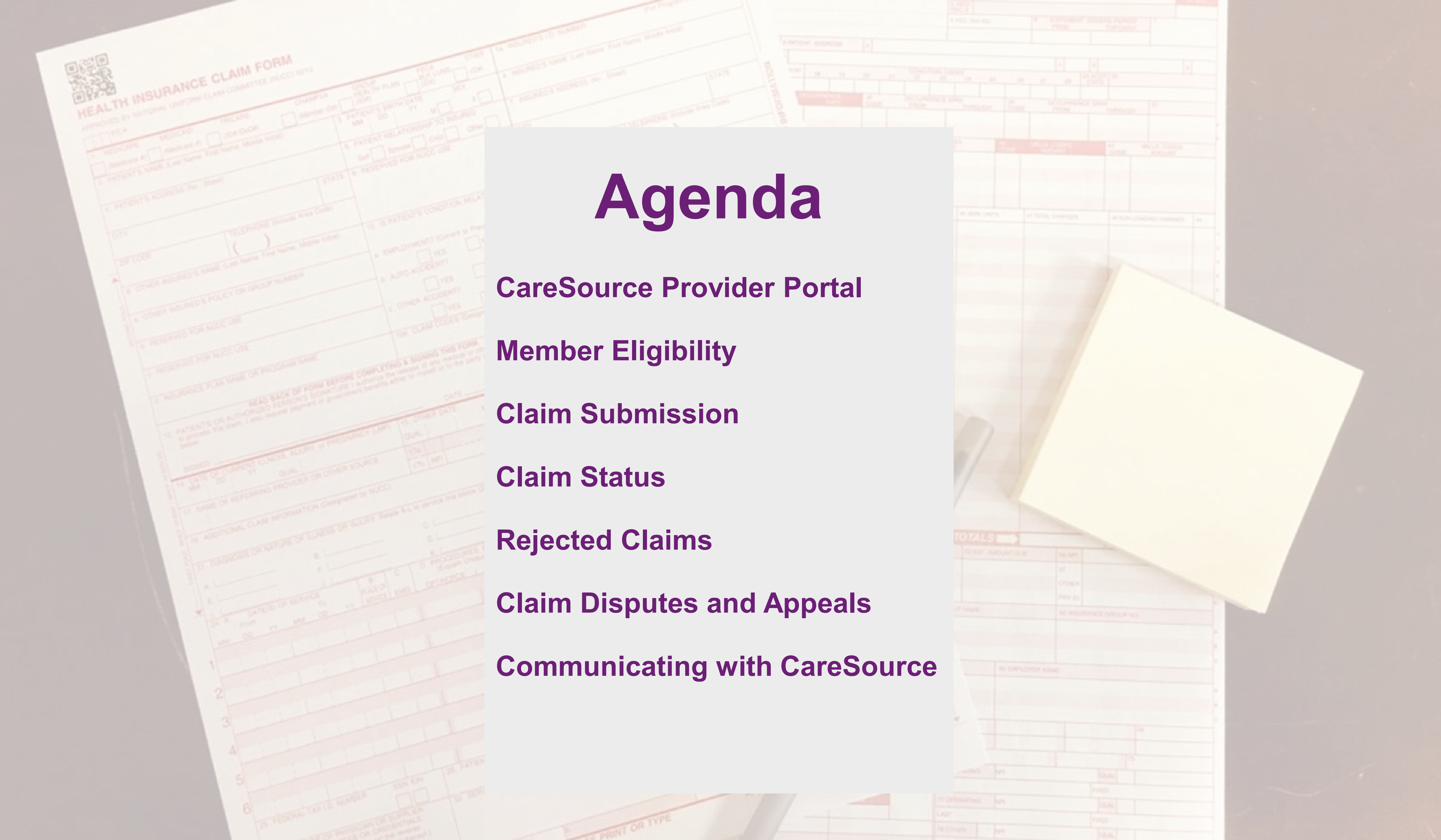
Claims

Presented by the CareSource Health Partner Engagement Specialists

CareSource®

2024 IHCP Works Annual Seminar



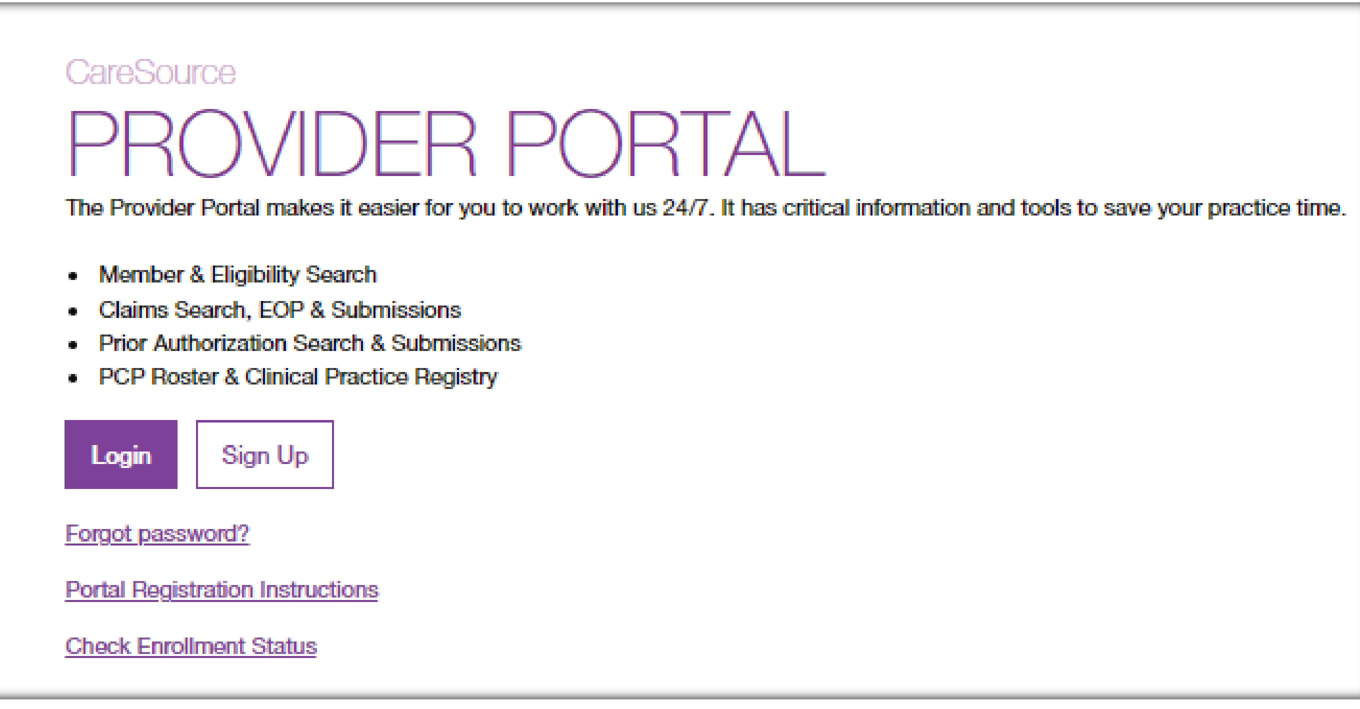
Agenda

- CareSource Provider Portal
- Member Eligibility
- Claim Submission
- Claim Status
- Rejected Claims
- Claim Disputes and Appeals
- Communicating with CareSource

CareSource Provider Portal

Register for the Provider Portal

Go to CareSource.com. Click Provider from the Log-in drop-down.
Select **Indiana.**
Click Register For an Account under **Provider Portal Login.**
Enter your information, including your CareSource Provider Number (located in your welcome letter).
Follow remaining steps to register.



For issues with the Provider Portal contact CareSource Provider Services: **1-844-607-2831**

Benefits of CareSource Provider Portal

SAVE TIME AND MONEY

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

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

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

Provider Portal Training

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

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

USER GUIDE

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

Member Eligibility

Provider Network & Eligibility

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

OUT OF NETWORK SERVICES

Out-of-network services are NOT covered unless they are emergency services, services prior authorized by CareSource, or services considered by IHCP as "self-referral."

Provider Network & Eligibility Continued

MEMBER ELIGIBILITY

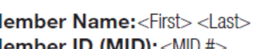
Be sure to ask to see each patient's CareSource member ID to ensure you take their plan. Confirm which CareSource plan the member is asking that you accept. Providers can confirm eligibility in our system to validate the member's coverage.

NOTE: For HHW/HIP members routine vision services are covered through Superior Vision. Provider eligibility to accept CareSource members can be confirmed in the CareSource Provider Portal.

ID Cards: Medicaid Members

HOOSIER HEALTHWISE

Hoosier Healthwise



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

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

CareSource Rxinnovations

RxBIN - 003858
RxPCN - MA
RxGRP - RXINN01

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

EMERGENCIES:
FOR EMERGENCIES CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM (ER)
If your health event is not life-threatening and you are not sure about going to the ER, call the RNs at **CareSource24®, Nurse Advice Line for help** at 1-844-206-5947 (TTY: 1-800-743-3333 or 711).

BEHAVIORAL HEALTH CRISIS LINE: 1-833-227-3464
ESI PHARMACY HELP DESK: 1-800-416-3632
PROVIDER SERVICES: 1-844-607-2831

RR2022-IN-MED-M-908313

HEALTHY INDIANA PLAN

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

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

CareSource Rxinnovations

RxBIN - 003858
RxPCN - MA
RxGRP - RXINN01

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

EMERGENCIES:
FOR EMERGENCIES CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM (ER)
For non-emergency visits to the ER, an $8 copay may apply. If your health event is not life-threatening and you are not sure about going to the ER, call the RNs at **CareSource24®, Nurse Advice Line for help** at 1-844-206-5947 (TTY: 1-800-743-3333 or 711).

BEHAVIORAL HEALTH CRISIS LINE: 1-833-227-3464
ESI PHARMACY HELP DESK: 1-800-416-3632
PROVIDER SERVICES: 1-844-607-2831

Other co-payments may apply. Review member handbook or contact Member Services for specific amounts.

RR2022-IN-MED-M-908350

Check Eligibility

Member Eligibility

Recipient Id	CareSource Id	Member Info	Multiple Recipient Ids	Multiple CareSource Ids

Offers ability to search by member information: first name, last name, and date of birth.

Recipient Id:

Date of Service 6/25/2024

Search

Member is eligible for service on the specified date

Use Recipient ID tab to search by the member's Medicaid number.

Contained demographic details on the searched member.

Member Information

Eligibility Response will be blue (see above) if member is eligible. If member is not eligible the red box below will display.

Member is not eligible for service on the specified date

Member Billing

BALANCE BILLING

State and federal regulations prohibit providers from billing CareSource members for services provided to them except under limited circumstances. CareSource monitors this activity based on our reports of billing from members.

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

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

Member billing exceptions can be found in the IHCP Provider Enrollment Module

Member Billing Continued

Charging for Missed Appointments

IHCP providers may not charge IHCP members for missed appointments. This policy is based on the reasoning that a missed appointment is not a distinct reimbursable service, but a part of the provider's overall costs of doing business. The Medicaid rate covers the cost of doing business, and providers may not impose separate charges on members. In addition, in accordance with 405 IAC 5-25-2, the IHCP will not reimburse a physician for missed appointments.

Member billing exceptions can be found in the IHCP Provider Enrollment Module

CareSource Member Benefit Information

VISIT CARESOURCE.COM FOR MORE DETAILS ON:

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

Member Communication

HELP YOUR CARESOURCE PATIENTS UNDERSTAND THEIR COVERAGE.

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

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

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

Claim Submission

Claim Submission Timelines

Initial Claim Contracted Provider	90 calendar days from date of service or discharge to submit a clean claim.
Initial Claim Non-Contracted Provider	180 calendar days from date of service or discharge to submit a clean claim.
Secondary Claims	90 calendar days from the date of the primary payer's explanation of payment (EOP) to submit a clean claim.
Corrected Claim	60 calendar days from the date of the EOP to submit a corrected claim.
Newborn	Same timely filing guidelines apply for newborns. Newborns receiving retroactive coverage are not subject to timely filing requirements.

Denied Claim Clarification on Filing Limit

CareSource will not be able to pay a claim if there is incomplete, incorrect, or unclear information on the claim, as the claim will be denied.

A corrected claim may be submitted for the denied claim with corrected information. For processing this is still considered an initial claim and will be subject to 90 day filing limit, from original date of service or discharge.

3 Ways to Submit Claims to CareSource

1 Electronically

- EDI transaction sent to CareSource through Availity. For list of EDI vendors who transmit to Availity EDI Gateway, click **here**.
- CareSource Payer ID **INCS1**
- Availity's Client Services
  1-800-282-4548

2 Portal

- Medical claims can be keyed on the CareSource Provider Portal.
- Medical Claim forms (1500/UB04) can be uploaded.
- Upload attachments for both keyed claims and uploaded claims forms.

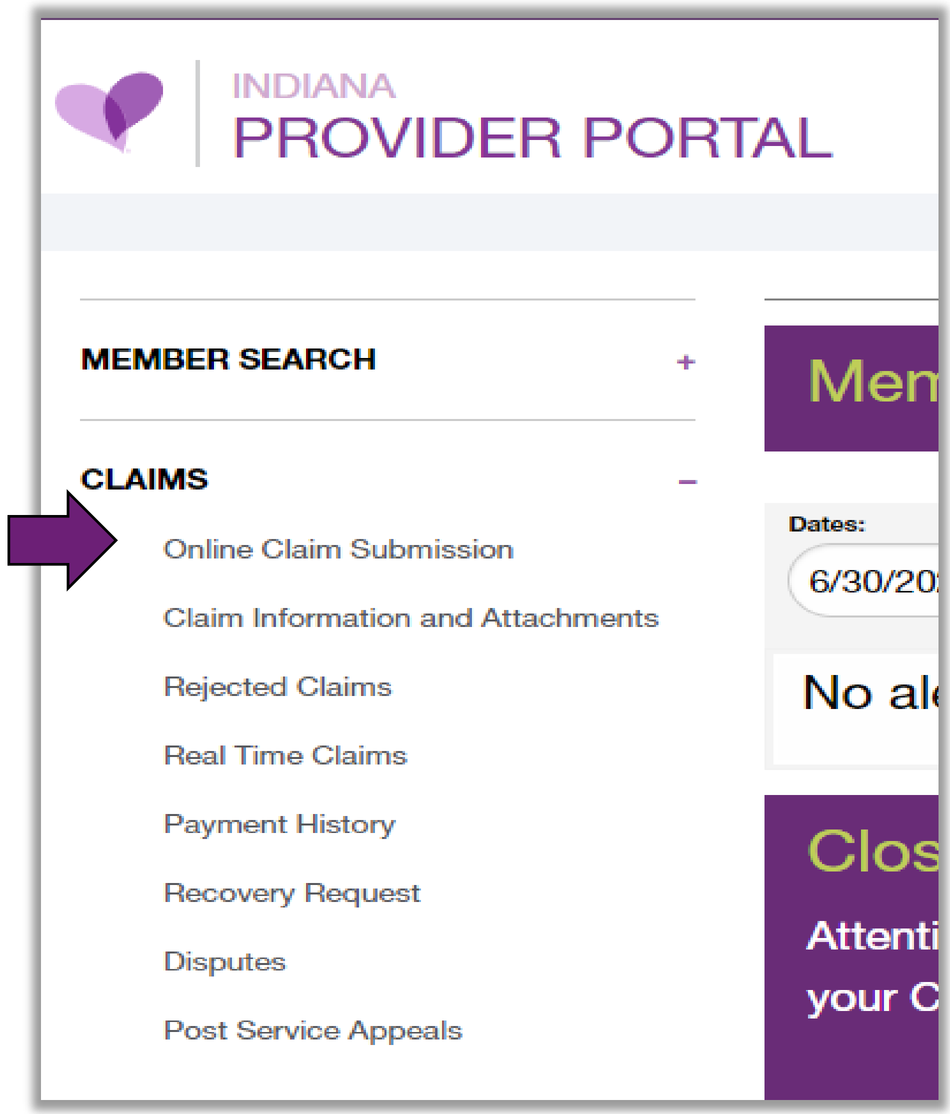
3 Mail

- Ensure printing is aligned to the form and legible.
- Paper claims have the same NPI, TIN, and taxonomy code requirements as electronic claims.
- Mail claims to:
  CareSource
  Attn: Claims Department
  P.O. Box 3607
  Dayton, OH 45401

Portal Claim Submission

Menu on the left side of screen

- Navigate to **CLAIMS**
- Expand the menu options
- Click on **Online Claim Submission**



Portal: Create Online Claim

Providers can key CMS-1500, UB-04 claims directly to CareSource. Attachments can be uploaded to your keyed claim

CLAIMS + New HCFA Claim + New UB Claim + New Dental Claim Upload Claim + Reports

HCFA Claims (0) UB Claims (0) Dental Claims (0)

SEARCH CLAIMS

Select filters Clear text

SUBMISSION DATE: Start Date (MMDDYYYY) End Date (MMDDYYYY) CLAIM ID: Type Claim ID INSURED ID: Type Insured Id STATUS: Select status DCN: Type DCN Search

Instead of submitting paper claims by mail, consider uploading on the CareSource Provider Portal

- Saves money on postage
- No lost or delayed mail
- Receive a claim ID for tracking uploads
- Attachments can be uploaded with claim

Portal Create Online Claim Continued

Online Claim form fields are the same as standard paper claims.

HCFA Claims > New

NEW HCFA CLAIM

Fill Healthcare Financing Administration form (CMS-1500).

Form | Attachments

Click on **Attachments** tab to upload supporting claims documents.

1. MEDICARE (MEDICARE #) | MEDICAID (MEDICAID #) | TRICARE (ID# / DOD#) | CHAMPVA (MEMBER ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

2. PATIENT'S NAME

LAST NAME: LAST NAME
FIRST NAME: FIRST NAME
MID. NAME: MIDDLE NAME
GENERATION: JR

3. PATIENT'S BIRTH DATE AND SEX

BIRTH DATE: MMDDYYYY
SEX: MALE / FEMALE

5. PATIENT'S ADDRESS (NO. STREET)

ADDRESS (NO., STREET): ADDRESS
ADDRESS II: ADDRESS 2
CITY: CITY
STATE: STATE
ZIP CODE: ZIP CODE

6.PATIENT'S RELATIONSHIP TO INSURED

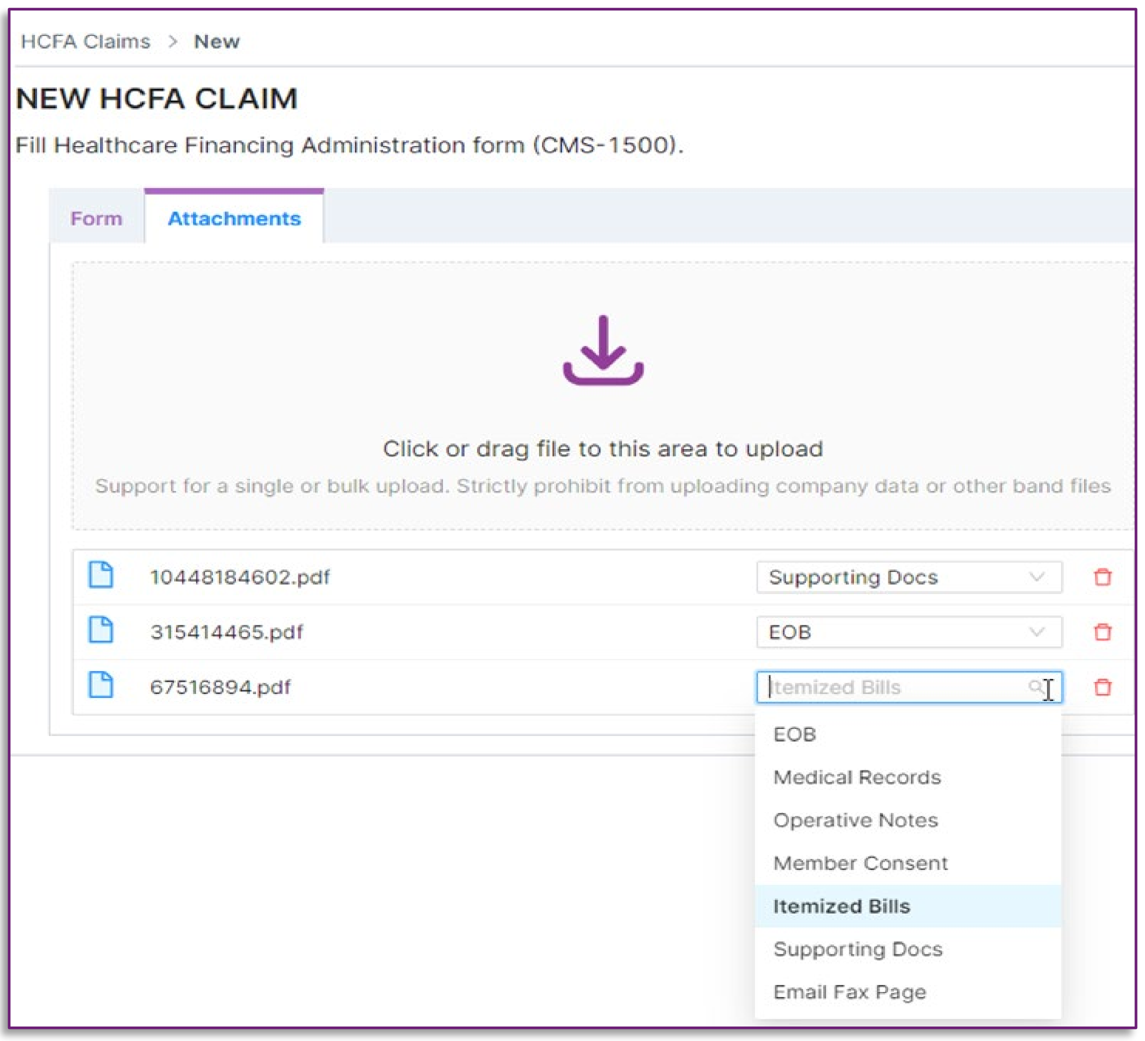
SELF / SPOUSE / CHILD

8. RESERVED FOR NUCC USE

NUCC

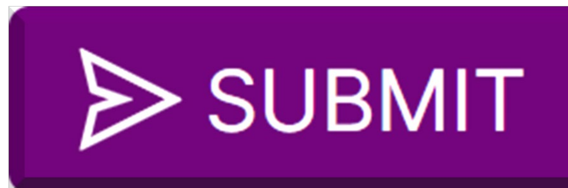
Uploading Attachments

- Click or drag single or multiple files to upload area.
- Use drop down on file to label the time of file uploaded.
- Files uploaded can be deleted by clicking on the red trash can to the right of the file.



Save VS. Submit

- Click **SAVE** if you are not ready to submit claim but want to come back and finish entering your claim information.
- Date of saved draft does not equal filing date of claim.
- Save copy of the claim ID for your records. This can be used to pull back up your claim when you are ready to finish.

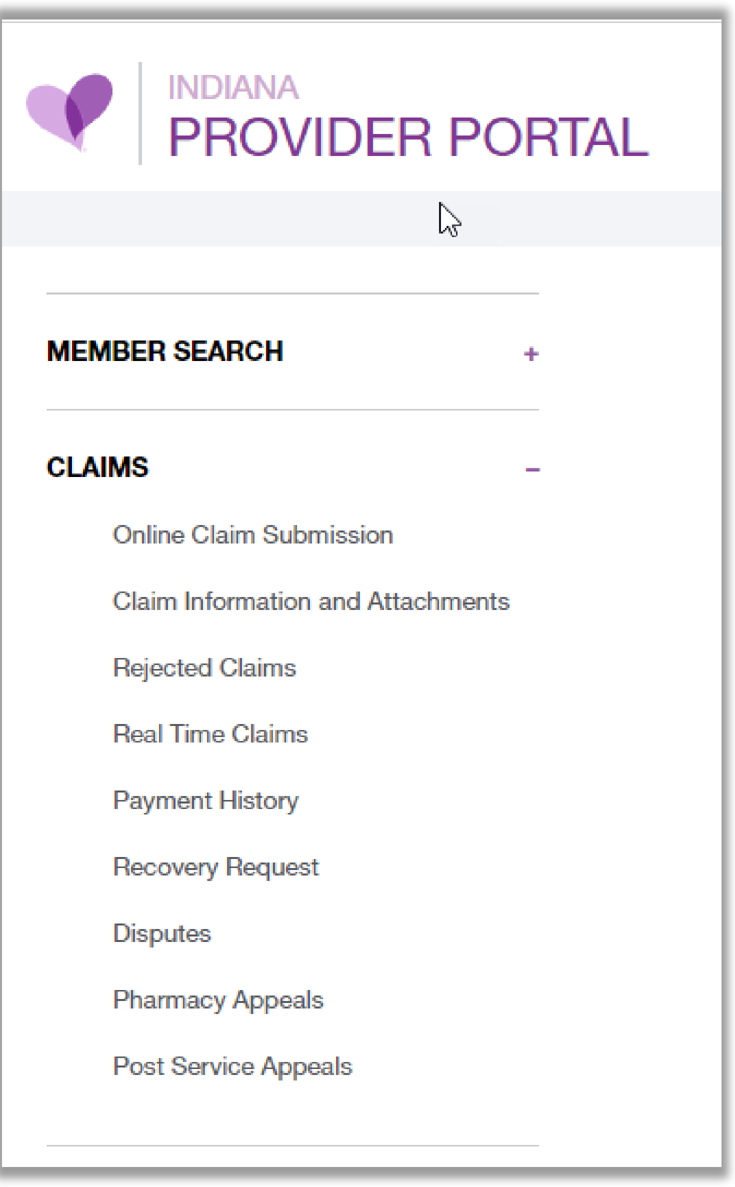


- Click **SUBMIT** when you are ready to submit your claim.
- All required fields must be completed prior to submitting claim or you will receive an error message.
- Date the claim is submitted on the CareSource Portal is your filing date.
- Save your Claim ID provided to check status of claim in **Online Claims Submission.**

Claim Status

Claim Information

Claim information including submission, status, and more can be located under the Claims menu from the left navigation.



Claim Search and Details

Claim Information and Attachments

Recent Claims | Claim Search | Active Credit Balance

Search by: Recipient ID

- Recipient ID
- CareSource ID
- Member Info
- Patient Number
- Check Number
- Claim Number
- External Reference Number

Recipient Id: *

Claim Summary

Claims | Claim Attachment

Page(s): 1 2 3 4 5 6 7 8 9 10 ...

Details	Claim Number	Status	Type	Received	DOS	CareSource Id	Servicing Provider
View Details		Pending	M	07/03/2024	07/02/2024		
View Details		Pending	M	07/03/2024	07/02/2024		
View Details		Pending	M	07/03/2024	07/02/2024		
View Details		Pending	M	07/05/2024	07/02/2024		
View Details		Pending	M	07/03/2024	07/02/2024		
View Details		Pending	M	07/05/2024	07/02/2024		
View Details		Pending	M	07/05/2024	07/02/2024		
View Details		Pending	M	07/05/2024	07/02/2024		
View Details | Original EOP		Processed	M	07/03/2024	07/02/2024		

Page(s): 1 2 3 4 5 6 7 8 9 10 ...

Export Claims List: CSV

Claim information and details may be located by searching for the claim by:

- Recipient ID
- CareSource ID
- Member Info
- Patient Number
- Check Number
- External Reference Number
- All Claims

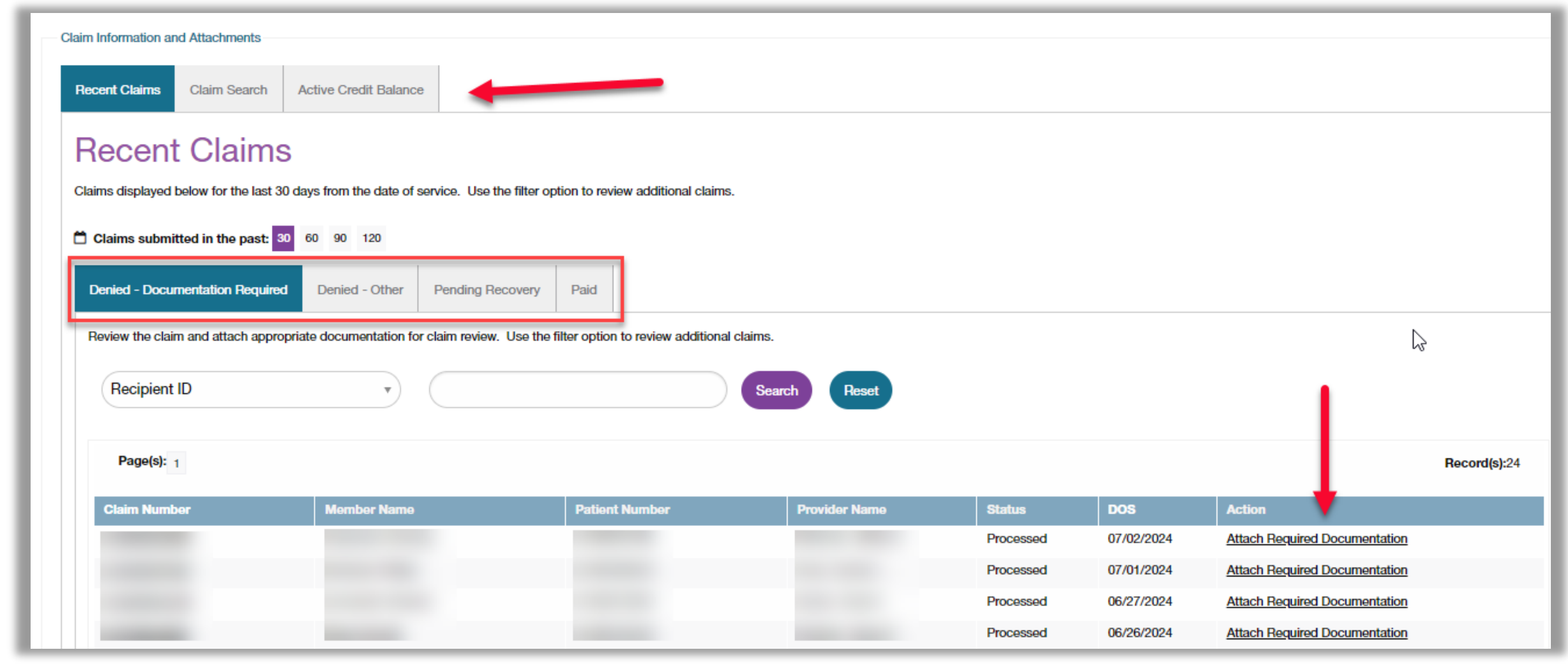
Once a claim has been located, click *View Details* to see additional information about the claim and processed status.

Recent Claims Dashboard

A feature available on the Provider Portal, called <u>*Recent Claims*</u>, is where you may see a consolidated view of recent claims.

This includes:

- Claims requiring documentation
- Denied Claims
- Pending Recoveries
- Paid Claims



Claim Documentation Attachments and Uploads

Documentation including medical records, explanation of benefits, etc. can be uploaded for future or processed claims. This can be completed by:

- Locating the claim and clicking the Document Upload tab.
- If the claim has not been submitted, an attachment can be uploaded by completing the *Claim Attachment* form.

NOTE: It is best to submit your claim number along with you
the attachments. For example, an attachment uploaded on 3

To upload attachments applicable to a previously submitted

File sizes must be limited to 100 MB.
Only files of types: bmp, png, tiff, jpeg, txt, pdf, xls, xlsx, doc

Files Uploaded:

Delete Selected

Claim Attachment Form

Do you have a claim number? Yes / No

Member CareSource ID:

Service Date * Required

Submission Reason: --Select Reason-- * Required

Provider Contact Email: * Required

Notes:

General Information

Claim #:		Date Received:	4/10/2023
Adjusted From Claim #:		Total Amount Charged:	$197.00
Adjusted To Claim #:		Total Patient Responsibility:	$0.00
Original Claim #:		Patient Account #:	
Processed Date:		Rendering Provider Name:	
Check Number:		Authorization Number:	-
Adjustment Amount:		Remaining Balance Due:	$0.00
Total Amount Paid:			

Claim Detail

List View | Table View | Document Upload | Dispute | Post Service Appeal | Related Documents | Recovery Request

Denial Reason: CBI - Disallow; primary carrier's information required-check website for COB information on file at www.caresource.com
PDC - The charge has been reduced based on a discount arrangement with the provider of service

Upload the COB related to the denied claim.
File sizes must be limited to 100 MB.
Only files of types: bmp, png, tiff, jpeg, txt, pdf, xls, xlsx, doc and docx may be uploaded.

Choose File No file chosen

Files Uploaded:

Consent for Sterilization Form

[BT202471 (in.gov)]

Providers may download the current version of the Consent for Sterilization form (HHS-687), and its Spanish language equivalent (HHS-687-1), from the Forms page at **in.gov/medicaid/providers**. An expiration date appears in the upper-right corner of the form. Completed consent forms that are not the current version available will cause full claim denial.

A properly completed Consent for Sterilization form (HHS-687 or HHS-687-1) must accompany all claims for voluntary sterilization and related services.

The form instructions are in the **Family Planning Services** provider reference module.

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202471 MAY 28, 2024

IHCP updates Consent for Sterilization form instructions

A properly completed *Consent for Sterilization* form (HHS-687 or HHS-687-1) must accompany all claims for voluntary sterilization and related services. Effective immediately, the Indiana Health Coverage Programs (IHCP) is updating the *Consent for Sterilization* form instructions.

Previously published guidance in *IHCP Bulletin* BT202427 is being revised. If an in-person interpreter is used, the interpreter must hand-write their signature and date in month, day and year format on the consent form. If an interpreter was used via teleconference (phone or video), the person obtaining the consent must write the interpreter's name and ID number (if applicable). The person obtaining the consent must initial, date and provide the method used (phone or video).

The form instructions are in the Family Planning Services provider reference module. The updated instructions as shown in this bulletin will be included in the module's next review.

Consent for Sterilization form instructions

All providers (attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, and other providers of related services) must attach a copy of the *Consent for Sterilization* form to each claim for voluntary sterilization and related services.

Providers may download the current version of the *Consent for Sterilization* form (HHS-687), and its Spanish-language equivalent (HHS-687-1), from the *Forms* page at in.gov/medicaid/providers. An expiration date appears in the upper-right corner of the form. Completed consent forms that are not the current version available will cause full claim denial.

When providers properly complete the *Consent for Sterilization* form, the IHCP receives all the necessary information regarding consent, interpreter's statement, statement of person obtaining consent and physician's statement.

Federal regulations require that certain elements of the consent form be handwritten. If providers or members make an error on the form, they must complete a new form rather than submitting the form with a strikethrough.

The IHCP contractor must receive a properly completed *Consent for Sterilization* form before making payment. To ensure timely payment to related service providers, the primary service provider should forward **exact** copies of the properly completed consent form to the related service providers.

Table 1 provides instructions for each item on the *Consent for Sterilization* form. Fields marked with an asterisk must be completed with exactly the same wording and must match the procedure billed on the claim.

See What’s New

Many new features are being added to the CareSource Provider Portal. Make sure to click on the See What’s New button often to see enhancements that have been made.

See What's New

New Features

June 2024

Care Management Referral

To refer a member for care management, use the **Providers** > **Care Management Referral** page to select a service that aligns to your member's needs and submit the request to the care management team.

Claims Withhold Amount

When applicable, you can now view the claim withhold amount while viewing the claim in either the detail or table view.

Behavioral Health Clinical Practice Measures

In addition to physical health measures, you can now also view alerts for behavioral health measures on the **Member Reports** > **Clinical Practice Registry** page.

Post Pay Audit Record Upload

If you are selected for a Post Pay Audit, you can use the **Member Search** > **Member File Upload** page to provide the appropriate documentation for the audit.

Member Alerts Permission

If you are an administrator and would like to limit who has access to your member's clinical alerts on the Home page, you can add/remove the Member Alerts permission from the **Users** > **Manage Users** page.

Questions on Portal

Look for the question mark button for quick links and education on specific categories.

How can we help you?

Help Policies

Type in your question...

- Claims
- Eligibility and Coverage
- Prior Authorization
- Disputes and Appeals
- Provider Information
- Provider Documents

How can we help you?

Help Policies

Type in your question...

- Pharmacy policies
- Provider policies

Rejected Claims

277 Claim Rejections

A rejection is the result of an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.

Rejected claims need to be corrected and submitted as a new claim.

A rejected claim submission date is not considered proof of timely filing.

Top Reasons for Rejected Claims for CMS-1500

CMS-1500 277 Rejection or Claim Denial

One-To-One Match/NPI Rejections

Address in Box 33 – 33a/b

- Address and Zip+4 in Box 33 must match service address for the billing NPI in Box 33a.
- Taxonomy Code in Box 33b must match the IHCP enrollment for the Group NPI and valid for the date of service of the claim.

Attending Provider is not in MPL (Master Provider List)

Attending Provider in Box 24j

- Provider NPI in Box 24j must be listed as attending provider under the IHCP enrollment for the Group NPI. With effective date prior to service date of the claim.
- Box 24j should include the service providers taxonomy code and match their IHCP enrollment.

Top Reasons for Rejected Claims UB-04

UB-04 277 Rejection or Claim Denials related to Provider Enrollment:

Attending Provider is not in MPL (IHCP Master Provider List)

Attending Provider on Claim

- Attending Provider listed on the UB-04 must be an active provider enrolled with IHCP.
- It is unlawful for CareSource to reimburse services if the attending provider is not enrolled with IHCP.

Top Reasons for Rejected Claims UB-04 and CMS-1500

UB-04 and CMS-1500

277 Rejection or Claim Denials invalid information:

Corrected Claim with no original claim ID

- Claim was submitted as a corrected claim and the claim referenced is not the most recent iteration.

Member not found for submitted member ID

- Member ID is not valid, or member is not active for the date of service of claim.

Claims Disputes and Appeal

Policy Information and Other Tools and Resources for Guidance

IHCP Provider Code Tables

General Billing Codes - Individual code tables related to general billing topics

Service- and Provider-Specific Codes - Groups of code tables related to a particular type of service or provider specialty ("Code sets" for certain provider types or specialties are included in this section)

Program- and Benefit-Specific Codes - Groups of code tables related to a particular member program, benefit or coverage policy

Covered services and prior authorization requirements can be found on the IHCP Fee Schedules

IHCP Professional and Outpatient Fee Schedules

The IHCP provider reference modules are the primary reference for billing and reimbursement guidance for providers

IHCP Provider Reference Modules

Claim Disputes

DEFINITION

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

All disputes must be:

- Submitted in writing via the CareSource Provider Portal, or paper by accessing the Paper Claims Form via the CareSource Provider Portal at: CareSource.com > Provider Portal > Claim Dispute Form.
- Submitted within 60 days after receipt of the Explanation of Payment (EOP).
- Submitted and completed prior to requesting an appeal.

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

Claim Appeals

All appeals must be:

- Submitted after completing the dispute process.
- Submitted within **60 calendar days of the resolution of the dispute.**
- Submitted via the CareSource Provider Portal, fax, or by paper to:

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

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

Communicating with CareSource

Communicating with Us

Provider Services	1-844-607-2831
Hours	Monday – Friday 8 a.m. to 8 p.m. Eastern Time

Member Services	1-844-607-2829
Hours	Monday – Friday 7 a.m. to 7 p.m. Eastern Time

Health Partner Engagement Representatives – Regional Specialist

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Franciscan Alliance, Fresenius (Statewide)

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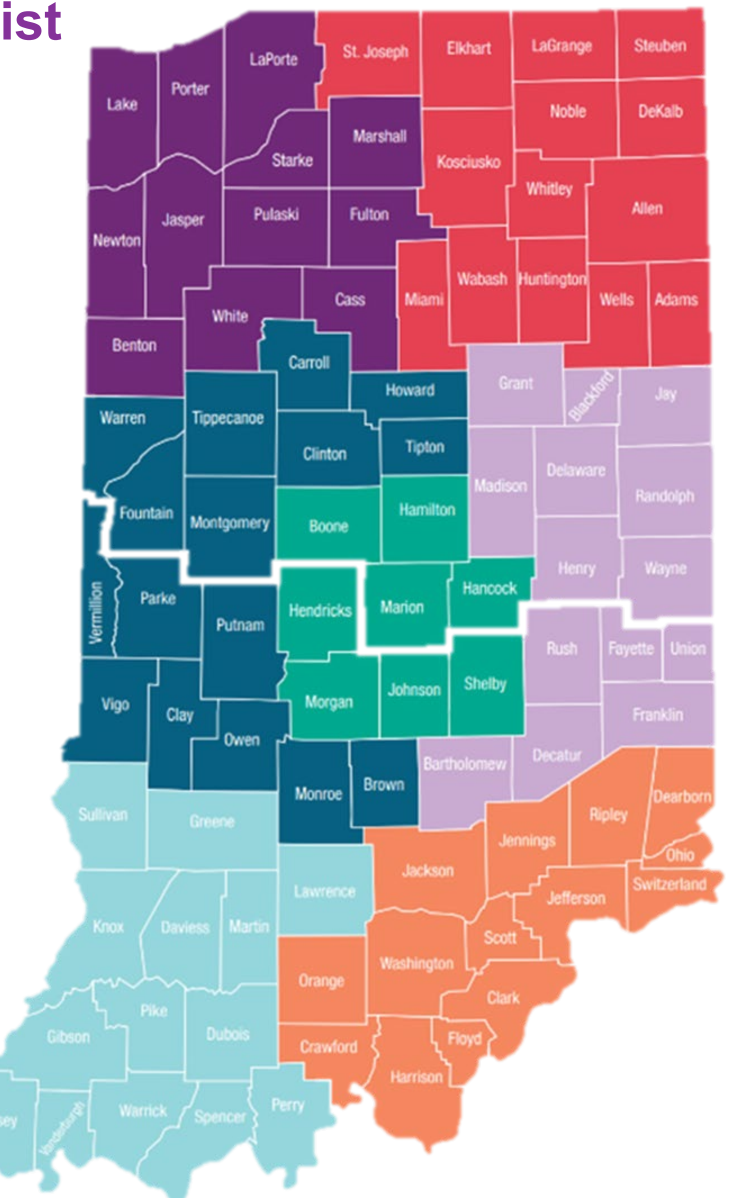

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University of Louisville, Norton, Baptist Health Floyd, ATI Physical Therapy (Statewide)

Contact Us | Indiana – Medicaid | CareSource

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Manager Health Partnerships
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Amy.Williams@CareSource.com

Health Partner Engagement Representatives – Ancillary

Brian Grcevich
Health Partner Engagement Specialist Ancillary, Dental, Skilled Nursing Facilities, Home Health and Hospice
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Contact Us | Indiana – Medicaid | CareSource

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Stephanie Gates, Behavioral Health
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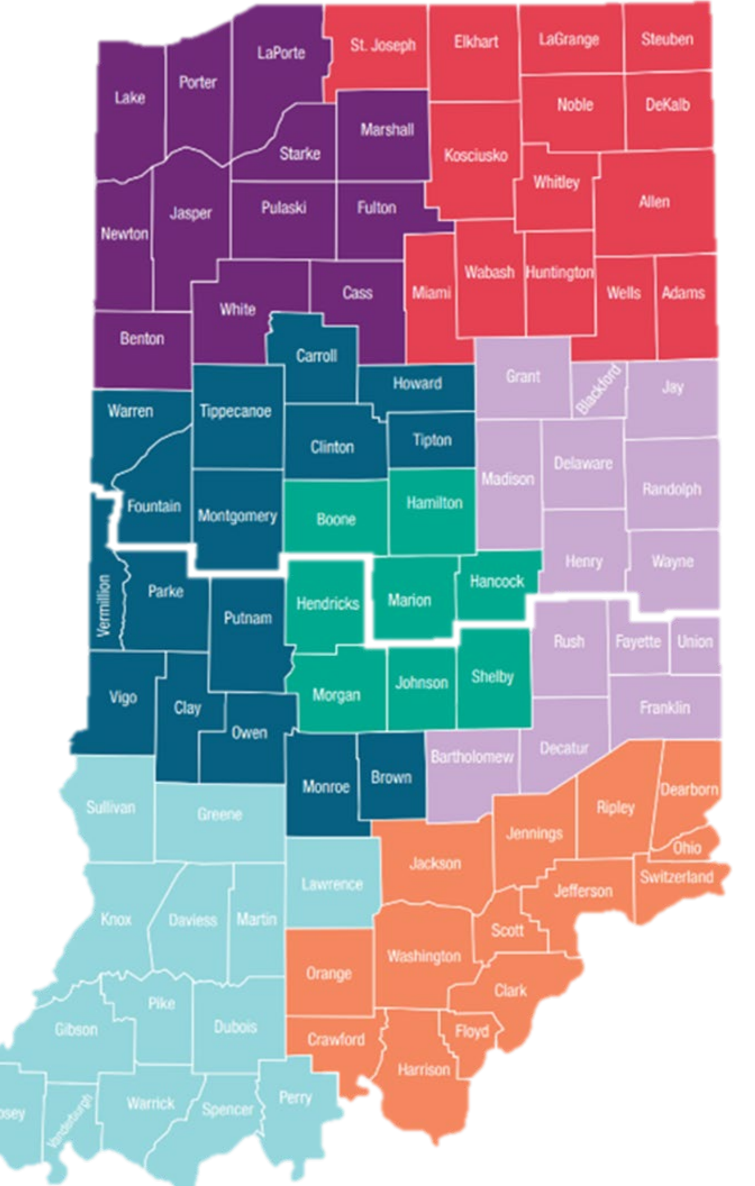
317-501-6380
Stephanie.Gates@CareSource.com



Contracting Managers – **Hospitals/Large Health Systems**

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317-416-6854
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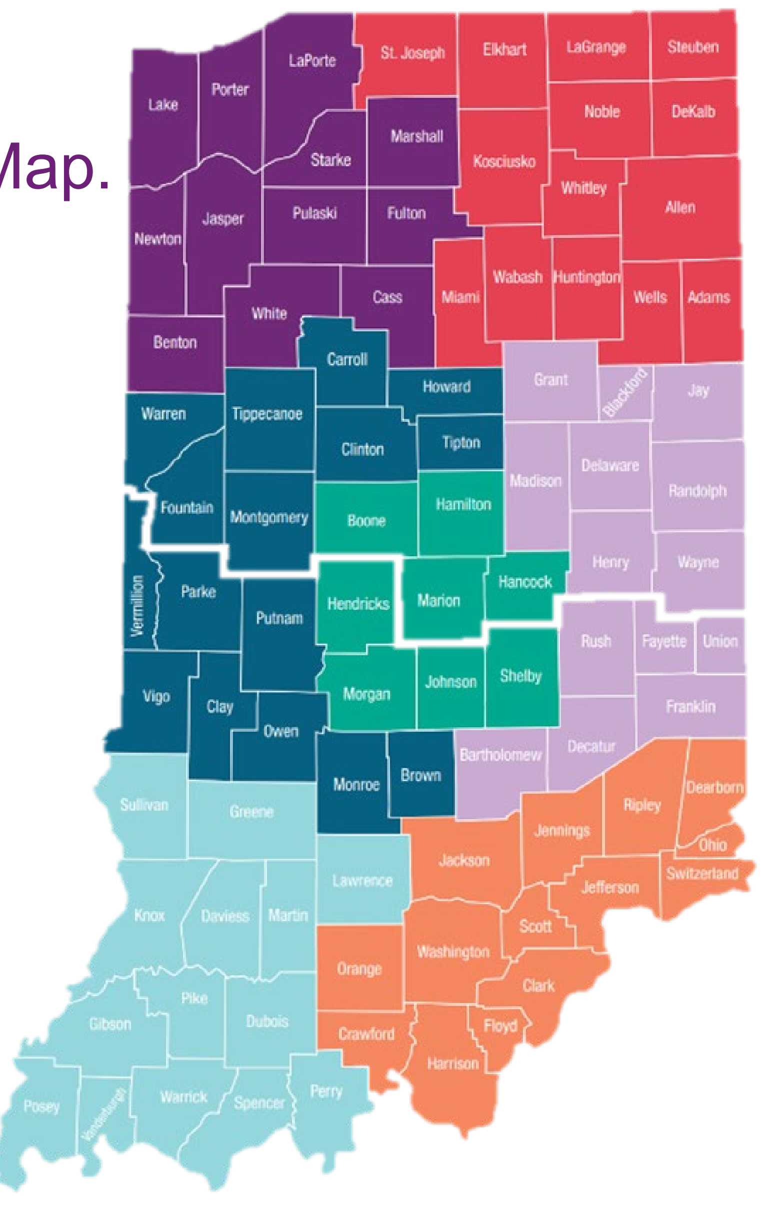
Sara Culley (Southern Territory)
765-256-0423
Sara.Culley@CareSource.com

Contact Us | Indiana – Medicaid | CareSource

Scan to Save Copy of the Health Partner Specialist Map.



Thank you!