CareSource®

INDIANA
HEALTH PARTNER MANUAL

HOOSIER HEALTHWISE | HEALTHY INDIANA PLAN

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

CareSource®
Health Care with Heart

DEAR CARESOURCE HEALTH PARTNER,

Welcome to CareSource, and thank you for your participation. CareSource values you as a health partner, and we are actively working to make it easier for you to deliver quality care to our members.

The CareSource Health Partner Manual is intended as a resource for working with our plan. The manual communicates policies and information about our programs. This manual also outlines key information, such as claim submission and reimbursement processes, authorizations, member benefits and more to make it easier for you to do business with us.

CareSource communicates updates with our network regularly on our secure Provider Portal. The most up-to-date information can be found on the CareSource Provider Portal at **https://providerportal.caresource.com/IN/**.

In an effort to better support our health partners and offer an immediate response to questions, concerns and inquiries, we offer claims, policy and appeals assistance through our call center by calling **1-844-607-2831**.

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

Sincerely,

CareSource

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Welcome

Welcome, and thank you for participating with CareSource.

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

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

We are a nonprofit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. CareSource serves consumers of:

- Hoosier Healthwise (HWW)
- Healthy Indiana Plan (HIP)

We focus on prevention and partnering with local health partners to offer the services our members need to remain healthy.

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

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

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

ABOUT US

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

Vision and Mission

- *Our vision is transforming lives through innovative health and life services.*
- *Our mission is to make a lasting difference in our members' lives by improving their health and well-being.*

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

Our Services

- Health partner services and support
- Member eligibility/enrollment information
- Claims processing
- Credentialing/recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory
- Compliance
- Special investigations for fraud, waste and abuse
- Member services
- CareSource24® (nurse advice line)

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

- High-risk case management
- Onsite case management (clinics and facilities)
- Emergency department diversion
- High emergency department utilization focus (targeted at members with frequent utilization)
- Health care home
- Maternal and healthy baby program
  - – Dedicated neonatal intensive care unit (NICU) care management nurses
  - – Outreach programs in partnership with community agencies to target members at greatest risk
- Disease management program for
  - – Attention deficit hyperactivity disorder (ADHD)
  - – Asthma
  - – Autism spectrum disorders
  - – Congestive heart failure (CHF)
  - – Chronic kidney disease (CKD)
  - – Chronic obstructive pulmonary disease (COPD)
  - – Coronary artery disease (CAD)
  - – Depression
  - – Diabetes
  - – Hepatitis C
  - – Human immunodeficiency virus (HIV)
  - – Pregnancy
- Care transitions
  - – Discharge planning and transitional care support

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

The CareSource Foundation

CareSource gets actively involved in the communities that we serve, from employees serving on hundreds of nonprofit boards to The CareSource Foundation investing more than $14 million in Ohio communities since its inception. We listen, we learn and we are driven to action. As a result, The CareSource Foundation was launched in 2006 to add another component to our professional services – **community response**. Areas of focus 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 and homelessness.

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

Corporate Compliance

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

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

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

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

CareSource's corporate compliance plan is a formal company policy that outlines how everyone who represents CareSource should conduct themselves. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as health partners, consultants and vendors.

HEALTH PARTNER EXPECTATIONS

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

For questions about health partner expectations, please call Health Partner Services at **1-844-607-2831**.

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

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

Personally Identifiable Information

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

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace, and shred this content when no longer needed.
- Encrypt laptops and other portable media like CD-ROMs and USB flash drives.
- Ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

There may be times when we share patient information with you or ask you to share with us. CareSource, like you, is a covered entity under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment, or health care operations.

ACCREDITATION

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our Ohio Medicaid and Health Insurance Marketplace plans. We have an Interim accreditation status for our Kentucky, Indiana and West Virginia Health Insurance Marketplace plans. NCQA is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement. CareSource will be applying for interim NCQA accreditation our Hoosier Healthwise and Healthy Indiana plans. Visit **www.NCQA.org** for more information.

CLAIM SUBMISSIONS

In general, CareSource follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. Claims for services provided to members assigned to CareSource must be sent directly to CareSource, not Hewlett Packard Enterprise (HPE). For expedited claim processing and payment delivery, please ensure your address(es) and phone number(s) on file with CareSource are up-to-date. You can email **ProviderMaintenance@caresource.com** to update this information. When you have information to update, be sure to update it with both CareSource and the Indiana Health Coverage Programs (IHCP).

VALUE-BASED PURCHASING

Your success is important to us. We offer a series of value-based reimbursement (VBR) programs for our health partners. These programs provide a progressive approach along a continuum of payment programs that will reward you as you attain higher levels of quality.

Our flexible approach will enable you to participate in VBR programs at an initial level and grow to successively higher levels of reimbursement. Under the guidance of CareSource quality improvement, you are rewarded for providing better value for services and achieving better health outcomes for our members.

BILLING METHODS

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

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

ELECTRONIC FUNDS TRANSFER

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

Benefits of EFT:

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

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

ELECTRONIC CLAIMS SUBMISSION

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

EDI Clearinghouses

To submit claims electronically, health partners must work with an electronic claims clearinghouse. CareSource currently accepts electronic claims from Indiana health partners through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claims submission.

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

Clearinghouse	Phone	Website
Availity (RealMed)	1-800-282-4548	www.availity.com
Change Healthcare (formerly Emdeon)	1-800-845-6592	www.changehealthcare.com
Quadax	1-440-777-6305	www.quadax.com
Relay Health (McKesson)	1-866-735-2963	https://connectcenter.relayhealth.com

File Format

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

5010 TRANSACTIONS

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This was in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format. All trading partners and payers should be 5010 compliant.

Transactions Covered Under the 5010 Requirements

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

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

NPI AND TAX ID NUMBERS

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

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

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

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

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

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

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

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

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

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

PAPER CLAIMS

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

- CMS 1500
- AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental Claim Form

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

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

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

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

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

All claims (EDI and paper) must include:

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

Prenatal or Delivery Services Claims

For prenatal or delivery services, the last menstrual period date* is required on claims. For delivery services, the birth weight is required.

* Last menstrual period may be calculated – For Medicaid health partners, 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 health partner who delivers the baby, especially if the member received prenatal care from another health partner or facility. Please remember that participating health partners may estimate the LMP on delivery claims based on the gestational age of the child at birth.

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

What to Include on Claims That Require NDC:

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

Instructions for NDC on Paper Claims

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:

- EDI claims 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 SuperBills 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.
- NPI, GNPI (is applicable) and federal tax ID number or physician SSN is required for all claim submissions.

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

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

SHADOW CLAIMS

"Shadow claims," also referred to as encounter claims, are claims that are submitted by a health partner in order to record and capture services delivered by the health partner. Typically, an encounter claim is paid at a preset and prearranged amount. The idea behind an encounter claim is to offer confirmation that a payment previously made was earned, or to assist the State with their justification for a higher reimbursement. Certain health partners are at higher risk than others for the cost of uncompensated care—shadow billing seeks to spread that risk across all populations by setting aside a portion of managed care payments for direct payment to those higher-risk health partners.

As such, CareSource has chosen to establish relationships with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as critical safety net health partners. CareSource will reimburse FQHCs and RHCs at no less than the reimbursement level CareSource would make to a non-FQHC or non-RHC for the same services. The State requires CareSource to identify and report any performance incentives it offers to the FQHC or RHC in relation to the cost of providing FQHC covered or RHC covered services to its members. Given the State makes supplemental payments to FQHCs and RHC's that contract with CareSource, the payments are meant to represent the difference, if applicable, between the payment an FQHC or RHC would be entitled to under the Benefits Improvement and Protection Act of 2000 (BIPA).

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

CLAIM SUBMISSION TIMELY FILING

For in-network providers, claims must be submitted within 90 calendar days of the date of service or discharge. For out-of-network providers, claims must be submitted within 365 calendar days of the date of service or discharge. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim. If this happens, health partners have 365 calendar days from the date of service or discharge to submit a corrected claim or 60 calendar days from the date of receipt of the claim decision notification to file a claim dispute.

Claims Processing Guidelines

For in-network providers, claims must be submitted within 90 calendar days of the date of service or discharge. For out-of-network providers, claims must be submitted within 365 calendar days of the date of service or discharge.

- If you do not agree with the decision of the processed claim, you will have 365 calendar days from the date listed on the Explanation of Payment (EOP) to file an appeal.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a member has other insurance and CareSource is secondary, the health partner may submit for secondary payment within 90 calendar days of the primary carrier's EOP.
- If a claim is denied for Coordination of Benefits (COB) information needed, the health partner must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.
- There will be times when a member is hospitalized for a longer period of time. The health partner will be able to submit interim bills, which CareSource will pay at 30 percent of the billed charges submitted. When the patient is discharged, the health partner will be required to submit a final bill, which includes the entire bill from date admitted to date discharged. CareSource is not able to determine correct payment unless the full, final bill is submitted. The health partner will have 90 calendar days from the date of discharge to submit the complete bill. If this information is not submitted within the timely filing guidelines, the claim will be denied and previous payments will be recouped.
- All claims for newborns must be submitted using the newborn's CareSource ID number. Do not submit newborn claims using the mother's CareSource ID number; the claim will deny. Claims for newborns must include the birth weight. The same timely filing guidelines apply for newborns.

Claims that Require Completed Consent Forms

- Abortion – This type of service requires a completed abortion certification form and prior authorization. Please refer to the Referral and Prior Authorization section of this manual for information on the prior authorization process.
- Hysterectomy procedures must comply with federal regulations.
- A hysterectomy performed solely for the purpose of rendering a woman permanently incapable of reproducing, whether performed as a primary or secondary procedure, is not reimbursable by Medicaid.
- The acknowledgment of the hysterectomy information statement must be signed by the recipient, or recipient's representative, but is not required where the recipient is already sterile or where a life-threatening emergency situation exists.
- Where the hysterectomy is performed on an already sterile patient, the health partner who performs

the hysterectomy must certify in writing that the recipient was already sterile at the time the hysterectomy was performed and state the cause of the sterility.
- Where the hysterectomy is performed under a life-threatening emergency situation, the health partner who performed the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation and that prior acknowledgement was not possible. The health partner must include a description of the nature of the life-threatening emergency.
- The individual must be informed orally and in writing that this procedure will render her permanently incapable of reproducing, and she must sign a written acknowledgement of receipt of this information.
- Hysterectomy is subject to prior authorization. Where the hysterectomy is performed under a life-threatening emergency situation, the health partner shall notify the contractor within 48 hours of the procedure, not including Saturday, Sunday, and legal holidays, to obtain prior authorization.
- All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement may be made.
- Sterilization – This type of service requires a completed Consent for Sterilization Form – HHS-687
- AIDS/HIV/Substance use disorders

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

SEARCHING FOR CLAIMS INFORMATION ONLINE

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

Additional claims enhancements on the Provider Portal:
- Claim history available up to 24 months from the date of service
- Submit claim appeal
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date
- Vision claim information

DENTAL CLAIM SUBMISSIONS

Dental health partners may submit claims online at https://pwp.sciondental.com/PWP/Landing. Contact the web portal team at **ProviderPortal@scion.com** to get registered and request a demonstration.

PROCEDURE AND DIAGNOSIS CODES

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

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM). Available from the U.S. Government Printing Office at 202-512-1800, 202-512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at **www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page.**
- HCFA Common Procedure Coding System (HCPCS). Available at **http://www.cms.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/en/.**
- National Drug Codes (NDC). Available at **www.fda.gov/**.

Procedures That Do Not Have a Corresponding CPT Code

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

CODE EDITING

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

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

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

CORRECTED CLAIMS SUBMISSIONS

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

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

EDI Billing Instructions:

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

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

Paper Form Billing Instructions:

Professional Claims:

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

Institutional Claims:

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

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

HEALTH PARTNER CODING AND PAYMENT POLICIES

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

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

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

- Medicare: **www.cms.hhs.gov/home/medicare.asp**
- Indiana Medicaid: **http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp**

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

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

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

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

EXPLANATION OF PAYMENT (EOP)

Explanation of Payments (EOPs) are statements of the current status of your claims that have been submitted to CareSource and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated, depending on your claim submission activity. Health partners who receive EFT payments will receive an Electronic Remittance Advice (ERA) and can access it on the Provider Portal.

Information Included on EOPs

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

Check Claim Status Online

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

PENDED CLAIM REPORT

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

CareSource is responsible for resolving any pended claims, not the health partner. The report may be sent to you merely to acknowledge receipt. Please do not resubmit pended claims; this may further delay processing.

To check the status of a pended claim, visit the CareSource Provider Portal. To modify a claim, please follow the process noted in the Corrected Claims section of this manual to submit a corrected claim.

OTHER COVERAGE – COORDINATION OF BENEFITS (COB)

Coordination of Benefits

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

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

Search COB on the Provider Portal By:

- CareSource assigned member number
- CareSource case number
- Medicaid number/MMIS number
- Member name and date of birth

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

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

COB Overpayment

If a health partner receives a payment from another carrier after receiving payment from CareSource for the same items or services, this is considered an overpayment.

Adjustments to the overpayment will be made on subsequent reimbursements to the health partner, or the health partner can issue refund checks to CareSource for any overpayments. Health partners should not refund any money received from a third party to a member.

WORKERS' COMPENSATION

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

THIRD-PARTY LIABILITY/SUBROGATION

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

MEMBER BILLING POLICY

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

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

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

Generally, health partners enrolled in the Indiana Health Coverage Programs (IHCP) can bill members only under the following conditions:

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

It is never appropriate to balance bill a Medicaid member for a Medicaid covered service.

POWER ACCOUNT

Indiana offers HIP members a comprehensive benefit package through a $2,500 deductible health plan paired with a personal health care account. The state will contribute most of the required amount, but members will also be responsible for making a small contribution to their account each month. The amount of a member's contribution is based on income.

Frequently Asked Questions

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

Who contributes?
HIP Plus members, the State, and (in some cases) non-profits and employers may contribute to the POWER Account to meet their deductible. HIP Basic members are required to make copayments for most services, per the benefits grid. Health partners are expected to collect the copayment at the time of service.

How can members contribute?

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

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

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

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

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

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

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

How do I charge the member's POWER Account?
Health partners should submit a claim for every service. CareSource will deduct the member's cost sharing responsibility from the member's POWER Account at the time of claim processing. CareSource will then reimburse the health partner for the remainder amount of the claim.

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

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

COPAYMENTS/COST SHARING

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

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

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

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

- Members are no longer required to pay any further POWER Account contributions or copayments for the remainder of the quarter that the 5 percent is reached.
- CareSource will notify the State that the member's 5 percent cost-sharing threshold has been met. This will be visible to health partners via the CareSource Provider Portal and the Indiana CoreMMIS.
- Health partners must refund any copays collected after cost-sharing was turned off.
- Members enrolled in HIP Basic or HIP State Plan Basic are not required to make monthly contributions to their POWER Account, but are required to pay the following copayments at the time services are rendered:
  - $8 copayment for initial non-emergent emergency room (ER) visit
  - $4 copayment for outpatient services
  - $4 copayment for preferred drugs
  - $8 copayment for non-preferred drugs
  - $75 copayment for inpatient services

However, no copayment is required for preventive care, including early periodic screening, diagnostic and testing services (EPSDT), or family planning services. When cost sharing is turned off, HIP Basic members will not incur copayments, including copayments for non-emergent ER visits.

COMMUNICATING WITH CARESOURCE

CareSource communicates with our health partner network through a variety of channels, including phone, fax, Provider Portal, newsletters, CareSource.com and network notifications. We encourage you to reach out to your assigned health partner engagement representative with any questions. The list may be found at CareSource.com.

CARESOURCE HOURS OF OPERATION

Health Partner Services

CareSource Medicaid (Hoosier Healthwise and Healthy Indiana Plan)	M-F	8 a.m. to 8 p.m.

Member Services

CareSource24®	24/7/365	
CareSource Medicaid (Hoosier Healthwise and Healthy Indiana Plan)	M-F	8 a.m. to 8 p.m.

Please visit **CareSource.com** for the holiday schedule or contact Partner Services for more information.

PHONE AND FAX NUMBERS

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

For member calls, Katie, our automated phone system, will assist in reaching the best person to care for them in the quickest, more efficient way possible.

Phone Numbers

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

Fax Numbers

Care Management Referral	844-417-6263
Credentialing	866-573-0018
Contract Implementation	937-396-3632
Fraud, Waste and Abuse	800-418-0248
Medical Prior Authorization	844-432-8924
Health Partner Appeals	844-417-6262
Health Partner Maintenance *(e.g., office changes, adding/deleting health partners)*	937-396-3076

STATE OF INDIANA CONTACT INFORMATION

FSSA	
Address	Indiana Family and Social Services Administration (FSSA) 402 W. Washington St. Room W374, MS07 Indianapolis, IN 46204-2739
Phone	317-655-3240
Website	www.in.gov/fssa/
Hoosier Healthwise Enrollment	1-800-889-9949
Healthy Indiana Plan Enrollment	1-877-438-4479

CARESOURCE.COM

Our website, **CareSource.com**, is a tool to you can use to access important information quickly and easily. On the Provider section of the site, you will find:

- Commonly used forms
- Newsletters, updates and announcements
- The CareSource Health Partner Manual
- Claim submission information
- Frequently asked questions
- Clinical and preventive guidelines
- Benefit grid
- Behavioral health information
- And much more

PROVIDER PORTAL

https://providerportal.caresource.com/IN

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

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

Provider Portal Benefits

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

Provider Portal Functions

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

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

PORTAL REGISTRATION

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

1. Visit **CareSource.com** > Providers > Indiana > Medicaid and click on "*Provider Login*."
2. Click on the "*Register Now*" button and complete the three-step registration process.
   Note: you will need to have your tax ID number.
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 Health Partner Services at **1-844-607-2831**.

HEALTH PARTNER DEMOGRAPHIC CHANGES AND UPDATES

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a health partner to your practice helps us keep our records current and are critical for claims processing. If the provider profile is being edited, this must be done with each entity the service location is contracted with (e.g. Hewlett Packard Enterprise); changes made with one entity will not be communicated to others.

Email: ProviderMaintenance@caresource.com

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

Fax: 937-396-3076

HOW TO COMMUNICATE WITH CARESOURCE BY MAIL

CareSource

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

Claims Submission Mailing Address

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

Medical and Behavioral Health Prior Authorization Submission Address

CareSource
Attn: Medical Management Department
P.O. Box 743
Dayton, OH 45401

Pharmacy Claims Submission Mailing Address

CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2136

Health Partner Credentialing Mailing Address

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

Health Partner Dispute Mailing Address

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

Health Partner Appeals Mailing Address

CareSource
Attn: Health Partner Appeals
P.O. Box 2008
Dayton, OH 45402

Please visit our website at **CareSource.com** for more information on how appeals can be submitted online.

Member Appeals and Grievances Mailing Address

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

Fraud, Waste and Abuse Address

CareSource
Attn. Special Investigations Unit
P.O. Box 1940
Dayton, OH 45401-1940
Email: fraud@caresource.com

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

NEWSLETTERS

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

NETWORK NOTIFICATIONS

Network notifications are published for CareSource health partners to regularly communicate updates and changes to policies and procedures. Network notifications are found on the Updates/Announcements page of our website and are sent via email to registered health partners.

REQUESTING A HARD COPY

The CareSource Health Partner Manual is available online under Plan Resources. You may also request a hard copy by calling Health Partner Services at **1-844-607-2831**. Upon request, CareSource will mail a hard copy at no cost to you.

COVERED SERVICES AND EXCLUSIONS

COVERED SERVICES

Please visit the CareSource website at CareSource.com for information on services, including dental services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Referrals and Prior Authorizations" section of this manual for more information about referral and prior authorization procedures. For the most comprehensive and up-to-date list of CareSource covered benefits, please see the full CareSource Covered Benefits grid.

HOOSIER HEALTHWISE BENEFIT SUMMARY

Office Visits/Hospital	Package A	Package C	Package P	Prior Authorization Needed?
Doctor Visits	Yes	Yes	Yes	No
Early Periodic Screening Diagnosis and Testing (EPSDT)	Yes	Yes	Yes	No
Checkups	Yes	Yes	Yes	No
Dental Care	Yes	Yes	Yes	Prior authorization needed for dental care in hospitals and ambulatory surgery centers
Chiropractors	Yes	Yes	Yes	No
Family Planning Services	Yes	Yes	Yes	No
Clinic Services	Yes	Yes	Yes	No
Nurse Practitioner Services	Yes	Yes	Yes	No
Hospital Care	Yes	Yes	Yes	Yes
Pharmacy and Medicine	**Package A**	**Package C**	**Package P**	**Prior Authorization Needed?**
Preferred Drug List Medications	Yes	Yes	Yes	No

Emergencies, Tests and Transportation	Package A	Package C	Package P	Prior Authorization Needed?
Emergency Services	Yes	Yes	Yes	No
Lab and X-ray Services	Yes	Yes	Yes	No
Emergency Transportation	Yes	$10 copay for ambulance transportation	Yes	No
Non-Emergency Transportation	Available for up to 20 one-way trips of less than 50 miles per year without prior authorization.	$10 copay for ambulance service for non-emergencies between medical facilities when requested by a participating physician. Any other non-emergency transportation is not covered.	Available for pregnancy-related trips to a physician and prenatal care.	No

Specialty Services	Package A	Package C	Package P	Prior Authorization Needed?
Anesthesia	Yes	Yes	Yes	No
Nursing Facility Services (Short Term)	Yes less than 30 days	No	Yes	Yes
Hospice Care	No	No	No	
Nurse Midwife Services	Yes	Yes	Yes	No
Foot Care	Surgical Procedures involving the foot, laboratory or x-ray services and hospital stays are covered when medically necessary. No more than six routine foot care visits per are covered.	Routine foot care services are not covered. Surgical procedures, lab or x-ray services, and hospital stays involving the foot are covered.	Coverage is limited to services related to pregnancy.	No

Therapies	Package A	Package C	Package P	Prior Authorization Needed?
Behavioral Health Care (Outpatient)	Yes	Yes	Yes	No
Rehabilitation Services	Yes	Yes	Yes	No
Speech Therapy	Yes	Yes	Yes	No
Occupational Therapy	Yes	Yes	Yes	No
Substance Use Disorder Therapy	Yes	Yes	Yes	No

Other Benefits and Services	Package A	Package C	Package P	Prior Authorization Needed?
Education/Training Services	Yes	Diabetes Self-Management	Pregnancy-Related	No
Enhanced CareSource Services (e.g. job counseling, non-emergency transportation to and from coaching and training sessions for Job Connect program, Smartphones, etc.)	Yes	Yes	Yes	No
Home Health Services	Yes	Yes	Yes	Yes
Medical Supplies and Equipment	Yes	Yes	Yes	Yes

HEALTHY INDIANA PLAN BENEFIT SUMMARY

	HIP Plus	HIP Basic	HIP Maternity	HIP State Plan	
	Available to all members who make their POWER Account Contribution	For members at or below 100% FPL who fail to make a POWER Account Contribution		Plus	Basic
Deductibles	$2,500	$2,500	$0	$2,500	$2,500

Office Visits/ Hospital	HIP Plus	HIP Basic	HIP Maternity	HIP State Plan		Prior Authorization
				Plus	Basic	
Doctor Visits	Yes	$4 copay	Yes	Yes	$4 copay	No
Early Periodic Screening Diagnosis and Testing (EPSDT)	Yes, EPSDT for ages up to 21	Yes, EPSDT for ages up to 21	Yes, EPSDT for ages up to 21	Yes, EPSDT for ages up to 21	Yes, EPSDT for ages up to 21	No
Checkups	Yes	Yes	Yes	Yes	Yes	No
Chiropractors	Yes Limited to 6 spinal manipulation visits per year[1]	No	Yes	Yes Limited to 50 visits	$4 copay Limited to 50 visits	No
Family Planning Services	Yes	Yes	Yes	Yes	Yes	No
Clinic Services	Yes	$4 copay	Yes	Yes	$4 copay	No
Nurse Practitioner Services	Yes	Yes	Yes	Yes	Yes	No
Nurse Midwife Services	Yes	Yes	Yes	Yes	Yes	No
Hospital Care	Yes	up to $75 copay	Yes	Yes	up to $75 copay	Yes

[1]HIP Plus chiropractic coverage available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic.

Pharmacy and Medicine	HIP Plus	HIP Basic	HIP Maternity	HIP State Plan		Prior Authorization
				Plus	Basic	
Preferred Drug List (PDL) Medications	Yes	Copays: $4 Preferred Drugs $8 Non-Preferred Drugs	Yes	Yes	Copays: $4 Preferred Drugs $8 Non-Preferred Drugs	No

Emergencies, Tests and Transportation	HIP Plus	HIP Basic	HIP Maternity	HIP State Plan		Prior Authorization
				Plus	Basic	
Emergency Services	If the service is deemed non-emergent, copay is $8	If the service is deemed non-emergent, copay is $8	Yes	If the service is deemed non-emergent, copay is $8	If the service is deemed non-emergent, copay is $8	No
Lab and X-ray Services	Yes	$4 copay	Yes	Yes	$4 copay	No
Emergency Transportation	Yes	Yes	Yes	Yes	Yes	No
Non-Emergency Transportation	No	No	Yes	Yes	Yes	No

Specialty Services	HIP Plus	HIP Basic	HIP Maternity	HIP State Plan		Prior Authorization
				Plus	Basic	
Foot Care	Yes, 6 visits per year	$4 copay 6 visits per year	Yes, 6 visits per year	Yes, 6 visits per year	$4 copay 6 visits per year	No
Vision Care	Yes, 1 routine exam/yr. (up to age 20)	No	Yes, 1 routine exam/yr. (up to age 20)	Yes, 1 routine exam/yr. (up to age 20)	Yes, 1 routine exam/yr. (up to age 20)	No
	1 routine exam every 2 years (over age 20)		1 routine exam every 2 years (over age 20)	1 routine exam every 2 years (over age 20)	1 routine exam every 2 years (over age 20)	
	1 pair glasses/ yr. (up to age 20)		1 pair glasses/ yr. (up to age 20)	1 pair glasses/ yr. (up to age 20)	1 pair glasses/ yr. (up to age 20)	
	1 pair glasses/ every 5 years (over age 20)		1 pair glasses/ every 5 years (over age 20)	1 pair glasses/ every 5 years (over age 20)	1 pair glasses/ every 5 years (over age 20)	
Dental Care	Yes, Periodic exams covered every 6 months	No	Yes, Periodic exams covered every 6 months	Yes, Periodic exams covered every 6 months*	Yes, Periodic exams covered every 6 months*	Yes, for dental care in hospitals and ambulatory surgery centers
Nursing Facility Services	Yes, 100 day limit per benefit period	$75 copay, 100 day limit per benefit period	Yes, when related to pregnancy	Yes	Yes	Yes
DME/Orthotics/ Prosthetics	Yes	$4 copay	Yes	Yes	$4 copay	Yes
Home Health Services	Yes, 100 visits	$75 copay, 100 visits	100 visits	Yes	Yes	Yes
Hospice Care	Yes	$4 copay	Yes	Yes	Yes	Yes
Medical Supplies and Equipment	Yes	$4 copay	Yes	Yes	$4 copay	Some items require prior authorization

Therapies	HIP Plus:	HIP Basic:	HIP Maternity	HIP State Plan		Prior Authorization
				Plus	Basic	
Behavioral Health	Yes	$4 copay	Yes	Yes	$4 copay	Yes, Inpatient Services
Substance Use Disorder Services	Yes	$4 copay	Yes	Yes	$4 copay	Yes, Inpatient Services
Physical, Occupational, Speech	Yes	$4 copay	Yes	Yes	$4 copay	Yes
Rehabilitation Services	Yes	$4 copay	Yes	Yes	$4 copay	Yes

IHCP-COVERED SERVICES EXCLUDED FROM HOOSIER HEALTHWISE

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

- **Long-term institutional care**: Package A members and HIP members requiring long-term care in a nursing facility or intermediate care facility (ICF) for members with intellectual and developmental disabilities must be disenrolled from the Hoosier Healthwise or HIP programs and converted to fee-for-service eligibility in the IHCP. Before the nursing facility can be reimbursed by the IHCP for the care provided, the nursing facility must request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State must then approve the PASRR request, designate the appropriate level of care in CoreMMIS, and disenroll the member from Hoosier Healthwise or HIP. CareSource coordinates care for its members who are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR. CareSource is responsible for payment for up to 60 calendar days for its members placed in long-term care facilities while the level of care determinations are pending. However, CareSource may obtain services for its members in a nursing-facility setting on a short-term basis, such as for fewer than 30 calendar days. This may occur if this setting is more cost-effective than other options, and the member can obtain the care and services needed in the nursing facility. CareSource may negotiate rates for reimbursing the nursing facilities for these short-term stays. Health partners are encouraged to immediately contact CareSource for case management and to arrange care for a member needing services outside of their covered benefits.
- **Hospice care**: Hoosier Healthwise members must be disenrolled from managed care in order to receive hospice care. HIP members do not need to be disenrolled from managed care in order to receive hospice care.
- **Home and community-based waiver services**: Home and community-based waiver services are also excluded from the Hoosier Healthwise and HIP programs. Similar to the situations described previously, members who have been approved for these waiver services must be disenrolled from managed care, and CareSource will coordinate care for its members who are transitioning into a HCBS waiver program until the disenrollment from Hoosier Healthwise or HIP is effective.

- **Psychiatric treatment in a State hospital**: Hoosier Healthwise members receiving psychiatric treatment in a state hospital are disenrolled from Hoosier Healthwise. HIP members receiving psychiatric treatment in a state hospital are not disenrolled from HIP, but must be directed to an alternative inpatient facility.
- **Psychiatric Residential Treatment Facility (PRTF) Services**: Members receiving treatment in a PRTF are not CareSource's responsibility and will be disenrolled from Hoosier Healthwise. When the prior authorization vendor enters a PRTF level of care for a Hoosier Healthwise member, the managed care assignment is automatically end-dated as of the date the PRTF level of care is entered in CoreMMIS. Once the member is discharged from the PRTF and the LOC is end-dated, the auto-assignment process immediately reassigns the member to his or her previous managed care entity (MCE) with an effective date of the 15th of the month for discharges occurring on day one through day 14 of the month; or effective the first day of the following month for discharges that occur on day 15 through the last day of the month.

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

EMERGENCY ROOM COPAYMENTS FOR HIP

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

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

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

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

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

The member must receive an appropriate medical screening examination under section 1867 of the Emergency Medical Treatment and Active Labor Act (EMTALA).

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

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

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

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

BENEFIT LIMITS

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Health Partner Services at **1-844-607-2831**.

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 prior authorization. Please visit our website at **CareSource.com** for the most up-to-date list of services that require prior authorization. Prior authorization requirements for members enrolled with CareSource are determined and enforced by CareSource.

Medical Necessity Standards and Practice Guidelines

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

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

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

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

Covered services and exclusions for CareSource members can be found at **CareSource.com**.

OTHER COVERED BENEFITS AND SERVICES

Abortions and Sterilizations

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

Abortion – Abortion services are covered in the following circumstances without prior authorization:

- This patient 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 place this woman in danger of death unless an abortion is performed.
- The pregnancy is the result of rape.
- The pregnancy is the result of incest.

Certification of Necessity for Abortion

Before reimbursement for an abortion can be made, the health partner performing the abortion must certify that one of the three circumstances above has occurred. The certification must be made on the Abortion Consent State Form 55320 and filled out at least 18 hours before the abortion. The health partner's signature must be in the physician's own handwriting. All certifications must contain the patient's name, medical record number, signature, date and time. The certification form is kept by the health partner as part of the patient's medical record and a copy must be attached to the claim.

Requirements for Sterilization

Sterilization procedures are covered if the following requirements are met:

- The member is at least 21 years of age at the time of the informed consent.
- The member is mentally competent and not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.
- Sterilization is the result of a voluntary request for services by a member legally capable of consenting to such a procedure.
- For a female member, a hysterectomy is only rendered for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental retardation; she must be informed prior to the hysterectomy that she will be permanently incapable of reproducing.
- The member is given a thorough explanation of the procedure. In instances where the individual is blind, deaf or otherwise handicapped or unable to understand the language of the consent, an interpreter must be provided for interpretation.

- Informed consent is obtained on the Consent to Sterilization Form [HHS-687 (5/2010)], which is located on our website, with legible signature(s) and submitted to our health plan with the claim.
- Informed consent is not obtained while the individual to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness.
- The procedure is scheduled at least 30 calendar days before, but not more than 180 calendar days, after the consent is signed, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form).

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

CONSENT FORM REQUIREMENTS

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

IMMUNIZATIONS

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

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

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

ANNUAL WELLNESS EXAMS FOR ADULTS

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

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

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

CREDENTIALING AND RECREDENTIALING

CareSource credentials and recredentials all licensed independent practitioners including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action. Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners. Our Senior Medical Director is responsible for the credentialing and recredentialing program.

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) ENROLLMENT

In partnership with the State of Indiana, CareSource must certify that all of its network health partners are eligible and enrolled with IHCP. To ensure our health partners receive proper reimbursement, we encourage all of our health partners to enroll with IHCP via the State's website. For more information on IHCP enrollment please go to **http://provider.indianamedicaid.com/become-a-provider/ihcp-provider-enrollment-transactions.aspx**.

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

CAQH APPLICATION

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

1. Log on to the CAQH website at **www.CAQH.org** utilizing your account information.
2. Select the **Authorization** Tab.
3. Make sure **CareSource** is listed as an authorized health plan.
4. If not, please check the **Authorized** box to add.

Please submit a complete CAQH application or CAQH number and national provider identifier (NPI) number via one of three vehicles:

- **Email**: Contract.Implement@caresource.com
- **Fax**: 866-573-0018
- **Mail**: Send by certified mail with return receipt to:

  CareSource
  Attn: Contract Implement
  P.O. Box 8738
  Dayton, OH 45401-8738

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

Please also include copies of the following documents:

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

DEBARRED HEALTH PARTNER EMPLOYEE ATTESTATION

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

CareSource Debarment/Criminal Conviction Attestation

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

CareSource conducts credentialing and recredentialing activities utilizing the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and credentialing as defined in the Indiana Code and Indiana Department of Insurance.

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

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

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

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

HEALTH PARTNER SELECTION CRITERIA

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

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

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

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

Selection Criteria:

a. Active and unrestricted license in the state issued by the appropriate licensing board.
b. Current DEA or CSR certificate (if applicable).
c. Successful completion of all required education.
d. Successful completion of all training programs pertinent to one's practice.
e. For MDs and DOs, successful completion of residency training pertinent to the requested practice type.
f. For dentists and other health partners where special training is required or expected for services being requested, successful completion of training.
g. Board certification is not required for primary care specialties. PMPs who are approved by the CareSource Credentialing Committee will appear in CareSource Provider Directories.
h. Health partners approved by the CareSource Credentialing Committee in non-primary care specialties will be listed in the Provider Directory as specialists if certified by a specialty board, which is recognized by the CareSource Credentialing Committee.
i. An advanced practice nurse (APN) may be credentialed as a preferred medical provider if that APN maintains compliance with the rules set forth by the Indiana State Board of Nursing defined in "Compilation of the Indiana Code and Indiana Administrative Code, 2013 Edition." The APN is expected to be familiar with these rules. "Advanced practice nurse" means a registered nurse holding a current license in Indiana who:
    i. Has obtained additional knowledge and skill through a formal, organized program of study and clinical experience, or its equivalent, as determined by the board;
    ii. Functions in an expanded role of nursing at a specialized level through the application of advanced knowledge and skills to provide healthcare to individuals, families, or groups in a variety of settings.
j. Education, training, work history and experience are current and appropriate to the scope of practice requested.
k. Malpractice insurance at specified limits established for all practitioners by the credentialing policy.
l. Good standing with Medicaid and Medicare.
m. Quality of care and practice history as judged by:
    i. Medical malpractice history.
    ii. Hospital medical staff performance.

iii. Licensure or specialty board actions or other disciplinary actions, medical or civil.
iv. 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.
v. Other quality of care measurements/activities.
vi. Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing.
vii. Lack of issues on HHS-OIG, SAM/ EPLS, or state site for sanctions or terminations (fraud and abuse).

n. Signed, accurate credentialing application and contractual documents.
o. Participation with Care Management, Quality Improvement and Credentialing programs.
p. Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
q. Agreement to comply with plan formulary requirements or acceptance of plan preferred drug list (PDL) as administered through the pharmacy benefit manager.
r. Agreement to access and availability standards established by the health plan.
s. Compliance with service requirements outlined in the provider agreement and Health Partner Manual.

Note: Any pending and/or suspected fraud, waste, and abuse investigation(s) or case(s) against the health partner may affect the health partner's credentialing application.

Organizational Credentialing and Recredentialing

The following organizational health partners are credentialed and recredentialed:

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

Additional organizational health partners are also credentialed:

- Hospice health partners
- 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 health partner responsible for medical services will be credentialed using the standard credentialing and recredentialing processes.

The following elements are assessed for organizational health partners:

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

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

PRACTITIONER RIGHTS

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

HEALTH PARTNER RESPONSIBILITIES

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

RECREDENTIALING

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

BOARD CERTIFICATION REQUIREMENTS

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

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

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

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

To be credentialed as a subspecialist physicians must:

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

DELEGATION OF CREDENTIALING/RECREDENTIALING

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

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

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

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

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

RECONSIDERATION AND APPEALS OF CREDENTIALING/RECREDENTIALING DECISIONS

CareSource may decide that an applying or participating health partner may pose undue risk to our members and should be denied participation or be removed from CareSource's network. If this happens, the applying or participating health partner will be notified in writing. 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 health partner is notified of the decision. The request, along with any supporting information, will be presented to the credentialing committee for review at the next meeting. The committee will respond within 30 calendar days of that meeting, and the health partner will be notified in writing of the committee's decision.

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

Appeals may be sent to:

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

Applying health partners may submit additional documents for reconsideration by the credentialing committee to the address above. An application rejection due to the health partner'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 see our website at **CareSource.com**. Search "Fair Hearing."

HEALTH PARTNER DISPUTES

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

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

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

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

QUALIFIED PROVIDERS

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

QPs must meet the following regulations:

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

QPs must meet the following state requirements:

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

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

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

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

FRAUD, WASTE AND ABUSE

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

DEFINITION OF TERMS

Fraud

Fraud is defined as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law” (42 CFR, Part 455.2).

Waste

Waste involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients).

Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight (Inspector General).

Abuse

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

Improper Payment

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

Examples of Member Fraud, Waste and/or Abuse:

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple health partners or multiple pharmacies
- Altering or forging prescriptions – i.e. changing prescription form to get more than the amount of medication prescribed by their physician
- Sharing a member ID card
- Non-disclosure of other health insurance coverage
- Changing prescription forms to get more than the amount of medication prescribed by a physician
- Obtaining unnecessary equipment and supplies
- Member receiving services or picking up prescriptions under another person's name or ID (identity theft)
- Providing inaccurate symptoms and other information in order get treatment, drugs, etc.
- Any other action by a member that CareSource considers to be fraud, waste, and/or abuse

Note: This is not an all-inclusive list.

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

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

Note: This is not an all-inclusive list.

Examples of Pharmacy Fraud, Waste and/or Abuse:

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

It is also important for you to tell us if a CareSource employee acts inappropriately.

Examples of Employee Fraud, Waste and/or Abuse:

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

Examples of Vendor Fraud, Waste and/or Abuse:

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

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

Corrective actions can include, but are not limited to:

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

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

REPORTING FRAUD, WASTE AND ABUSE

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

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

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

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

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

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

The Deficit Reduction Act of 2005

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

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

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

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

Indiana Law

- Indiana has enacted a false claims statute that meets the requirements of Section 1909 of the Social Security Act. Section 1909 provides a financial incentive for a state to enact a false claims statute that is at least as effective in rewarding and facilitating qui tam actions for false claims as those described in the federal False Claims Act.

- Indiana's False Claims and Whistleblower Protection Act applies to any individual or entity that knowingly or intentionally:

  – Presents a false claim to the State for payment or approval;
  – Makes or uses a false record or statement to obtain payment or approval of a false claim from the State;
  – With intent to defraud the State, delivers less money or property to the State than the amount recorded on the certificate or receipt the person receives from the State;
  – With intent to defraud the State, authorizes issuance of a receipt without knowing that the information on the receipt is true;
  – Receives public property as a pledge of an obligation on a debt from an employee who is not lawfully authorized to sell or pledge the property;
  – Makes or uses a false record or statement to avoid an obligation to pay or transmit property to the State;
  – Conspires with another person to commit a violation of any other section of the statute; or
  – Causes or induces another person to violate any other section of the statute.

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

OTHER FRAUD, WASTE AND ABUSE LAWS

Under the Federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program (42 U.S.C. §1320a-7b).

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

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

- As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. (18 U.S.C. §1347).

PROTECTION FOR REPORTERS OF FRAUD, WASTE OR ABUSE

Federal and state law and CareSource's policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our Special Investigations Unit using one of the reporting methods outlined at the end of this section.

INCENTIVES FOR WHISTLEBLOWERS

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement. Additional information on the False Claims Act can be found on **CareSource.com**.

PROHIBITED AFFILIATIONS

CareSource is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended or otherwise excluded from participating in federal procurement and non-procurement activities (42 C.F.R. § 438.610). Relationships must be terminated with any trustee, officer, employee, health partner or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that your corporate entity, those with more than five percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us immediately utilizing the contact information in the "How to Report Fraud, Waste or Abuse" reporting section below.

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 health partners are subject, and in accordance with accepted practices.

Disclosure of Ownership, Debarment and Criminal Convictions

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

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

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

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

HOW TO REPORT FRAUD, WASTE OR ABUSE

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

Options for reporting anonymously:

- Call: **1-844-607-2831** and follow the appropriate menu option for reporting fraud
- Write: CareSource
  Attn: Special Investigations Unit
  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 at **CareSource.com**.

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

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

A ROADMAP TO AVOID MEDICARE AND MEDICAID FRAUD AND ABUSE

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

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

KEY CONTRACT PROVISIONS

To make it easier for you, we have outlined key components of your contract. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

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

60-day notice is required if you plan to close your practice to new patients. If we are not notified within this time period, you will be required to continue accepting CareSource members for a 60 calendar day period following notification.

- For PMPs only:
  - 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 PMP or a back-up health partner to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up health partner and only recommends emergency room use for after hours.
  - Being available to see members at least three days per week for a minimum of 20 hours per week, or any combination of no more than two locations.
  - Providing members telephone access to the PMP (or appropriate designate) in English and Spanish 24/7.
- For behavioral health partners only:
  - Notify CareSource of missed appointments.
  - Schedule members receiving inpatient psychiatric services for outpatient follow-up and/or continuing treatment prior to discharge, within 7 calendar days from the member's date of discharge.
  - Document and share with physical health partners the following information:
    - Primary and secondary diagnoses,
    - Findings from assessments,
    - Medication prescribed,
    - Psychotherapy prescribed; and
    - Any other relevant information
  - Notify CareSource within five calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications, and other pertinent information.
- Submission of claims should be submitted within 90 days of the date of service or discharge.
- Submission of corrected claims should be submitted within 365 days of the date of service or discharge.
- Submissions of claim disputes should be submitted 60 calendar days from the date of receipt of the claim decision notification.
- Health partners should keep all demographic and practice information up-to-date. Email updates to **ProviderMaintenance@caresource.com**.

Our agreement also indicates that CareSource is responsible for:

- Paying clean electronic claims within 21 days of receipt.
- Paying clean paper claims within 30 days of receipt.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the "Health Partner Appeals" section of this manual.
- Offering a 24-hour nurse advice line for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance, which involves subtracting the primary payment from the lessor of the primary carrier allowable or the Medicaid allowable. If the member's primary insurer pays a health partner equal to or more than Indiana's Hoosier Healthwise and/or Healthy Indiana Plan fee schedule for a covered service, CareSource will not pay the additional amount. The Hoosier Healthwise fee schedule is based on the Medicaid fee schedule, and the Healthy Indiana Plan fee schedule is based on the Medicare fee schedule.

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

For example:

- Participating health partners, or their designee, are expected to make daily visits to their patients who have been admitted as inpatient to an acute care facility or arrange for a colleague to visit.
- Participating PMPs are expected to have a system in place for following up with patients who miss scheduled appointments.
- Participating health partners are expected to treat members with respect. CareSource members should not be treated any differently than patients with any other health care insurance. Please reference member rights in the "Member Support Services and Benefits" section of this manual.

CareSource expects participating health partners to verify member eligibility and ask for all 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 health partner to your practice helps us keep our records current and are critical for claims processing.

TIMELINE OF PROVIDER CHANGES

Type of Change	**Notice Required** (Please notify CareSource of the change prior to the time frames listed below)
New health partners or deleting health partners	Immediate
Health partners leave the practice	Immediately upon health partner notice
Phone number change	10 calendar days
Address change	60 calendar days
Change in capacity to accept members	60 calendar days
Health partners 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:

Email: ProviderMaintenance@caresource.com

Fax: 937-396-3076

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

AMERICANS WITH DISABILITIES ACT (ADA) STANDARDS:

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

a. Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities

b. Accessibility along public transportation routes, and/or provide enough parking

c. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities

d. Providing secure access for staff-only areas

MEMBER ENROLLMENT AND ELIGIBILITY

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

HOOSIER HEALTHWISE ELIGIBILITY

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

HHW Enrollment Categories

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

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

HHW Packages

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

- **Package A (Standard plan)** – Provides full coverage for children and pregnant women
- **Package C (Children's plan)** – Preventive, primary and acute care services for children under 19 years old in families with incomes greater than 208 percent but less than 250 percent of the federal poverty level (FPL)
- **Package P (Pregnancy presumptive eligibility)** – Presumptive eligibility for pregnant women with incomes at or less than 200 percent of the FPL who are not current IHCP members and whose pregnancy has been confirmed by a qualified health partner
  - Coverage includes pregnancy-related outpatient services only and excludes all delivery and postpartum services

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

HEALTHY INDIANA PLAN

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

HIP Eligibility Requirements

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

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

HIP Categories

- **HIP Plus**: HIP Plus is the preferred plan for all HIP members. HIP Plus provides the best value coverage and includes vision and dental services. In HIP Plus, members pay an affordable monthly contribution and do not pay any other costs or copayments unless they visit the emergency room when they don't have an emergency health condition. HIP Plus members with incomes over 100 percent of the FPL who don't pay or miss their monthly POWER contribution will lose their HIP Plus coverage and will drop to Basic (detailed below). In most cases, members that lose HIP Plus coverage with incomes over 100 percent of the FPL will be locked out for six months.
- **HIP Basic**: HIP Plus members who do not pay their monthly POWER Account contributions are disenrolled from HIP Plus and fall to Basic if they are below 100 percent of the FPL. This includes those with incomes of $990 or less per month for an individual or $2,025 or less per month for a family of four; they will receive HIP Basic benefits when they stop paying their POWER Account contributions. HIP Basic benefits provide coverage for all required services but are more limited and do not provide vision or dental coverage, along with some other benefits. In HIP Basic, members have to make a copayment for most services other than preventive services. These copayments may range from $4 to $8 per doctor visit or prescription filled and may be as high as $75 per hospital stay. HIP Basic can be much more expensive than HIP Plus overall. HIP Basic members that are Basic at the end of their benefit period and qualify for rollover can buy up to HIP Plus. This is also an option when a member redetermines after 12 months.
- **HIP State Plan**: Available to individuals who qualify as low-income parents and caretakers, low-income 19- and 20-year-olds, and individuals with serious and complex medical conditions who are deemed "medically frail." The HIP State Plan provides access to comprehensive Indiana Medicaid State Plan services and includes cost-sharing responsibilities through POWER Account contributions (HIP State Plan Plus) or copayments (HIP State Plan Basic), as determined by a member's eligibility category and income level.
  - **HIP State Plan Plus**: Individuals enrolled in State Plan benefits have access to the greater benefit package available under the state plan. Those in State Plan Plus have the same cost sharing requirements as HIP Plus, they must make a POWER Account contribution, and they do not have copayments for services.
  - **HIP State Plan Basic**: Individuals enrolled in State Plan benefits have access to the greater benefit package available under the state plan. Those in State Plan Basic have the same cost sharing requirements as HIP Basic and they have the same copayments for services.

MEMBER ID CARDS

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

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

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

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.

PRESUMPTIVE ELIGIBILITY

Presumptive eligibility (PE) provides immediate, temporary coverage for certain groups of individuals who are likely to be eligible for HIP or other Medicaid coverage.

Aid categories eligible for hospital PE include:

- Children ages 1 to 18
- Infants
- Low-income parents or caretakers
- Non-disabled adults, ages 19 to 64
- Former foster care children
- Pregnant women
- Individuals eligible for the Family Planning Eligibility Program only

Individuals who qualify for hospital PE/PE in categories that are HIP-eligible will be placed into managed care immediately upon approval for hospital PE/PE and will have the option to choose their managed care entity. All other individuals are placed into the fee-for-service program during their presumptive eligibility period which will run until the end of the following month while full IHCP eligibility is being determined. Qualified PE health partners make a preliminary assessment of eligibility based on a short list of eligibility questions, including age, income, pregnancy status, and residency status. Individuals found presumptively eligible have temporary health coverage starting that same day. The member receives a PE acceptance letter that serves as proof of coverage during the temporary PE coverage period. Members who are found eligible in other categories (not adult PE) are placed in the fee-for-service program, and their benefits last until the last day of the month following their PE determination or, if they apply to the IHCP, until a decision is made on their IHCP application.

Presumptive Eligibility for Pregnant Women (PEPW) provides earlier prenatal care and improved birth outcomes for eligible pregnant women. Low-income pregnant women are determined presumptively eligible for Medicaid through a simplified application process. PE is different from pending Medicaid, because health partners are eligible for reimbursement at the time services are rendered versus waiting for retroactive coverage when Medicaid eligibility is determined. Pregnant women found to be presumptively eligible by qualified health partners have coverage for their first prenatal visit.

HEALTHY INDIANA PLAN PREGNANCY

HIP provides coverage for pregnancy-related services. If a woman becomes pregnant while enrolled in HIP, she will transfer to the HIP Maternity plan if her income is below 138% of federal poverty level (FPL). Members above 138% of FPL will be enrolled in Hoosier Healthwise in the MAGP aid category. Pregnant members shall not be subject to any cost-sharing. A pregnant member enrolled in HIP Maternity will have a POWER Account established but immediately suspended until after her post-partum period is over.

If a pregnant woman chooses to stay in HIP, she will receive maternity services through her existing HIP benefit package, as well as additional benefits during her pregnancy, such as non-emergency transportation. Pregnant members shall not be subject to any cost-sharing.

Eligibility Transfer

When a member becomes pregnant, she must notify the State and CareSource of her pregnancy. To obtain coverage under Hoosier Healthwise, the woman must request a transfer through the DFR.

MCEs and health partners can help pregnant members transfer to MAGP coverage or obtain maternity coverage under HIP. Pregnant women can also contact the DFR call center directly to report a pregnancy and request a transfer from HIP to MAGP.

MEDICALLY FRAIL MEMBERS

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

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

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

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

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

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

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

HEALTH PARTNER-INITIATED REQUESTS FOR MEMBER REASSIGNMENT

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

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

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

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

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

- **Member's medical needs may be better met by another PMP** – A PMP may request member reassignment because the PMP believes a member's medical needs would be better met by a different PMP. This request must be documented as to the severity of the condition and must be reviewed by the CareSource's medical director. CareSource's medical director must review the request based on the specific condition or severity of the condition as a PMP scope-of-practice matter, not based on a bias against an individual member.
- **Breakdown of physician and patient relationship** – CareSource must conduct an upper-level review, as defined previously, to ensure that the breakdown in the relationship between the PMP and the member is mutual.
- **Member accessing care from other than the selected or assigned PMP** – CareSource must conduct member education about the health plan and the PMP selection process. If the member does not initiate a PMP change and continues to access primary care services from a health partner other than the PMP, the PMP may request the member's reassignment. Misuse of the emergency room is not a valid reason for requesting a member's reassignment.

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

Unacceptable reasons for PMP-initiated member reassignment requests:

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

NEW MEMBER IDENTIFICATION CARDS AND KITS

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

New Member Kit Includes:

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

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 health partners 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 health partner directly to confirm they are in network. The most current list of health partners can be found at any time on CareSource's website under our "Find a Doctor/Provider" tool.

MEMBER ELIGIBILITY VERIFICATION

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

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

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

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

The EVS consists of interactive, real-time options:

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

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

NEWBORN ENROLLMENT

When a mother gives birth, the newborn child will automatically be enrolled into the mother's health plan starting on the baby's date of birth. CareSource and pregnant mothers coordinate PMP preselection for newborn members. IndianaAIM retroactively assigns newborns to their respective mothers' MCEs as soon as the newborns' eligibility is passed from ICES to IndianaAIM.

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

MEMBER DISENROLLMENT

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

Reasons for Member Disenrollment

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

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

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

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

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

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

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.

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

Key features of this service include nurses who:

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

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

CARESOURCE CARE MANAGEMENT

CareSource provides the services of care management medical 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 compliant patients, reinforcing medical instructions, and assessing social and safety needs, as well as educating pregnant women on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many conditions.

Direct Access for Medicaid

"Direct Access" for Care Management referrals and assistance with member needs is available at **1-844-607-2831.**

CARE4U – POPULATION HEALTH MODEL

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 for the CareSource member population.

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:

1. Improve the member experience of care (including clinical quality and satisfaction);
2. Improve the health of populations; and
3. 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 health partner's office. This one-on-one personal interaction with outreach specialists and 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.

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

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

- High risk pregnancy and complex newborns
- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Depression
- Members with special health care needs
- Members with serious and persistent mental illness (SPMI)
- Attention-deficit/hyperactivity disorder (ADHD)
- Autism spectrum disorders

CARE MANAGEMENT OF HIGH-RISK MEMBERS

CareSource applies a particular community-based 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. Community health workers help patients overcome health care access barriers and strengthen our health partner and community resource partnerships through collaboration.

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

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

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

Care Transitions Planning

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

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

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

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

CARESOURCE DISEASE MANAGEMENT PROGRAM

CareSource Medicaid members with chronic conditions, including attention deficit hyperactivity disorder (ADHD), asthma, autism spectrum disorders, congestive heart failure (CHF), chronic kidney disease (CKD), chronic pulmonary disease (COPD), coronary artery disease (CAD), depression, diabetes, hepatitis C, human immunodeficiency virus (HIV) and pregnancy will be automatically enrolled into CareSource's enhanced disease management program.

Members enrolled in the program will receive free information to help them better manage their specific conditions. Information sent to members will include care options for them to discuss with their health partners.

Members identified as high risk will have a nurse assigned to their case to help educate, coordinate and provide resources and tools to help the member reach their health care goals.

CARESOURCE DISEASE MANAGEMENT PROGRAM FOR KIDS, TEENS AND PARENTS

CareSource takes a unique approach to meeting the disease management needs of our children and adolescent members. CareSource provides educational materials to our kids, teens and parents across a variety of communication channels, including the CareSource web site, our member portal and mobile and email options, based upon the preference of our members. Content includes a multimedia approach including videos, motivational and educational text messages, age-specific tips based on the child's age, medication reminders and newsletters. This approach to relatable content encourages family dialogue and helps parents understand what their children are experiencing related to their diagnoses. Our approach to managing disease engages the entire family and helps prepare our youngest members to be future decision makers in their own health care. CareSource strives to achieve better outcomes and healthier families.

How to Refer Medicaid Members to Disease Management

If you have a CareSource patient with one of the above listed chronic conditions who you believe would benefit from this program and is not already enrolled, call **1-844-607-2831**.

HEALTH INCENTIVE INITIATIVE

The goal of this program is to promote active member engagement in targeted chronic disease activities that result in improved member outcomes. Through this initiative, members are incentivized to participate in online education, self-management and health coaching activities that foster an understanding of the disease process, knowledge of comorbidities, importance of prescribed medication and monitoring of signs and symptoms indicating the need for intervention. Such awareness is known to lead to reduction in emergency department visits and hospitalizations among targeted populations.

SMOKING CESSATION

CareSource wants to help members maintain a healthy lifestyle. This includes not using tobacco products. The Tobacco-Free Program aims to increase members' knowledge of the risks associated with tobacco use and the benefits of cessation. The program provides regular health coaching as well as information on how to obtain pharmacotherapy from a health partner to assist with quitting.

PERINATAL AND NEONATAL CARE MANAGEMENT

CareSource's perinatal and neonatal care management program utilizes a multi-disciplinary team with extensive obstetrical and neonatal intensive care unit (OB/NICU) clinical experience. Specialized nurses are available to help manage high-risk pregnancies and medically complex newborns by working in conjunction with health partners 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 health partners.

Notification of Pregnancy

We encourage our prenatal care health partners to notify our Care Management Department at **1-844-607-2831** when a member with a high-risk pregnancy has been identified. Prenatal care health partners are encouraged to electronically complete the Notification of Pregnancy (NOP) risk assessment. The submitted information will be used by CareSource to determine the member's health risk during her pregnancy and the level of care coordination needed. Prenatal care health partners that electronically complete the NOP in adherence to IHCP guidelines through the Web interchange may be eligible for a $60 incentive payment. To receive the incentive payment the woman's pregnancy must be less than 30 weeks gestation at the time of the office visit on which the NOP is based and the NOP must be submitted within five calendar days from the date of service. Health partners must bill for the NOP incentive payment using Current Procedural Terminology (CPT®1) code 99354 with modifier TH. The date of service (DOS) on the NOP claim should be the date of the office visit on which the information on the NOP is based. CareSource will disburse an additional $10 to the health partner if the NOP is completed within the first trimester of the member's pregnancy. No additional action is required by the health partner to receive this incentive.

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. Additionally, the program encourages well-baby visits as recommended to help ensure mom and baby will be as healthy as possible. Through this program, members can earn rewards and incentives for completing specific activities related to prenatal, postpartum, and well-baby care.

Upon completion and verification, the Member will have the option of choosing a gift card or other limited items (baby car seat, healthy items, baby toys, etc.) from a limited selection of merchants, such as Walmart or CVS. Regardless of the merchant selected, the rewards card will block the purchase of items such as alcohol and/or tobacco, and cannot be converted to cash.

Members can enroll in Babies First by completing the form at **CareSource.com** or call Member Services at **1-844-607-2829**.

INTERPRETER SERVICES

Non-Hospital Health Partners

CareSource offers sign and language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. We can also provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services are available at no cost to the member or health partner. As a health partner, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. Health partners who have 24 hour access to health care-related services in their service area or via telephone must provide members with 24 hour oral interpreter services, either through interpreters or telephone services. To arrange services, please contact our Health Partner Services Department at **1-844-607-2831.** We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

Hospital Health Partners

CareSource requires hospitals, at their own expense, to offer sign and language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking ability. We can provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services should be available at no cost to the member. You are also required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. If you do not have access to interpreter services, contact Health Partner Services at **1-844-607-2831**. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

SCHOOL-BASED CLINICS PROVIDING CARE

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

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

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

Guidelines When Submitting Risk Assessment Forms to CareSource:

- You must use the designated form found on the CareSource Provider Portal.
- We must receive the forms, filled out completely, no later than 5 business days after the member's clinic visit. Please be sure to include services covered under the child's IEP.
- Any change to the status of our member should be reported using designated form to denote these changes.
- There is no member limit to the number of assessments forms that may be completed.
- Please use code H1000 on the associated claim to indicate that an assessment form was submitted. This will help ensure that you are reimbursed appropriately.

HEALTHWATCH – EPSDT GUIDELINES

HealthWatch is the State of Indiana'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 on Medicaid that provides periodic, preventive health care and medically necessary follow-up care. EPSDT services are a covered benefit for HIP members ages 19 and 20 and HHW members under the age of 21. The purpose of the program is to discover and treat health problems early. If a potential health problem is found, further diagnosis and treatment are covered by Medicaid. All CareSource members under the age of 21 should receive HealthWatch exams.

Periodic screenings will be provided in accordance to the HealthWatch exam frequency schedule and do not require a prior authorization. Treatment services are subject to prior authorizations requirements for services as outlined in the IHCP Manuals and Policies and Procedures. If the PMP is unable to provide all of the components of the HealthWatch exam, or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating health partner within CareSource's health partner network in accordance with CareSource's referral procedures. The member's medical record must indicate where the member was referred.

Exam Components

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

- A comprehensive health, psycho-social and developmental history;
- Documentation of vital signs;
- An unclothed comprehensive physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination);
- Assessment of growth and nutritional status;
- Assessment of immunization status and provision of appropriate immunizations. Use the Advisory Committee on Immunization Practices (ACIP) schedules;
- Screening for vision, hearing, lead poisoning and development, as per AAP guidance;
- Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance;
- Oral health screening, preventive counseling and referral to a dentist for ongoing dental care;
- Screening for and if suspected, reporting of child abuse and neglect;
- Anticipatory guidance (health education); and
- Referrals/follow-ups where appropriate based on history and exam findings.

Exam Frequency

CareSource's recommended schedule for HealthWatch exams is as follows:

- Birth
- Three to five days
- One month
- Two months
- Four months
- Six months
- Nine months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- after 30 months, one exam per year until age 21

PMPs receive a list of eligible CareSource members at the beginning of each month who have chosen or been assigned to the PMP as of that date. The list also includes indicators for patients who appear not to have had their initial HealthWatch exam and/or who are not in compliance with the EPSDT periodicity schedule. Initial HealthWatch exams are to be completed within 90 days of the initial effective date of membership for new enrollees. You can find this list on our Provider Portal.

HealthWatch Codes

In order to receive proper payment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/ HealthWatch 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.

IMMUNIZATIONS

Immunization Schedule

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

Vaccines for Children Program

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

CareSource encourages health partners 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 health partners at no cost. CareSource will not reimburse costs for vaccines obtained outside the VFC program. CareSource will pay for the administration of the vaccine only.

Immunization Codes

Please bill CareSource with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. Effective October 1, 2015, CareSource requires health partners to use ICD-10-CM Codes and CPT Codes on claims. For a list of VFC-available vaccines, see the Injections, Vaccines, and Other Physician-Administered Drug Codes on the Code Sets page at indianamedicaid.com. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

Statewide Web-Based Immunization Registry

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

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

EMERGENCY DEPARTMENT DIVERSION PROGRAM

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 for our members.

We instruct members to call their PMP or the CareSource24 nurse advice line if they are unsure if they need to go to an ER. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. We also offer enhanced reimbursement to PMP 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 "Preferred Medical Provider" section 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 and Outreach 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.

Medicaid Transportation

Transportation can be provided for member medical appointments, Women, Infants and Children (WIC) appointments, and Medicaid redetermination appointments:

- For Package A members, the non-emergent transportation benefit is limited to 10 round-trip visits (20 one-way trips) of less than 50 miles annually per member for Medicaid. A copayment of $.50 to $3 applies.
- For Package C members, the non-emergent transportation benefit is covered only between medical facilities, when requested by a participating health partner. A copayment of $10 applies.

Members can arrange transportation by calling the Member Services phone number on their ID card and selecting the option for transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

Telemedicine

CareSource covers telemedicine services to members. The coverage is currently limited but expanding as we continue to build partnerships to improve our members' access to health care across Indiana. Please verify your patient's coverage before providing services.

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 interactive guides

All of the tools are accessible via web or mobile.

MEMBER RIGHTS AND RESPONSIBILITIES

As a CareSource health partner, you are required to respect the rights of our members.

CareSource members are informed of their rights and responsibilities via their Member Handbook. The list of our members' rights and responsibilities are listed below.

All members are encouraged to take an active and participatory role in their own health and the health of their family. Member rights, as stated in the Member Handbook, are as follows:

1. CareSource notifies members of their rights and responsibilities in the Member Handbook.
2. As a member of CareSource, members have the following rights:
    a. To receive information about CareSource, its services, its practitioners and health partners, and member rights and responsibilities.
    b. To receive all services that CareSource must provide.
    c. To be treated with respect and with regard for their dignity and privacy.
    d. To be sure that their medical records and personal information will be kept private.
    e. To be given information about their health. This information may also be available to someone who the member has legally authorized to have the information or who the member has said should be reached in an emergency when it is not in the best interest of the member's health to give it to him/her.
    f. To get information on any appropriate or medically necessary treatment options for the member's condition.
    g. To participate in decisions regarding his or her health care, including the right to refuse treatment.
    h. To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
    i. To be sure that others cannot hear or see the member when he/she is getting medical care.
    j. To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
    k. To request and receive a copy of his or her medical records and request to amend or correct the record.
    l. To be able to say yes or no to having any information about himself/herself given out unless CareSource has to by law.
    m. To be able to say no to treatment or therapy. If the member says no, the doctor or care management organization (CMO) must talk to him/her about what could happen and a note must be placed in the member's medical record about the treatment refusal.
    n. To be able to file an appeal, a grievance (complaint) or state hearing.
    o. To be able to get all CareSource written member information from CareSource:
        i. At no cost to the member.
        ii. In the prevalent non-English languages of members in CareSource's service area;
        iii. In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
    p. To be able to get help free of charge from CareSource and its health partners if the member does not speak English or needs help in understanding information.
    q. To be able to get help with sign language if the member is hearing impaired.
    r. To be told if the health care health partner is a student and to be able to refuse his/her care.
    s. To be told of any experimental care and to be able to refuse to be part of the care.
    t. To make advance directives (a living will).
    u. To freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated.
    v. To know that CareSource must follow all federal and state laws, and other laws about privacy that apply.

w. To choose the health partner that gives the member care whenever possible and appropriate with the ability to seek care from an out of network health partner when the necessary covered medical services are not available within sixty (60)-miles of the member's residence.
x. To be able to get a second opinion from a qualified health partner on CareSource's panel. If a qualified health partner is not able to see the member, CareSource must set up a visit with a health partner not on its panel.
y. To not be held liable for the supplier's debts in the event of insolvency.
z. To not be held liable for the covered services provided to the member for which OMPP does not pay the supplier.
aa. To not be held liable for covered services provided to the Member for which OMPP or the CMO does not pay the health care health partner that furnishes the services.
bb. To not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the supplier provided the services directly.
cc. To be responsible for cost sharing.
dd. To not be billed for any service covered by Medicaid.
ee. To make recommendations regarding CareSource's member rights and responsibility policy.
ff. To contact the United States Department of Health and Human Services Office of Civil Rights at the address below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Office of Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave. Suite 240
Chicago, Illinois 60601
(312) 886-2359
(312) 353-5693 TTY

Members of CareSource are also informed of the following responsibilities:

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

HIPAA Notice of Privacy Practices

Members are notified of CareSource's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CareSource's Notice of Privacy Practices includes a description of how and when member information is used and disclosed within and outside of the CareSource organization. The notice also informs members how they may obtain a statement of disclosures or request their medical claim information. CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members.

As a health partner/covered entity, please remember that you are obligated to follow the same HIPAA regulations as CareSource and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

ADVANCED DIRECTIVES

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

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

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

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

BEHAVIORAL HEALTH

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

CareSource provides behavioral health benefits to our Medicaid members. Members may self-refer to behavioral health services within our provider network without a referral from their PMP. Note that although CareSource does not require members obtain referrals for the health partners below, the specific services rendered may still require prior authorization from CareSource. In addition, all services rendered are still subject to benefit limits.

PHYSICAL HEALTH AND BEHAVIORAL HEALTH COORDINATION

CareSource encourages communication and care coordination between PMPs, specialists and behavioral health partners to achieve optimal health for our members. Communication between PMPs, specialists and behavioral health partners is necessary to ensure continuity of care and member safety. CareSource requires every health partner to ask and encourage members to sign a consent permitting release of substance use disorder information to CareSource and to the primary medical provider (PMP) or behavioral health provider. CareSource providers are not permitted to release information related to substance use disorder services without written consent from the member. CareSource contractually requires that behavioral and physical health partners document and reciprocally share the following information for each member:

1. Primary and secondary diagnoses,
2. Findings from assessments,
3. Medication prescribed,
4. Psychotherapy prescribed, and
5. Any other relevant information

CareSource requires that behavioral health partners send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PMP, with the member's or the member's legal guardian's consent. CareSource requires that all members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. If a member misses an outpatient follow-up appointment or continuing treatment, CareSource requires the behavioral health partner to notify CareSource and to contact the member within three business days of notification of the missed appointment to reschedule.

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

CareSource will notify behavioral health partners and medical health partners when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. This notice will be provided within five calendar days of the hospital inpatient admission or emergency treatment.

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

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

Scope of Practice

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

CULTURAL COMPETENCY PLAN

Cultural competency within CareSource is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population.” It is the use of a system’s perspective which values differences and is responsive to diversity at all levels in an organization. Cultural competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills important in clinical practice, cross-cultural interactions and systems practices among health partners and staff to ensure that services are delivered in a culturally competent manner.

Participating health partners are expected to provide services in a culturally competent manner, which includes removing all language barriers to service and accommodating the unique ethnic, cultural, and social needs of the member. Participating health partners must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

Health partners can address racial and ethnic gaps in health care with an awareness of cultural needs and improving communication with their growing numbers of diverse patients. CareSource prohibits its providers or partners from refusing to treat, service 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 health partners 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).

Network health partners must ensure that:

- Members understand that they have access to medical interpreters, signers and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the members’ race/ethnicity and language and its impact/influence on the members’ health or illness.
- The office staff that is responsible for data collection makes reasonable attempts to collect race-and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify his/her own race/ethnicity and that of his/her children.
- Treatment plans are developed and clinical guidelines are followed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physician abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Participating health partners 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 its participating health partners to complete the US Department of Health and Human Services Physician Practical Guide to Culturally Competent Care, which is a free on-line accredited educational program. CareSource also provides a variety of cultural competency training resources online at **CareSource.com.**

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

PHARMACY

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

CVS Caremark administers the pharmacy program for CareSource. Members can use other retail pharmacies who are in the CVS Caremark pharmacy network. These include Kroger, Walgreens, Walmart, CVS, Rite Aid, as well as many independent pharmacies. Specialty medications must be ordered through CVS Specialty Pharmacy and are typically shipped directly to members.

Details of Plans with Prescription Drug Coverage:

- **Copayment requirements** – Depending on the plan chosen and the tier level of the drug, an individual may have a required copay. Some medical supplies are covered under the pharmacy coverage, including diabetes supplies, spacers, peak flow meters and condoms.
- **Other medical supplies and durable medical equipment (DME)** – To support member access and convenience, other medical supplies, such as wound care supplies and enteral feeds, may be filled through the retail pharmacy for a limited period of time (up to 30 days) until you coordinate delivery with a DME health partner.
- **Medications administered in the health partner setting** – Physician administered drugs/medications that are administered in a health partner setting (such as a physician office, hospital outpatient department, clinic, dialysis center, or infusion center) will be billed to the MCE. Prior authorization requirements exist for many injectable medications.
- **Transition period** – A 90-day transition period applies for members new to the plan who are on pre-existing drug regimens. Some medications are excluded from the transition period. After the 90-day transition period has ended, prior authorization may be applicable, depending on the member's medication. Check **CareSource.com** for what medications require prior authorization.

FORMULARY

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

CareSource uses Preferred Drug Lists (PDLs) or formularies. CareSource uses different PDLs for our HHW and HIP plans. These may be found online at **CareSource.com**. Some drugs require prior authorizations. The online formularies contain information about prior authorizations, quantity limits, step therapy protocols and therapeutic interchanges for most drug classes.

STEP THERAPY AND QUANTITY LIMITS

Certain medications on the PDL are covered if utilization criteria are met. Step therapy is one such utilization technique that requires using a formulary medication before the non-formulary medication would be approved for use.

Quantity limits are also placed on many medications, based on normal manufacturers' recommended dosing frequencies and safety considerations.

GENERIC SUBSTITUTION

Generic substitution occurs when a pharmacy dispenses a generic version rather than a prescribed brand-name product. In the online formulary, boldface type indicates generic availability. However, not all strengths or dosage forms of the generic name in **boldface type** may be generically available. In most instances, a brand-name drug for which a generic product becomes available will become non-formulary, with the generic product covered in its place, upon release of the generic product onto the market.

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

Generic drugs are usually priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Prescription generic drugs are:

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

When a generic drug is substituted for a brand-name drug, you can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic interchange).

A list of preferred drugs is available at **CareSource.com**. This site also includes other information about the CareSource pharmacy program.

PRIOR AUTHORIZATION REQUESTS

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

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

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

Pharmacy Questions

Online (preferred): CareSource.com
Phone: 1-844-607-2831

CARESOURCE SPECIALTY PHARMACY PROGRAM

All specialty medications are provided by CVS Caremark Specialty pharmacy to improve medication compliance, side effect management and disease state management. CareSource works with CVS Caremark to supply specialty medications your doctor may prescribe. CVS Caremark can:

- Help you get your prescription filled or moved from the pharmacy you get it from now
- Deliver your specialty meds to your home, workplace or to your doctor's office
- Help you learn about your specialty medication and give you support from specially-trained health care professionals

For more information, call CVS Health® at **1-800-237-2767**. They can take your call Monday through Friday from 7:30 a.m. to 9 p.m. Eastern Standard Time (EST). Please visit **CareSource.com** to learn more about the Specialty Pharmacy Program.

PRIMARY MEDICAL PROVIDERS

PMP SELECTION

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

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

If a member does not select a PMP, we will assign them one. CareSource encourages communication between all physicians and other health care professionals who are providing care to CareSource members.

ROLE OF THE PMP

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

Members select a PMP from the CareSource Provider Directory. Members have the option to change to another participating PMP as often as needed. Members initiate the change by calling our Member Services Department.

CareSource allows for PMPs to include not only traditional health partner types that have historically served as PMPs but also alternative health partner types such as specialists and patient-centered medical homes (PCMH) with documented physician oversight and meaningful physician engagement. Health partners serving as PMP's can designate up to two locations where they can receive member assignments.

PMP ROLES AND RESPONSIBILITIES

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

1. Assisting with coordination of the member's overall care, as appropriate for the member.
2. Serving as the ongoing source of primary and preventive care.
3. Recommending referrals to specialists, as required.
4. Triaging members.
5. Participating in the development of case management care treatment plans, and notifying CareSource of members who may benefit from care management. Please see the "Member Support Services and Benefits" section on how to refer members for case management.
6. Providing care that addresses the needs of HIP members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health.

7. Providing a written plan and evidence of ongoing, increased communication between the PMP, the MCP and the behavioral health partner.
8. Coordinating management of utilization of behavioral health care services with MRO and 1915(i) services and services for physical health.

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

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

PMPs are Responsible For:

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

HEALTH PARTNER RIGHTS

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

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

MEDICAL RECORDS

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

- Patient identification information (patient name or identification number) on each written page or electronic file record
- Personal biographical data
- Entry date
- Health partner identification
- Allergies
- Past medical history
- Immunizations
- Medical information
- Consultations
- Referrals
- Medical conditions and health maintenance concerns
- Written instructions for living wills or durable power of attorney for healthcare when the patient is incapacitated and has such a document
- A record of outpatient and emergency care
- Specialist referrals
- Ancillary care
- Diagnostic tests and findings
- Prescriptions for medications
- Inpatient discharge summaries
- Histories and physicals, including a list of smoking and chemical dependencies, including alcohol, legal and illegal drugs (member consent required to share substance use information)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
- Laboratory and X-ray tests and findings

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

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

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

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

Availability of Assistance in Filing

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

MEMBER GRIEVANCES

Members have the right to file a grievance or appeal and request a State Hearing or a review by an Independent Review Organization of a decision made by CareSource. As a CareSource health partner, we may contact you to obtain documentation when a member has filed a request for one of these reviews. CareSource does not retaliate or discriminate against any member or health partner for utilizing the grievance and appeals process. Members are encouraged to call or write to CareSource to let us know of any complaints regarding CareSource or the health care services they receive. Members or health partners, 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 can contact CareSource at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) to learn more about these procedures. Members must exhaust CareSource's internal appeals process before requesting a state hearing.

CareSource shall provide an expedited grievance review if adhering to the resolution time frame of thirty (30) calendar days would seriously jeopardize the life or health of a member, or the member's ability to regain maximum function. Expedited grievances shall be resolved within forty-eight (48) hours of receipt. If CareSource denies a request for an expedited review, we shall transfer the grievance to the standard grievance time frame. Further, CareSource shall make a reasonable effort, including a phone call to the member, to provide the member with prompt oral notification of the denial for an expedited review, and shall follow up with a written notice within two (2) calendar days.

Timeframes and Requirements

The member can file a grievance within 60 days of the date the member became aware of the issue. CareSource responds to all grievances within 30 calendar days. This period may be extended up to 14 calendar days if resolution of the matter requires additional time. A letter notifying the member of this extension is required.

Member Appeal of a Grievance Decision

If members are not satisfied with our response to a grievance, they can ask us to reconsider it by contacting CareSource within 33 calendar days of the grievance resolution date. CareSource will communicate a decision to the member within 30 calendar days of the receipt of the request. This period may be extended up to 10 business days if resolution of the matter requires additional time. CareSource must give the member written notice of the reason for the extension.

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

- Deny or limit authorization of a requested service, including the type or level of service.
- 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.

Members have the right to appeal the actions listed in the letter if they contact CareSource within 33 calendar days of the date of denial. CareSource will respond to the appeal in writing within 30 calendar days of when it was received. This period may be extended up to 10 business days if resolution of the matter requires additional time. CareSource must give the member written notice of the reason for the extension. Members will receive the appeal decision and any additional appeal rights in writing within 5 business days of the decision.

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

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

Member's Right to a State Hearing

CareSource members can request a state hearing through FSSA Hearings and Appeals after they have exhausted all of CareSource's internal appeals processes. The member must submit the request in writing within 33 calendar days of the initial action to be reviewed.

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

In certain member appeals, CareSource is required to continue the member's benefits pending the appeal, in accordance with 42 CFR 438.420.

HEALTH PARTNER GRIEVANCES

Health Partners may file grievances related to members, other health partners, or operational issues of the plan. CareSource will thoroughly investigate each health partner complaint using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying the CareSource written policies and procedures. We ensure that CareSource executives with the authority to require corrective action are involved in the health partner complaint process.

Claim Dispute Process

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

Process for Claim Disputes for participating and non-participating health partners:

1. Claim disputes must be submitted in writing.
2. The health partner must complete a claim dispute prior to requesting an appeal.
3. The dispute must be submitted within 60 days after the health partner's receipt of the written determination of the claim.
4. If CareSource fails to decision a claim within 30 days after receipt, the 90 day submission period for the dispute begins as of the claim submission date per 405 IAC 1.1-6.2.

Appeals for participating and non-participating health partners:

- Health partners may only submit appeals after completing the claim dispute process as outlined above. Appeals must be submitted within 60 days of the resolution of the informal dispute process. CareSource must issue a written decision within 45 days of receipt of the written request for appeal. If the appeal is not resolved within the 45 day time frame, the appeal will be determined as an approval. Appeal requests must be submitted utilizing one of the methods below, the portal is the preferred method of submission to ensure timely receipt and resolution of the appeal:
- Provider Portal: https://providerportal.caresource.com/IN
  – Under the Provider Portal, click on the "Claims Appeals" tab on the left.
- Writing: use the Health Partner Claim Appeal Request Form. Please include:
  – Member's name and CareSource member ID number.
  – The health partner's name and ID number.
  – The code(s) and why the determination should be reconsidered.
  – If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or Electronic Data Information (EDI) for reconsideration.
  – If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.

    Mail: CareSource
    Attn: Health Partner Appeals
    P.O. Box 2008
    Dayton, OH 45402
    Fax: 844-417-6262
- For additional information, contact Health Partner Services at **1-844-607-2831**.

Appeal requests must include:

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

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

Arbitration:

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

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

QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM

PROGRAM PURPOSE

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

- Coordinate care
- Promote quality
- Ensure performance and efficiency on an ongoing basis
- Improve the quality and safety of clinical care and services provided to CareSource Indiana Health Plan members

There are two guiding tenets for the program:

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

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

QUALITY STRATEGY

Our Quality Strategy aligns with the Institute for Healthcare Improvement's Triple Aim and the National Quality Strategy. The three tenants of the strategy are:

- Better health
- Better care
- Lower costs

The strategy focuses the direction for:

- Continuous quality improvement efforts
- Establishing a culture of improving quality of care and services for Healthy Indiana Plan and Hoosier Healthwise members
- Improving the quality of care for beneficiaries enrolled in Healthy Indiana Plan and Hoosier Healthwise

GOALS AND OBJECTIVES

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

The goals and objectives of the program are:

- NCQA Excellent accreditation
  - Compliance with NCQA accreditation standards
  - High level of HEDIS® performance
  - High level of CAHPS® performance
  - Comprehensive population health management program
  - Comprehensive health partner engagement program
- 5 Star NCQA health plan rating
  - High level of HEDIS performance
  - High level of CAHPS performance
  - Comprehensive population health management program
  - Comprehensive health partner engagement program

SCOPE

The CareSource Indiana Quality Management and Improvement Program governs the quality assessment and improvement activities for CareSource Healthy Indiana Plan and Hoosier Healthwise. The scope includes:

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

Our commitment to the Quality Management and Improvement Program is well aligned to Office of Medicaid Policy and Planning's (OMPP) expectations of Managed Care Entities (MCEs), as emphasized in the State's Medicaid Managed Care Quality Strategy Plan 2015:

- Improve overall health outcomes for the population
- Foster personal responsibility and healthy lifestyles with our members
- Increase consumer knowledge of health care by increasing health care literacy
- Providing price and quality transparency
- Improve access to health care services
- Engage in health partner and member outreach regarding preventive care, wellness and a holistic approach to better health
- Develop innovative utilization management (UM) techniques that incorporate member and health partner education to facilitate the right care, at the right time, in the right location

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

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 the Healthcare Effectiveness Data and Information Set (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 The National Committee for Quality Assurance (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 are:

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer and chlamydia)
  - Well-child care
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure
- Behavioral health
  - Follow-up after hospitalization for mental illness
  - Antidepressant medication management
  - Follow-up for children prescribed ADHD medication
- Safety
  - Use of imaging studies for low back pain

CareSource uses the annual member survey, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys, to capture member perspectives on health care quality. CAHPS is a program overseen by the United Stated 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 and specialists

PREVENTIVE GUIDELINES AND CLINICAL PRACTICE GUIDELINES

CareSource approves and adopts nationally accepted standards and guideline and promotes them to practitioners and members to help inform and guide clinical care provided to CareSource Healthy Indiana Plan and Hoosier Healthwise members. CareSource quality and clinical staff regularly and routinely monitor the status of evidence-based practices evaluated by federal agencies (e.g., Agency for Healthcare Research and Quality [AHRQ], US Preventive Services Task Force [USPSTF], National Quality Forum, etc.), and professional medical associations. In addition, our network health partners, care managers, members, and advocacy groups are often important information resources for identifying and validating evidence-based practice recommendations.

The use of these guidelines allows CareSource to measure the impact of the guidelines on outcomes of care. Review and approval of the guidelines are completed by the CareSource Clinical Advisory Committee every two years or more often as appropriate. The guidelines are then presented to the CareSource Quality Enterprise Committee. If new evidence-based clinical practices can be implemented or more effectively deployed in the field by care management staff and network health partners, those practices are discussed with OMPP and other MCEs and recommended for deployment across the Indiana Healthy Indiana Plan Program. Topics for guidelines will be identified through analysis of CareSource Healthy Indiana Plan members. Guidelines may include, but are not be limited to:

- Behavioral health (depression)
- Adult health (hypertension, diabetes, cardiovascular disease, cerebrovascular disease and chronic obstructive pulmonary disease)
- Population health (obesity and tobacco cessation)
- Well-child care

Guidelines will be promoted to health partners through health partner newsletters, the CareSource health partner website, direct mailings, health partner manual, and through focused meetings with CareSource Provider Relations representatives. Information about clinical practice guidelines and health information will be made available to CareSource Healthy Indiana Plan members via member newsletters, the CareSource member website, or upon request.

If you would like more information on CareSource Quality Improvement, please call Health Partner Services at **1-844-607-2831**.

ACCESS STANDARDS

CareSource has a comprehensive quality program to help ensure our members receive the best possible health care services. It includes evaluation of the availability, accessibility and acceptability of services rendered to patients by participating health partners. Participating health partners are expected to have procedures in place to see patients within these time frames and to offer office hours to their CareSource patients that are at least the equivalent of those offered to any other patient.

Please keep in mind the following access standards for differing levels of care. Thank you for adhering to these standards.

Primary Medical Providers (PMPs)

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Adult sick visit	Not to exceed 24 hours
Pediatric sick visit	Not to exceed 24 hours
Regular and routine care	Not to exceed 14 calendar days

Non-PMP Specialists

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

Behavioral Health

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 14 calendar 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 health partner is unable to see the member within the appropriate time frame, CareSource will facilitate an appointment with a participating health partner or a non-participating health partner, if necessary.*

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

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

How to Submit Changes to CareSource:

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

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.

REFERRALS AND PRIOR AUTHORIZATIONS

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

REFERRALS INFORMATION

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

Covered Services That Do Not Require a Referral

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

- Certified Nurse Practitioner (CNP) services
- Chiropractic care (within benefit limits)
- Dental care (excluding oral surgery and orthodontics)
- Services to treat an emergency
- Family planning services
- Laboratory services (must be ordered by a participating health partner)
- Podiatric care
- Psychiatric care
- Psychological care (from private practitioners or at Community Mental Health Centers)
- Care at public health clinics
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Most radiology services (must be ordered by a participating health partner)
- Routine eye exams (at participating vision centers, within benefit limits)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours
- Services for children with medical handicaps

- Behavioral health partners. Members may also refer to any IHCP-enrolled psychiatrist. The mental health partners to which the member may self-refer within network include:
  – Outpatient mental health clinics
  – Community Mental Health Centers
  – Psychologists
  – Psychiatrist
  – Certified psychologists
  – Health services providers in psychology (HSPPs)
  – Certified social workers
  – Psychiatric nurses
  – Independent practice school psychologists
  – Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
  – Persons holding a master's degree in social work, marital and family therapy or mental health counseling

Members May Go to Non-Participating Health Partners for:

- Emergency care
- Care at community mental health centers
- Family planning services provided at qualified family planning health partners
- Care at FQHCs and RHCs
- Necessary covered medical services if CareSource does not have in-network health partners within 60 miles of the member's residence

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 doctor 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 prior authorization for any services rendered to CareSource patients and must be enrolled as an IHCP provider. You can request a prior authorization by calling our Medical Management Department at **1-844-607-2831**, and select the option to request a prior authorization. Or you can submit a request online at **CareSource.com** and select the Provider Portal option from the menu.

If you have difficulty finding a specialist for your CareSource member, please call our Health Partner Services Department at **1-844-607-2831**.

Steps to Make a Referral:

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

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

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

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

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

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

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

PRIOR AUTHORIZATION INFORMATION

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

Online: **CareSource.com** and select the Provider Portal option from the menu
Email: **INMedMgt@caresource.com**
Fax: Fax the prior authorization form to 844-432-8924. The prior authorization form can be found on **CareSource.com**.
Mail: Send prior authorization requests to:
CareSource
Attn: Medical Management Dept.
P.O. Box 743
Dayton, OH 45401
Phone: **1-844-607-2831** then follow the appropriate menu prompts for the authorization requests, depending on your need.

Services that Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. Prior authorization requirements by service type may be found on the CareSource website or on the searchable authorization lookup tool.

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

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

There will be two ways ordering health partners can obtain prior authorization from NIA for an imaging procedure:

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

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

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

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

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 health partner who is not a participating health partner with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource member.

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

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. Denials will be reconsidered through the appeal process with pertinent clinical records.

PRIOR AUTHORIZATION PROCEDURES

When requesting an authorization, please provide the following information:

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

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

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

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

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

When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Health partners must verify eligibility on the date the service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

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

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

For standard prior authorization decisions, CareSource provides notice to the health partner and member as expeditiously as the member's health condition requires, but no later than 7 calendar days following receipt of the request for service.

Urgent prior authorization decisions are made within 72 hours of receipt of request for service. Please specify if you believe the request is urgent.

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

Authorization Type	Decision	Extension
Standard Pre-service	Seven (7) calendar days	Fourteen (14) calendar days
Expedited Pre-service	Seventy-two (72) hours	Forty-eight (48) hours
Urgent Concurrent	Twenty-four (24) hours	Forty-eight (48) hours
Post service (Retrospective Review)	Thirty (30) calendar days	Fourteen (14) calendar days

DENTAL AUTHORIZATIONS

Dental authorization requests may be submitted via paper or online at **https://pwp.sciondental.com/PWP/Landing.**

Online:

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

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

Paper:

Paper dental authorization requests may be sent to:

CareSource
IN: Authorizations
P.O. Box 745
Milwaukee, WI, 53201

BILLING FOR SERVICES DENIED PRIOR AUTHORIZATION

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

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

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

- The waiver is signed only after the member receives the appropriate notification stated in requirements 3 and 4.
- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
- Health partners must not use nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.
- The waiver must specify the date the services are provided and the services that fall under the waiver's application.
- The health partner must have the right to appeal any denial of payment by CareSource for denial of authorization.

This policy should not be interpreted as interfering with a health partner's ability to hold HIP members liable for the emergency services co-payment or HIP Basic or HIP State Plan Basic member liability for allowable copayment amounts.

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

UTILIZATION MANAGEMENT

Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The Medical Management Department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the CareSource care management team are made, if needed. CareSource makes it's UM criteria available in writing by mail, fax or email and via the web.

Mail: CareSource
Attn: Medical Management Dept.
P.O. Box 743
Dayton, OH 45401
Fax: 844-432-8924
Email: INMedMgmt@caresource.com

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

Access to Staff

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

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

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

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

Our members' health is always our number one priority. Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations when an adverse decision has been rendered. You may request the information by calling or faxing the CareSource Medical Management Department. If you would like to discuss an adverse decision with a CareSource Clinical Peer Reviewer, please call the Medical Management Department at **1-844-607-2831** then state "extension" once the automated phone system completes the introduction. Please then ask for extension 12830. This request for the discussion with the Clinical Peer Reviewer needs to occur within five business days of the determination.

HEALTH PARTNER APPEALS PROCEDURE

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

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. Authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. For all procedures, in the event that you fail to obtain prior authorization, you will have 180 days from the date of service, date of discharge, or 90 days from the other carrier's EOB (whichever is later).

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

Please note: If you are appealing on our member's behalf with their written consent, you have up to 30 business days after the mailing of the initial determination notice.

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

POST STABILIZATION SERVICES

Please call **1-844-607-2831** for any questions related to post-stabilization services. The definition of "Post-Stabilization Care Services" is covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition. Prior Authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a participating health partner. To request prior authorization for observation services as a non- participating health partner or to request authorization for an inpatient admission please call **1-844-607-2831**. When calling, follow the prompt for post-stabilization. During regular business hours, your call will be answered by our Medical Management Department. If calling after regular business hours, the call will be answered by CareSource24, our nurse advice line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

AMERICANS WITH DISABILITIES ACT (ADA)

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

The CareSource health partner network will reasonably accommodate persons and ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. CareSource and its health partner network will comply with the ADA (28 C.F.R. 35.130) and the Rehabilitation Act of 1973 (29 U.S.C. 794) and will maintain capacity to deliver services in a manner that accommodates the needs of its members.

Please see the following pages for information about the ADA. More information on this subject may be obtained at **www.cdihp.org**.

Q. Which health partners are covered under the ADA?

A. Private hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists and health clinics are among the health partners covered by the Title III of the ADA. Title III applies to all private health partners, regardless of size. It applies to health partners of both physical and mental health care. If a professional office is located in a private home, the portion of the home used for public purposes is covered by the ADA.

Hospitals and other health care facilities that are operated by state or local governments are covered by Title II of the ADA. Health partners that offer training sessions, health education, or conferences to the general public must make these events accessible to individuals with disabilities.

POLICIES AND PROCEDURES

Health partners are required to modify policies and procedures when necessary to serve a person with a disability. The ADA, however, does not require health partners to make changes that would fundamentally alter the nature of their service.

Q. What kinds of modifications to policies or procedures might be required?

A. Modifying standard policies, practices or procedures can be an inexpensive but effective way to provide access to health care services. This may mean taking extra time to explain a procedure to a patient who is blind or ensuring that a patient with a mobility impairment has access to an accessible exam room.

EFFECTIVE COMMUNICATION, AUXILIARY AIDS AND SERVICES

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

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

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

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

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

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

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

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

A. If a patient or responsible family member usually communicates in Sign Language, an interpreter should be present in all situations in which the information exchanged is lengthy or complex (for example, discussing a patient's medical history, conducting psychotherapy, communicating before or after major medical procedures, and providing complex instructions regarding medication).

If the information to be communicated is simple and straightforward, such as prescribing an X-ray or a blood test, the physician may be able to communicate with the patient by using pen and paper.

EXISTING FACILITIES/BARRIER REMOVAL

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

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

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

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

COMPLAINTS

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

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

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

FREQUENTLY ASKED QUESTIONS

How can I reach CareSource?
Call Health Partner Services at **1-844-607-2831** to reach CareSource. Health Partner Services is available Monday through Friday, 8 a.m. to 8 p.m. Eastern Standard Time (EST). See the "Communicating with CareSource" section for more information.

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

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

How do I submit a claim?
CareSource accepts paper and electronic claims. We encourage you to submit electronic claims for quicker processing. Please see the "Claim Submission" section for more information.

How do I optimize my claim payment time frame?
Claims submitted electronically are typically received and processed more quickly than paper claims. Health partners may submit claims electronically through the CareSource Provider Portal or through Electronic Data Interchange (EDI) clearinghouses listed in the "Claim Submission" section. For paper claim submissions, we require the most current form versions as designated by the Centers for Medicare & Medicaid Services (CMS), National Uniform Billing Committee (NUBC) and the American Dental Association (ADA). We cannot accept handwritten claims or superbills.

How soon will I know if my claim was paid?
CareSource shall pay or deny electronically filed clean claims within 21 calendar days of receipt. A "clean claim" is one in which all information required for processing the claim is present. CareSource shall pay or deny clean paper claims within 30 days. If we fail to pay or deny a claim in those time frames and subsequently pay the claim, we will also pay interest. A claim being investigated for fraud, waste, or abuse or pending review for medical necessity is not considered a "clean claim." Payment notification is made via EOP.

Because of the large volume of claims that CareSource receives and processes, we ask for your cooperation in allowing at least 45 days from submission date before calling about a claim status or submitting a duplicate claim.

How do I file a claim appeal?
We hope you will be satisfied with CareSource and the service we provide. However, health partners who are unhappy with CareSource's action concerning a medical necessity decision or a claim payment may appeal it. Please see our Grievance and Appeals section for more information.

Can I bill my CareSource patients?
Generally, health partners enrolled in the Indiana Health Coverage Programs (IHCP) can bill members only under certain condition. See the Member Billing Policy section in the Claim Submission chapter for more information about billing CareSource members.

How do I obtain a prior authorization?
Prior authorizations for health care services can be obtained by contacting the Medical Management Department online, by email, phone, fax or mail:

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

Email: **INMedMgt@caresource.com**

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

Fax: Fax the prior authorization form to 844-432-8924. The prior authorization form can be found on **CareSource.com**.

Mail: Send prior authorization requests to:
CareSource
Attn: Medical Management Dept.
P.O. Box 743
Dayton, OH 45401

Is authorization needed to referrals to specialists?
Some health care services provided by specialists do not require a referral from a primary medical provider (PMP) or dental health partner. Members may schedule self-referred services from participating health partners themselves, provided the service is covered under their specific plan. PMPs or dental health partners do not need to arrange or approve these services for members as long as any applicable benefit limits have not been exhausted. A list of some of the services that do not require a referral may be found in the Referral Procedures section of the Referrals and Prior Authorizations chapter.

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

What benefits does CareSource offer its members?
Please visit the CareSource website at **CareSource.com** for information on services, including dental services, the member's coverage status and other information about obtaining services. For the most comprehensive and up-to-date list of CareSource covered benefits, please see the full CareSource Covered Benefits grid.

How do I make a referral?
Steps to Make a Referral:

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

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

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

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

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

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

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

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