assist parents and guardians in appropriately using those resources. For the complete listing of the American Academy of Pediatrics Preventive Health Guidelines go to www.aap.org. For more information on Healthchek exam components, visit the "Member Support Services and Benefits" section on page page 48.

High-Risk Children

Children at high risk should be tested according to the AAP guidelines. Problems found or suspected during a well-child visit must be diagnosed and treated as appropriate. Referrals must be made based on standards of good practice and AAP's recommendations for preventive pediatric health care or presenting need.

ALL PLANS

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.

Provider Responsibilities

- 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. The time frames vary based on provider agreement.
  - **Minimum 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 Primary Care Providers (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 primary care provider (PCP) or a back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider and only recommends emergency room use for after hours.
- 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.
- Providers should keep all demographic and practice information up to date. Information updates can be submitted on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal

CareSource Responsibilities

- Paying 90 percent of clean claims within 30 days of receipt.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the "Provider Appeals Procedures" sections for each plan in this manual.
- Offering a 24-hour Nurse Advice Line for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance which involves subtracting the primary payment from the lessor of the primary carrier allowable or the Medicaid allowable. (If the member's primary insurer pays a provider equal to or more than CareSource's fee schedule for a covered service, CareSource will not pay the additional amount.)

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

Examples:

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

Participating providers are expected to treat members with respect. CareSource members should not be treated any differently than patients with any other health care insurance. Please reference member rights in the "Member Support Services and Benefits" chapter on oage 48 of this manual.

Submitting Provider Changes

Type of Change	**Notice Required** Please notify CareSource of the change prior to the timeframes listed below.
New providers or deleting providers	Immediate
Providers leave the practice	Immediately upon provider notice
Phone number change	10 calendar days
Address change	60 calendar days
Change in capacity to accept members	60 calendar days
Providers intent to terminate	90 calendar days

Why is it important to give changes to CareSource?

This information is critical to process your claims. In addition, it ensures our 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:

Information updates can be submitted on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

Other ways to submit changes include:

Email

ProviderMaintenance@caresource.com

Fax

937-396-3076

Mail

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

Americans with Disabilities Act Standards

Additionally, providers will remain compliant with Americans with Disabilities Act (ADA) standards, including but not limited to:

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

For more information on these ADA standards and how to be compliant, please see the ADA section of this manual.

Additional Plan-Specific Information

MEDICAID PROVIDERS

Additional Provider Responsibilities & Standards

- Paying 95 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 “Provider Appeals Procedures” chapter on page 70 of this manual.
- Offering a 24-hour Nurse Advice Line 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 providers to follow standard practice procedures even though they may not be spelled out in our provider agreement. For example:
  - Participating providers, or their designee, are expected to make daily visits to their patients who have been admitted as inpatient to an acute care facility or arrange for a colleague to visit.
  - Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.

Participating providers are expected to treat members with respect. CareSource members should not be treated any differently than patients with any other health care insurance. Please reference the "Member Rights and Responsibilities" chapter on page 48 of this manual.

CareSource expects participating providers to verify member eligibility and ask for all of their health care insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other health care insurance coverage that we have on file by logging 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 provider to your practice helps us keep our records current and are critical for claims processing.

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 Medicare Advantage Organization's (MAO) contractual obligations
- Prompt payment
- Compliance with applicable Medicare laws and regulations

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

ALL PLANS

FRAUD, WASTE AND ABUSE

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

Definition of Terms

Fraud is 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.

Waste involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs, 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/member has not knowingly and/or intentionally misrepresented facts to obtain payment.

Improper Payments are any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts. Anyone who identifies an improper payment should report it to CareSource using one of the reporting methods below.

Examples of Member Fraud, Waste and/or Abuse:

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers 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 providers to get treatment, drugs, etc.

Examples of Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Billing for services not provided
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Purchasing drugs from outside the United States
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using patient lists for the purpose of submitting fraudulent claims
- Drugs billed for inpatients as if they were outpatients
- Payments stemming from kickbacks or Stark Law 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.

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

The Program Integrity and Investigations department routinely monitors for potential billing discrepancies or potential fraud, waste and abuse. When found, an investigation is initiated and if warranted, corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider 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

Your provider agreement provides specific information on each type of termination/suspension. The Fair Hearing Plan, available at CareSource.com/documents/fhp, provides information on an appeal process for specific provider terminations.

Network providers are to report and return to CareSource any overpayment within sixty (60) calendar days of identification, and notify CareSource in writing of the reason for the overpayment.

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

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

The False Claims Act addresses those who:

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

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

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 provider, 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 Program Integrity and Investigations department.

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

Other Fraud, Waste and Abuse Laws

- Under the federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program. 42 U.S.C. §1320a-7b.
- Under the federal Stark Law, and subject to certain exceptions, providers are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs. 42 U.S.C. §1395(a) and §1903(s).
- As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. 18 U.S.C. §1347.
- 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.

Prohibited Affiliations

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

Relationships must be terminated with any trustee, officer, employee, provider 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 by emailing providermaintenance@caresource.com.

Disclosure of Ownership, Debarment and Criminal Convictions

Before CareSource enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment, proposed for debarment, suspension or declared ineligible status related to federal programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity. You must also notify CareSource of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration.

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

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

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

How to Report Fraud, Waste or Abuse

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

Options for Reporting Anonymously:

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

Write:

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

Options for Reporting That Are Not Anonymous:

- **Fax:** 800-418-0248
- **Email:** fraud@caresource.com

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

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

Physician Education Materials

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

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

OH-P-0073Q
SEPTEMBER, 2020

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