What is MyCare Ohio?

MyCare Ohio is the state of Ohio’s Dual Demonstration. MyCare Ohio is a system of managed care plans selected to coordinate the physical, behavioral, and long-term care services for individuals over the age of 18 who are dually eligible for both Medicaid and Medicare. This includes people with disabilities, older adults and individuals who receive behavioral health services.

The MyCare Ohio program connects Medicare and Medicaid Benefits for Medicare-Medicaid Enrollees. The goal of MyCare Ohio program is to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees, including long-term services and supports.

MyCare Ohio stresses a team approach to health care. The care team includes the individual, the individual’s family and/or caregiver, the CareSource care manager, the waiver service coordinator (if appropriate) the primary care provider, specialists and other providers as appropriate to support and coordinate the member’s care.

CareSource MyCare Ohio is serving people in these Ohio counties:

- Columbiana
- Cuyahoga
- Geauga
- Lake
- Lorain
- Mahoning
- Medina
- Portage
- Stark
- Summit
- Trumbull
- Wayne

Purpose of this CareSource MyCare Ohio Section

The information provided within this section of the Provider Manual is to address provider issues specific to the CareSource MyCare Ohio plan. This information should be used in tandem with the provider information provided elsewhere throughout this manual. Please refer to other areas of this manual for provider information about traditional Medicaid and the CareSource Advantage® (HMO SNP) plan.

Providers of personal care, long-term support, home modifications, home caregivers and other similar services apart from physicians, physician assistants, hospitals and similar health care services will find this section particularly important for information about submitting claims for payment, appeals, certification, referrals and prior authorization for services.
Opting Out of CareSource MyCare Medicare Coverage

MyCare Ohio allows for individuals to Opt-out of Medicare Coverage from the plan managing their MyCare benefits. Individuals will have the option to have CareSource provide their Medicare benefits or to opt out of the Medicare portion of the program, and stay with their current Medicare Advantage plan or traditional Medicare.

Providers need to confirm the MyCare Ohio member’s option for Medicare coverage. If a member chooses a different plan for their Medicare benefits, CareSource will only manage Medicaid benefits, and will only reimburse claims for Medicaid services. Claims for Medicare must be submitted to the plan managing their Medicare benefits.

Therefore, it is important to verify member eligibility prior to each service rendered. Providers may use our secure Provider Portal on our website to check member eligibility, or call our Provider Services Department.

Provider Portal: https://providerportal.caresource.com/OH/
Click on “Member Eligibility” on the left, which is the first tab.

Provider Services Department: 1-800-488-0134

Quick Reference Information

Note – the information below is available from the Provider Website as a printable PDF file.

Important Phone Numbers:

Provider Services: 1-800-488-0134 M-F 8am – 6pm
Prior Authorizations: 1-800-488-0134 M-F 8am – 5pm
Claims Inquiries: 1-800-488-0134 M-F 8am – 6pm
Member Services: 1-855-475-3163 M-F 8am – 8pm
CareSource 24, 24-Hour Nurse Advice Line: 1-866-206-7861 24/7/365
TTY for the Hearing Impaired: 1-800-750-0750 or 711 M-F 8am – 8pm

Important Fax Numbers:

Case Management Referral: 1-877-946-2273
Credentialing: 1-866-573-0018
Fraud, Waste and Abuse: 1-800-418-0248
Medical Prior Authorization Fax: 1-888-752-0012
Provider Appeals: 1-937-531-2398
Provider Maintenance (e.g., office changes, adding/deleting a provider): 1-937-396-3076
Important Addresses:

<table>
<thead>
<tr>
<th>Category</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Correspondence</td>
<td>CareSource P.O. Box 8738 Dayton, OH, 45401-8738</td>
</tr>
<tr>
<td>Claims</td>
<td>CareSource P.O. Box 8730 Dayton, OH 45401</td>
</tr>
<tr>
<td>Medical Prior Authorizations</td>
<td>CareSource P.O. Box 1307 Dayton, OH 45401-1307</td>
</tr>
<tr>
<td>Fraud, Waste and Abuse</td>
<td>CareSource Attn: Special Investigations Department P.O. Box 1940 Dayton, OH 45401-1940</td>
</tr>
<tr>
<td>Provider Appeals</td>
<td>CareSource Attn: Provider Appeals P.O. Box 2008 Dayton, OH 45401-2008</td>
</tr>
<tr>
<td>Provider Demographic Changes</td>
<td>CareSource Attn: Provider Maintenance P.O. Box 8738 Dayton, OH 45401-8738</td>
</tr>
<tr>
<td>Member Appeals &amp; Grievances</td>
<td>CareSource Attn: Member Appeals P.O. Box 1947 Dayton, OH 45401</td>
</tr>
</tbody>
</table>

Web Services:
Website = CareSource.com
Secure Provider Portal = https://providerportal.caresource.com

EDI: CareSource Payer ID = 31114

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emdeon</td>
<td>1-800-845-6592</td>
<td><a href="http://www.emdeon.com">www.emdeon.com</a></td>
</tr>
<tr>
<td>Quadax</td>
<td>1-440-777-6300</td>
<td><a href="http://www.quadax.com">www.quadax.com</a></td>
</tr>
<tr>
<td>Relay Health</td>
<td>1-800-527-8133 Opt 2</td>
<td><a href="http://www.relayhealth.com">www.relayhealth.com</a></td>
</tr>
<tr>
<td>CPS (Emdeon)</td>
<td>1-888-255-7293</td>
<td><a href="http://www.cpsedi.com">www.cpsedi.com</a></td>
</tr>
<tr>
<td>ZirMed</td>
<td>1-877-494-7633</td>
<td><a href="http://www.zirmed.com">www.zirmed.com</a></td>
</tr>
</tbody>
</table>

EFT Enrollment: Instamed – Call 1-215-789-3682; Note: In order to receive EFT payment from CareSource (Medicaid Managed Care Organization), you must enroll with Instamed.

Other Network Contact Information

<table>
<thead>
<tr>
<th>Category</th>
<th>Address</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology</td>
<td>NIA</td>
<td>Online: <a href="http://www.RADMD.com">www.RADMD.com</a></td>
</tr>
</tbody>
</table>
Services That Require Prior Authorization:

- All Abortions
- All Home Care Services
- All Inpatient Care
- All Intensive Outpatient Program services
- All Partial Hospital Program services
- Assertive Community Treatment (ACT)
- Ambulance transportation – except for emergent or facility-to-facility transfers
- Chiropractic Visits greater than 12 per calendar year
- Community Psychiatric Supportive Treatment (CPST)
- Cosmetic procedures and plastic surgery
- Day Treatment
- Durable Medical Equipment over $750.00 billed charges
- All powered or customized wheelchairs
- Manual wheelchair rentals over three months
- All miscellaneous codes (ex: E1399)
- Hospice Care
- Mental Health visits greater than 10 per calendar year
- Non-emergent diagnostic imaging procedures:
  - CT/CTA scans
  - MRI/MRAs
  - PET scans
- Non-Formulary Drug Requests
- Nursing Facility Services
- Occupational Therapy visits greater than 20 per calendar year
- Organ Transplants
- Pain Management Services
- Physical Therapy visits greater than 20 per calendar year
- Podiatry office visits greater than 8 per calendar year
- Orthotics/Prosthetic devices over $750.00 billed charges
- Some Dental Services
- Some Part B and Part D drugs
- Speech Therapy visits greater than 15 per calendar year
- Substance abuse services greater than 12 per calendar year

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

NOTE – All Waiver Services require Prior Authorization

Model of Care Training

CareSource has created a web-based information training module that can be accessed at the CareSource Provider web site. Visit CareSource MyCare Ohio Model of Care Training.

This training module will provide the background information you need to understand the CareSource MyCare Ohio model of care.

CareSource Member ID Card

All new CareSource MyCare Ohio members receive a membership ID card, which replaces the state Medicaid card. If the member has selected CareSource to provide both their Medicare and Medicaid benefits, they will have a single ID card replacing both their state Medicaid and their Medicare Card. These members will require only one card for both plans.

However, if a member does not select CareSource to provide their Medicare benefits, they will continue to use the card for their selected Medicare plan.
Providers need to confirm the MyCare Ohio member’s option for Medicare coverage. If a member chooses a different plan for their Medicare benefits, CareSource will only manage Medicaid benefits, and will only reimburse claims for Medicaid services. Claims for Medicare must be submitted to the plan managing their Medicare benefits.

Therefore, it is important to verify member eligibility prior to each service rendered. Providers may use our secure Provider Portal on our website to check member eligibility, or call our Provider Services Department.

Provider Portal: https://providerportal.caresource.com/OH/
Click on “Member Eligibility” on the left, which is the first tab.

Provider Services Department: 1-800-488-0134

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.

CareSource MyCare Ohio Medicare-Medicaid Member ID Card

Back of MyCare Ohio Medicare-Medicaid Member ID Card
How to Submit Claims for Reimbursement / Claims Appeals

All claims for reimbursement or appeals for claim denials should be submitted electronically through our secure Provider Portal on our website. The Portal can be accessed at CareSource.com/MyCare. Click on “Providers and the link for “Provider Portal.”

**Video instructions for submitting claims** can be found at the provider website and at the portal.

To access the Provider Portal: **https://providerportal.caresource.com/OH/**

**How to Submit Clinical Appeals**

There are three ways to submit clinical appeals, through our Provider Portal, by fax or in writing:

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

Fax: 937-531-2398 8 a.m. to 6 p.m. Monday through Friday Eastern Standard Time.

Writing: CareSource
   Attn: Provider Appeals – Clinical
   P.O. Box 2008
   Dayton, OH 45401-2008
Certifications and Provider Sanctions

Provider Network

Credentialing process: network facilities/services
It is the policy of CareSource to ensure the quality and qualifications of professionally licensed practitioners and organizational providers through a credentialing and re-credentialing process which complies with regulatory and accreditation standards. Please see the Credentialing Chapter in the current Ohio Provider Manual for full details and explanations located at https://www.caresource.com/providers/

The ultimate goal of the Credentialing Program is to ensure the highest quality of care for our members. CareSource, for the purpose of the Credentialing program and bringing and retaining providers on our panel, embraces the Institute of Medicine’s definition as “Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Prohibited Affiliations
Revocation of licensure will result in immediate termination of the contract between the provider and CareSource. Provider Relations staff will assist in obtaining the provider’s attestation that there are no Provider Employees who have been debarred, suspended or have been criminally convicted and that the provider will notify CareSource of any changes in ownership. The Credentialing Department will monitor the Provider Attestations upon re-credentialing. Should an adverse determination be made against a provider either during the time of re-credentialing, or between credentialing cycles, for quality of care and/or service, the provider is given the determination in writing and provided with the appeal process. Depending on the reason for the determination, CareSource notifies the appropriate authorities.

Any providers found to be noncompliant with CareSource credentialing requirements will be given the opportunity to provide explanation for the noncompliant area. The information will then be presented to the Credentialing Committee for review and determination of panel status. Action may be taken based on the data collected. Examples of action taken include continuation in the program, required participation in continuing education, required supervision, a clear plan for improvement with the practitioner, evidence of changes in the scope of practice, or termination of the practitioner from the program.

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

Providers: Home and Community-Based Services Waiver Programs
The Ohio Department of Aging (ODA) is responsible for the certification of providers who provide services for Medicaid waiver programs administered through the Community Long-Term Care Division. In addition to holding a Medicaid
provider Agreement, providers of services must meet Ohio Administrative Code 173-39-02 Conditions of participation.

Provider sanctions are specifically addressed in the Ohio Administrative Code 173-39-05, Disciplinary Actions.

**OAC Waiver Rules**

Providers are obligated to abide by the regulations and policies of the state. They must read and understand all Ohio Administrative Code (OAC) rules that pertain to their provider type and the services they deliver.

The following OAC chapters can be used as reference for providers.
- State plan home health and private duty nursing services
  - Chapter 5101:3-12, Ohio Home Care Program
- Waiver providers and services
  - Chapter 5101: 3-45, Administered Waiver Service Providers
  - Chapter 5101:3-46, Ohio Home Care Waiver
  - Chapter 5101:3-50, Transitions Carve-out Waiver

There are multiple additional state websites that will be helpful to providers. They include the following:
- ODJFS Main Website
  - [http://jfs.ohio.gov](http://jfs.ohio.gov)
- ODJFS Consumer Website
  - [http://medicaid.ohio.gov/](http://medicaid.ohio.gov/)
- ODJFS Provider Website
  - [http://medicaid.ohio.gov/providers.aspx](http://medicaid.ohio.gov/providers.aspx)
- MITS (Medicaid Information Technology System) Website
  - [http://medicaid.ohio.gov/providers/mits.aspx](http://medicaid.ohio.gov/providers/mts.aspx)
- MITS eTutorial Website
  - [http://www.odjfs.state.oh.us/tutorials/MITs-External-Training](http://www.odjfs.state.oh.us/tutorials/MITs-External-Training)
- eManuals
  - [http://emanuals.odjfs.state.oh.us/emanuals](http://emanuals.odjfs.state.oh.us/emanuals)

Providers need to be aware pursuant to section 173.391 of the Revised Code, “ODA (or ODA’s designee) may take disciplinary action against a provider for good cause, including misfeasance, malfeasance, nonfeasance, confirmed abuse or neglect, financial irresponsibility or any conduct ODA determines in injurious or poses a threat, to the health, safety, or welfare of the consumers of the provider’s services”.

Providers are encouraged to review and be familiar with Chapter 173-39-05, “Disciplinary Actions” for the definitions including and not limited to Level-one disciplinary action, Level-two disciplinary action, Level-three disciplinary action, and Appeals.

**Fraud, Waste and Abuse**

**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: 1-800-488-0134 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: 1-800-418-0248
- Email: fraud@caresource.com
- Or you may choose to use the Fraud, Waste and Abuse Reporting Form located at CareSource.com.

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

To assure all enrollees receive safe, reliable care, CareSource utilizes an Incident Management reporting system. This system allows CareSource to identify and report enrollee issues referred as “Incidents”. Examples of an Incident include issues such as enrollee falls, thefts, complaints of or dissatisfaction with their care provider, complaints of abuse or neglect, and even enrollee’s death.

Some incidents require CareSource to investigate the issue and report it to CMS and the state within 24 hours. At times, local law enforcement may be called to be involved. All incidents are monitored for trends.

Allegations of possible provider Fraud, Waste and Abuse are also investigated and reported by CareSource’s Special Investigations Unit (SIU). Appropriate actions are taken by SIU and reported to the appropriate authorities.

For more information about Fraud, Waste or Abuse, please see refer to the Fraud, Waste and Abuse chapter of this manual.

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.

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

Referrals
If you have questions about referrals and prior authorizations, please call our Medical Management Department at 1-800-488-0134.

Medicare Referral Procedures

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

If you have difficulty finding a specialist for your member, please call our Provider Services Department at 1-800-488-0134 and select the option to speak to someone in our Medical Management Department.

Please note that members may go to non-participating providers for:
• Emergency care
• Out of area dialysis care
• Out of area urgently needed care

Services Rendered by Out-of-Plan Providers – A member may be sent to out-of-plan providers if the member needs medical care that can only be received from a doctor or other health care provider who is not participating with our health plan. PCPs must get prior authorization from our health plan before sending a member to an out-of-plan provider. You can request prior authorization by calling our Medical Management Department at 1-800-488-0134, and select the prompt to request prior authorization.

Second Opinions – A second opinion is not required for surgery or other medical services. However, health care providers, or members may request a second opinion at no cost to the member other than applicable co-payments, coinsurance and deductibles. The following criteria should be used when selecting a provider for a second opinion:
• The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a non-participating provider (see the “Prior Authorization” section below).
• The provider must not be affiliated with the member’s PCP or the specialist practice group from which the first opinion was obtained.
• The provider must be in an appropriate specialty area.
• Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.
Medicaid Services That Do Not Require a Referral

Some health care services provided by specialists do not require a referral from a Primary Care Provider (PCP). Members may schedule self-referred services from participating providers themselves. PCPs 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 Midwife (CNM) services
- 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 (for example Planned Parenthood)
- Laboratory services (must be ordered by a participating provider)
- Podiatric care
- Psychiatric care at Community Mental Health Centers only
- Psychological care (from private practitioners or at Community Mental Health Centers)
- Care at public health clinics
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Most radiology services (must be ordered by a participating provider)
- Routine eye exams (at participating vision centers, within benefit limits)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours

Medicaid Members May Go to Non-Participating Providers For:

- Emergency care
- Care at Community Mental Health Centers
- Family planning services provided at Qualified Family Planning Providers (for example Planned Parenthood)
- Care at FQHCs and RHCs
- Care at Ohio Department of Mental Health and Addiction Services (MHA) facilities that are Medicaid providers

Medicaid 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. You can request a prior authorization by calling our Medical Management Department at 1-800-488-0134, 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 Provider Services Department at 1-800-488-0134.
Medicaid 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 PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure.

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

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

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

The following criteria should be used when selecting a provider for a second opinion:
- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a non-participating provider.
- The provider must not be affiliated with the member’s PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

**Services that Require Prior Authorization**

Services are provided within the benefit limits of the member’s enrollment. They include, but are not limited to the following services:
Medical Services That Require Prior Authorization

Services are provided within the benefit limits of the member’s enrollment. They include, but are not limited to the following services:

- All Inpatient Care
- All Abortions
- All Home Care Services
- Nursing Facility Services
- Hospice Care
- Organ Transplants
- Durable Medical Equipment over $750.00 billed charges
- Prosthetic and Orthotic devices over $750.00 billed charges
- Cosmetic procedures and plastic surgery
- Partial Hospitalization
- Hearing aids
- Ambulance transportation – except for emergent or facility-to-facility transfers
- Ambulette transportation
- Physical Therapy visits greater than 20 per calendar year
- Occupational Therapy visits greater than 20 per calendar year
- Speech Therapy visits greater than 15 per calendar year
- Chiropractic Visits greater than 12 per calendar year
- Mental Health/Psychiatry visits greater than 10 per calendar year
  - ACT
  - CPST
- Podiatry office visits greater than 8 per calendar year
- Substance abuse services greater than 12 per calendar year
- Outpatient diagnostic/therapeutic radiology services:
  - CT, CTA
  - MRI, MRA
  - PET Scans

Some dental services require prior authorization; please reference our Dental Handbook online at CareSource.com under Provider Materials.

In addition, any health care provider who is not a participating provider with CareSource must obtain prior authorization for all non-emergency services provided. (For example: Tobacco Cessation Counseling for Pregnant Women, Freestanding Birth Center Services, Outpatient hospital services, ambulatory surgical center services, Specialists...)

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.

Please note that our prior authorization requirements are subject to change. Please refer to the CareSource.com for the most current information on services that require prior authorization and the prior authorization process.

EPSDT is a federally-mandated program of comprehensive preventive health services available to Medicaid-eligible persons from birth through twenty years of age. EPSDT is designed to maintain health by providing early intervention to discover and treat health problems. The scope of services provided to an individual depends on the individual’s age, gender, family medical history, ethnic background,
or findings of the EPSDT screening or other covered medical services. When an
EPSDT screening visit indicates the need for further evaluation, diagnosis, and/or
treatment, and the service requires prior authorization, providers can request prior
authorization to exceed coverage or benefit limits for members under the age of 21.
All requests will be reviewed for medical necessity.

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

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

Email: mmauth@caresource.com

Fax: Fax the prior authorization form to 1-888-752-0012. The prior authorization

Mail: Send prior authorization requests to:

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

Phone: 1-800-488-0134 and follow the appropriate menu prompts for the

When requesting an authorization, please provide the following information:

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

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

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. Authorizations are not a guarantee
of payment. Providers 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.
Benefits may be subject to limitations and/or qualifications and will be determined
when the claim is received for processing.
All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the provider. CareSource will notify you of prior authorization determinations by a letter mailed to the provider’s address on file.

For standard prior authorization decisions, CareSource provides notice to the provider and member as expeditiously as the member’s health condition requires, but no later than 14 calendar days following receipt of the request for service. Urgent prior authorization decisions are made within 72 hours of receipt of request for service. Please specify if you believe the request is urgent.

**Utilization Management (UM)**

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

**Mail:** CareSource  
P.O. Box 1307  
Dayton, OH 45401-1307  
**Fax:** 1-888-752-0012  
**Email:** mmauth@caresource.com

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

**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 care providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician’s medical judgment about individual patients. CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. CareSource also has a medical policy developed to supplement nationally recognized criteria. If a patient’s clinical information does not meet the criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health care providers or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.
Our members' health is always our number one priority. Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations. You may request the information by calling or faxing the CareSource Medical Management Department. If you would like to discuss an adverse decision with CareSource's physician reviewer, please call the Medical Management Department at **1-800-488-0134, ext: 2830**, within five business days of the determination.

**Provider 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. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. In the event that you fail to obtain prior authorization, you will have 180 days from the date of service, date of discharge, or 90 days from the other carrier’s EOB (whichever is later).

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.

A request for retrospective review can be made by contacting the Medical Management Department at **1-800-488-0134** and following the appropriate menu prompts, or by faxing the request to **1-888-527-0016**. Clinical information supporting the request for services must accompany the request.

**Please note:** If you are appealing on our member's behalf with their written consent, you have up to 90 days to request the appeal from date of service, discharge date or date of the denial if the service is not yet rendered (whichever is later).

**Post Stabilization Services**

Please call **1-800-488-0134** for any questions related to post-stabilization services. The definition of “Post-Stabilization Care Services” is covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition. Prior Authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a participating provider. To request prior authorization for observation services as a non-participating provider or to request authorization for an inpatient admission please call **1-800-488-0134**. 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 CareSource 24, our nurse triage line. “Post-Stabilization Care Services” are defined by 42 C.F.R 422.113.