DME & Home Health Providers Refresher

2025 IHCP Works Annual Seminar

Health Care with Heart

MISSION-FOCUSED Comprehensive, member-centric health, and life services

EXPERIENCED With over 30 years of service, CareSource is a leading non-profit health insurance company

DEDICATED We serve over 2 million members through our programs

Agenda

- Contracting/Enrollment
- Policies and Guidelines
- Prior Authorization
- Claim Submission
- Dispute and Appeal
- How to Contact CareSource

Contracting/Enrollment

The Process:

Understanding the Process

Application

The correct completion and submission of a Health Partner Contract Form by the provider.

Contracting

The process of the provider and Managed Care Entity (MCE) formally executing an agreement for the provider to deliver medical services that outlines reimbursement rates, scope of services, etc.

Credentialing

The process of reviewing the qualifications and appropriateness of a provider to join the health plan's network.

Enrollment

Provider Enrollment is the process of loading a contracted and credentialed provider to all MCE internal systems, loading for claims payment, and loading to the provider directory (if applicable).

For additional information on enrollment, please refer to the CareSource Medicaid Provider Manual

Disclosure of Ownership, Debarment, and Criminal Convictions

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

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

3. 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.

4. 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.

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

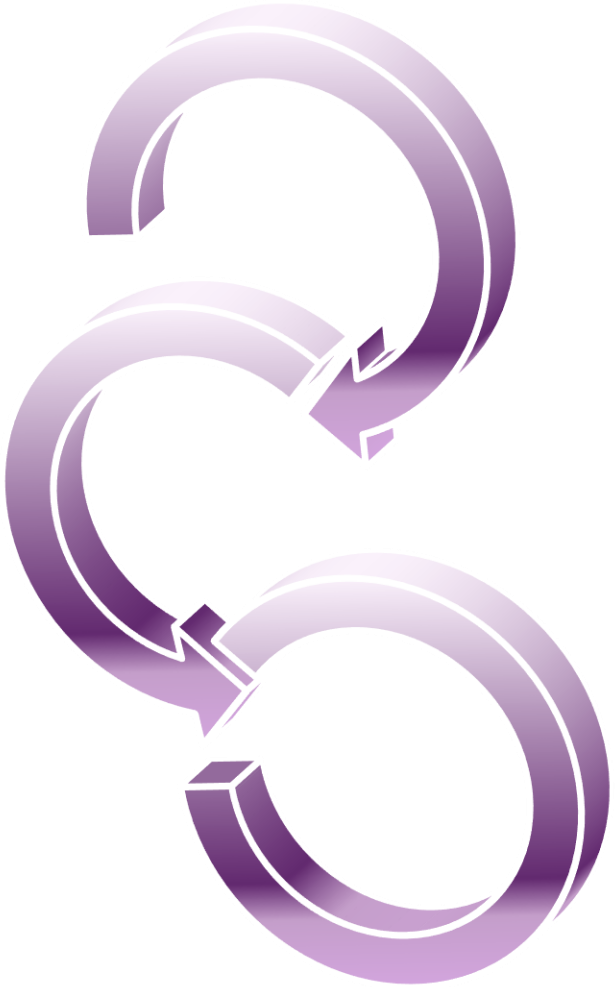
6. To obtain a copy of the Debarment Form, please download and fill out the form **here**.

Indiana Medicaid - ATTENTION!

IN Medicaid Organizational Provider Types that operate under the provider types listed, are required to also attach a CareSource organizational application found here to the supporting documents button.

- Ambulatory Surgery Center
- Birthing Center
- Community Mental Health Center (CMHC)
- Substance Use Disorder (SUD)
- Dialysis/ End State Renal
- Health Departments
- Home Health Providers
- Home Infusion
- Hospice Hospital
- Opioid Treatment Program (OTP)
- Orthotic Suppliers
- Pathology Laboratories
- Rehabilitation Facility
- Skilled Nursing Facility
- Urgent Care

Notification of Incomplete Request



Notification of an incomplete network participating request will be sent by email within **five (5) business days** after receipt of initial request.

- An incomplete network participation request is defined as a request that CareSource cannot fully process due to missing/illegible documentation or information needed to write a contract.

If CareSource does not receive the additional information requested within **five (5) business days** of the email, the request will be closed.

- The provider will have to restart the process by re-requesting.
- This will also change the effective date of the request.

Contracting and Enrollment Tips:

Add New Product

Use this option when adding IN Medicaid to your existing contract.

Attaching Documents

DO NOT attach Zip Files

Large Group

A roster can be uploaded please use the CareSource Large Group Roster

Checking Status

Always keep a record of your application ID from original submission so you can check status on the portal.

Policies and Guidelines

Tools & Resources

Access information to help you with practice administration.

Most Popular

DRUG FORMULARY

QUICK REFERENCE MATERIALS

PROVIDER MANUAL

Additional Links

COVID-19 Information

Procedure Code Lookup Tool

Provider Policies

Request Patient Services

Forms

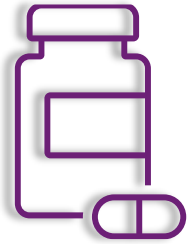
Updates & Announcements

Provider Policies

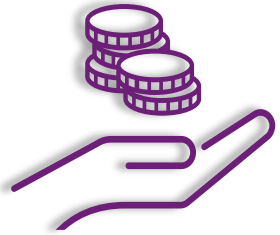
- CareSource maintains medical, payment, and administrative policies for our health partners.
- We use Indiana Administrative Code, Indiana Health Coverage Programs (IHCP) policies, and Milliman Care Guidelines (MCG) guidelines, as appropriate and applicable, to determine medically necessity.
- These policies are regularly reviewed, updated, withdrawn or added; and therefore, subject to change.

Administrative

Medical



Pharmacy



Reimbursement

IHCP Resources

IHCP Provider Reference Modules

Durable and Home Medical Equipment and Supplies

Home Health Services

IHCP Fee Schedule

Fee Schedule

Code Sets

Durable and Home Medical Equipment and Supplies Codes

Prior Authorization

What is a Prior Authorization?

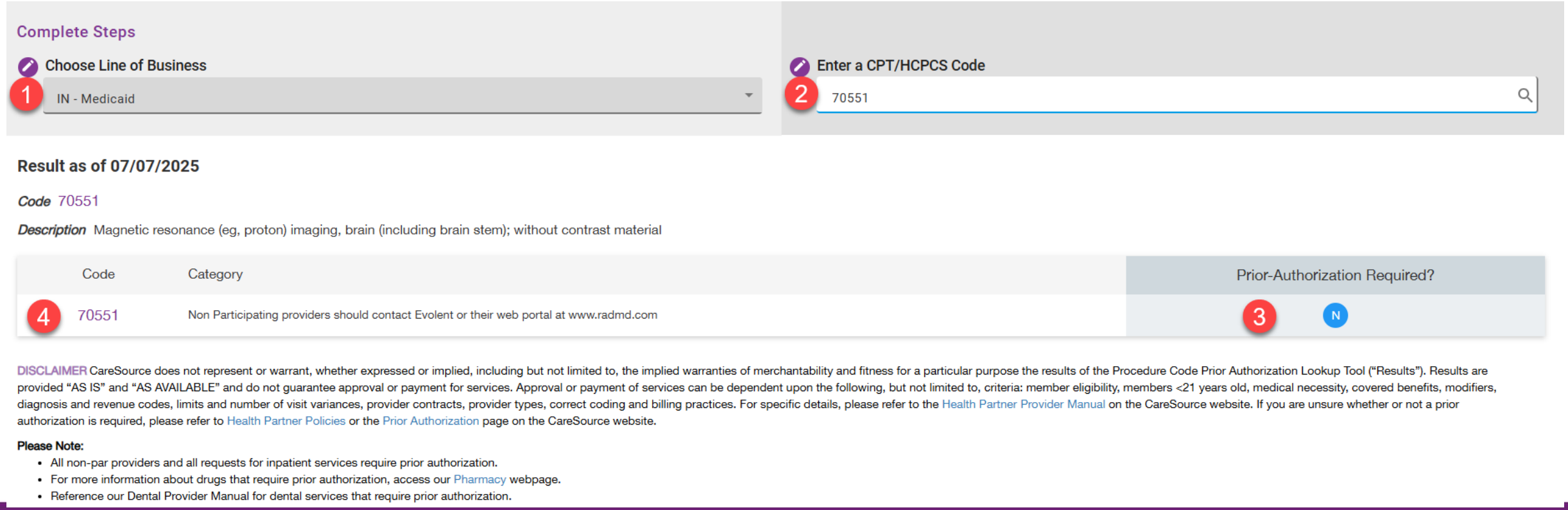
CareSource evaluates prior authorization requests based on medical necessity, medical appropriateness, and benefit limits.

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.

WHAT SERVICES REQUIRE AUTHORIZATION?

Refer to the Procedure Code Lookup Tool to check whether a service requires prior authorization.

Prior authorization requirements may differ between Healthy Indiana Plan and Hoosier Healthwise.



PRIOR AUTHORIZATION SUBMISSION OPTIONS

Provider Portal (Preferred)	You can receive immediate approval and review the status of an authorization. For assistance with submitting your prior authorization or questions regarding submissions via the portal, email CiteAutoAssistance@caresource.com and a representative will be in contact. This email is only for assistance and questions regarding prior authorizations within the Provider Portal.
PHONE	1-844-607-2831 Monday – Friday 8:00 a.m. to 5:00 p.m. Eastern Time Confidential voicemail available 24/7
FAX	Medical: 1-844-432-8924 Behavioral Health:1-937-487-1664
MAIL	CareSource P.O. Box 1307 Dayton, OH 45401-1307

Fax and Mailed requests should be submitted using the Medical Prior Authorization Request Form.

PRIOR AUTHORIZATION TIME FRAMES

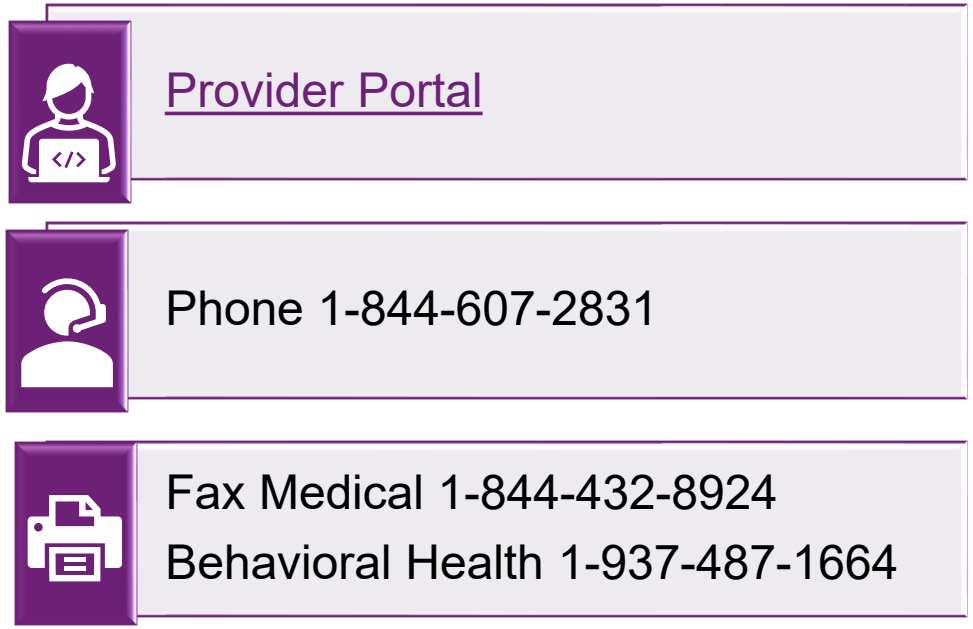
Authorization Type	Decision	Extension
Standard Pre-Service	Forty-eight (48) business hours* *Excludes weekends and holidays*	Fourteen (14) calendar days
Urgent Pre-Service	Twenty-four (24) hours business hours* *Excludes weekends and holidays*	Fourteen (14) calendar days
Urgent Concurrent	Forty-eight (48) hours	No extension
Post-Service (Retrospective Review)	Thirty (30) calendar days	No extension
Approved Authorization	Valid for 365 calendar days	NA

*Updated July 1, 2025

To check the status of a prior authorization request, call **844-607-2831** or log into the Provider Portal.

UPDATING AN APPROVED PRIOR AUTHORIZATION SUBMISSION

Any changes to an existing prior authorization must be submitted to CareSource:



Example of Changes	Rendering provider
	Current Procedure Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes
	Location of service
	Dates of service
	Units (service and/or medication)

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 (IN Medicaid)	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.

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 (Monday – Friday, 8am- 8pm EST)

2 Portal

- Medical claims can be keyed on the CareSource Provider Portal.
- Medical Claim forms (*CMS-1500/UB-04*) 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

When to Submit a Corrected Claim

If a claim paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider may submit a corrected claim. The corrected claim must be filed within 60 calendar days from the date of receipt of the claim decision notification, also referred to as the EOP.

Timely Filing

For CareSource Primary Claims: Was the claim submitted within 90 calendar days of date of service?

Review

- Was this the first claims submission or a corrected claim?
  - If corrected claim was claim was the frequency “7” submitted?
- Was the original claim number submitted?
  - Rejected and Voided claims can not be used as proof for timely filing, corrected, or disputed claims.
- Was the claim received within 90 calendar days of the original date of service if claim paid?

For CareSource Secondary Payer Claims: Was the claim submitted within 90 calendar days of date of primary payer EOP?

Review

- Was the primary payer reported on the claim?
- Was the primary payment reported on the electronic claim or copy of primary EOP included uploaded, keyed or mailed claim?
- Was this a corrected claim?

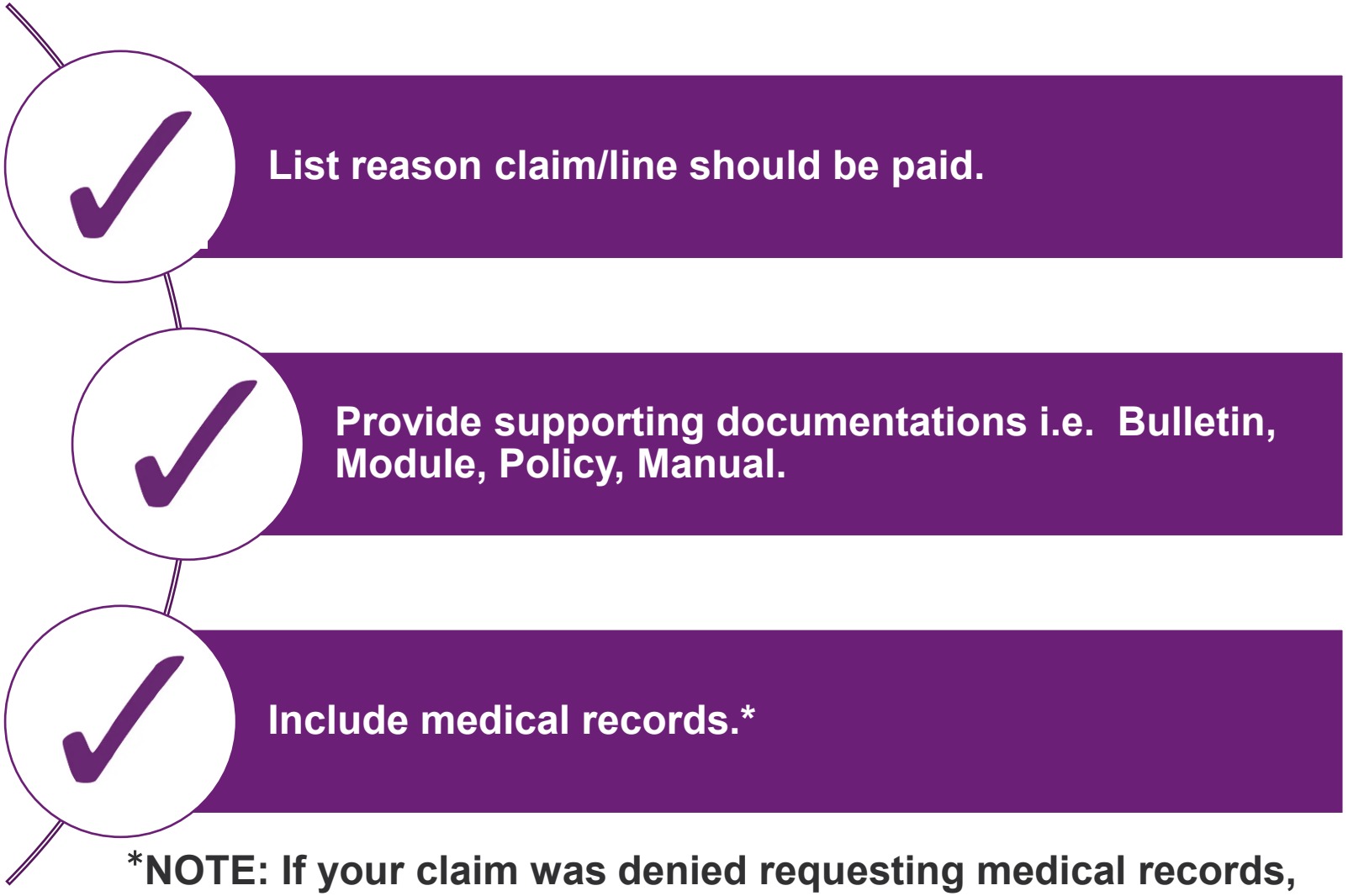
Dispute and Appeal

Definition of a Claims Dispute

A dispute is the **first** formal review of the processing of a claim by CareSource (excluding denials based on medical necessity) and is submitted prior to submitting a claim appeal.

You can submit a claim payment dispute when you disagree with payment and any other post-service claim denial.

Key Information to Include with Dispute



*NOTE: If your claim was denied requesting medical records, those should be submitted via the CareSource Provider Portal.

Definition of a Claims Appeal

An appeal is the **second** formal review of the processing of a claim by CareSource (excluding denials based on medical necessity) and is typically submitted after submitting a claim dispute.

You can submit a claim payment appeal when you disagree with payment and any other post-service claim denial.

Providers must exhaust the claim dispute process as outlined above before filing a claim appeal.

Key Information for a Claims Appeal

Include the following required documentation:

• Progress notes including symptoms and their duration, physical exam findings, conservative treatment that the member has completed, preliminary procedures already completed, and the reason service is being requested.

• Any documentation of specialists' reports or evaluations, any pertinent previous diagnostic reports and therapy notes.

• If the service has already been provided, a copy of the original remittance advice and/or the denied claim.

• 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.

How to Contact CareSource

Communicating with CareSource

Provider Services		
Medicaid	1-844-607-2831	Monday to Friday 8 a.m. to 8 p.m. (EST)
Member Services		
Medicaid	1-844-607-2829	Monday to Friday 8 a.m. to 8 p.m. (EST)

Health Partner Engagement Representatives – Regional Specialist

Tammy Garrett
219-221-7065
Tammy.Garrett@CareSource.com
Franciscan Alliance, Fresenius (Statewide)

Amy Dagon
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Amy.Dagon@CareSource.com
Community Health Network, Union Hospital, American Health Network

Paula Egan
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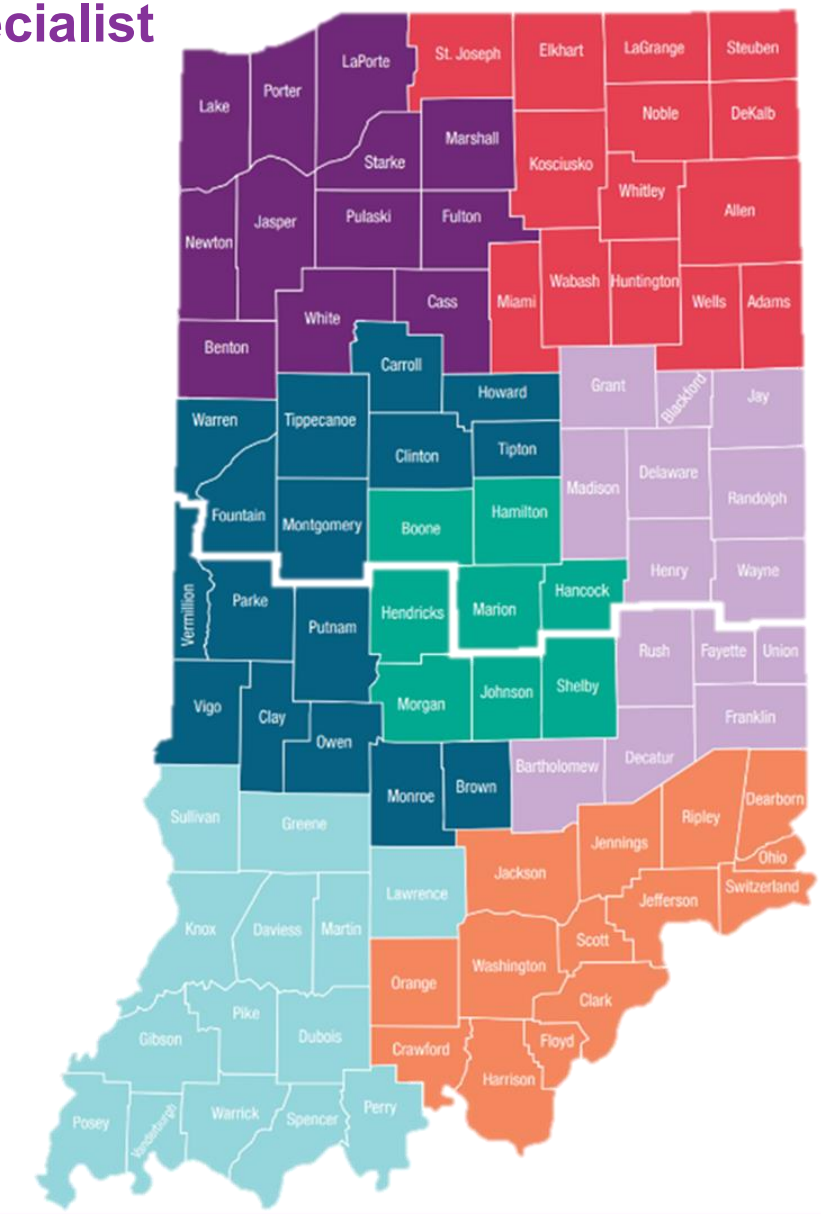
Paula.Egan@CareSource.com
Deaconess, Ascension – St. Vincent Health



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Francesca Mekos
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Indiana University, Suburban Health Organization

Bonnie Waelde
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Health Partner Engagement Representatives – **Behavioral Health**

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Amanda.Denny@CareSource.com

Stephanie Gates, Behavioral Health
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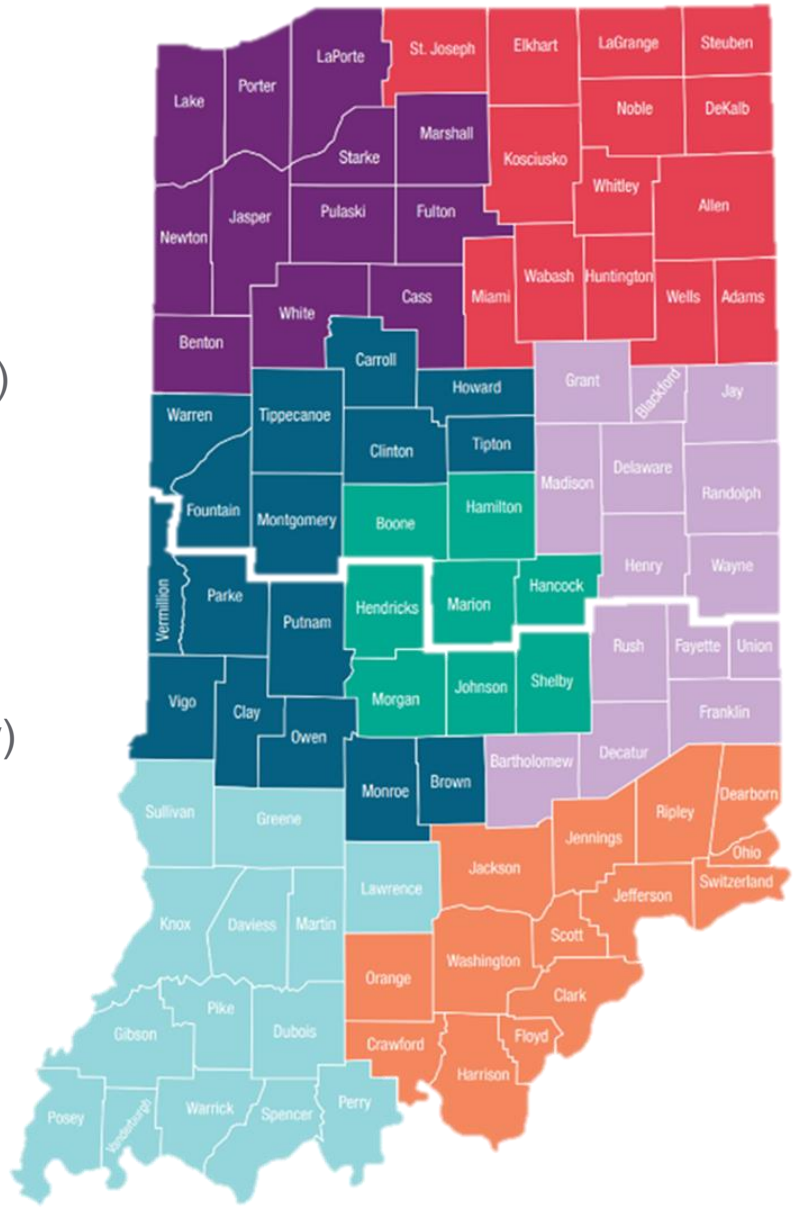
Stephanie.Gates@CareSource.com



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

Maria Crawford (Northern Territory)
317-416-6854
Maria.Crawford@CareSource.com

Sara Culley (Southern Territory)
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Sara.Culley@CareSource.com

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Health Partner Engagement Representatives – **Manager**

Amy Williams
Manager Health Partnerships
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Amy.Williams@CareSource.com

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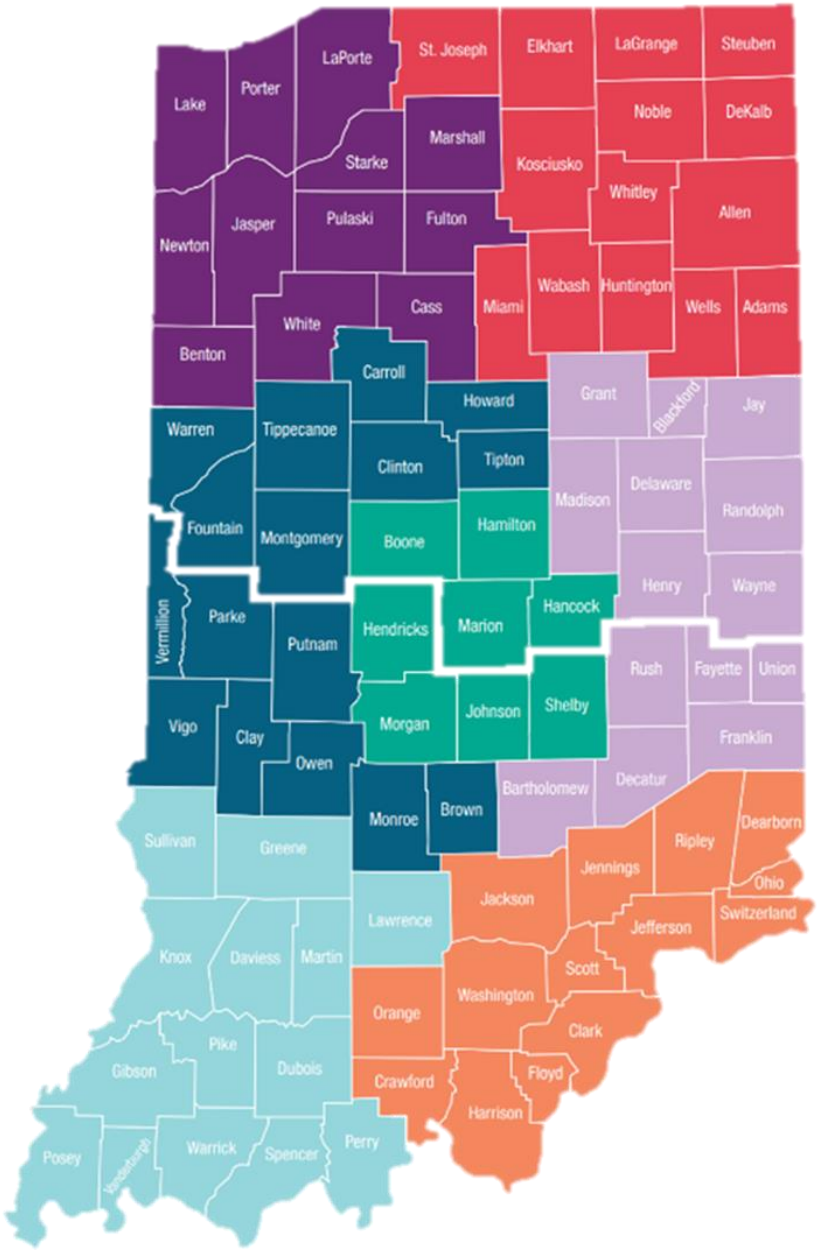
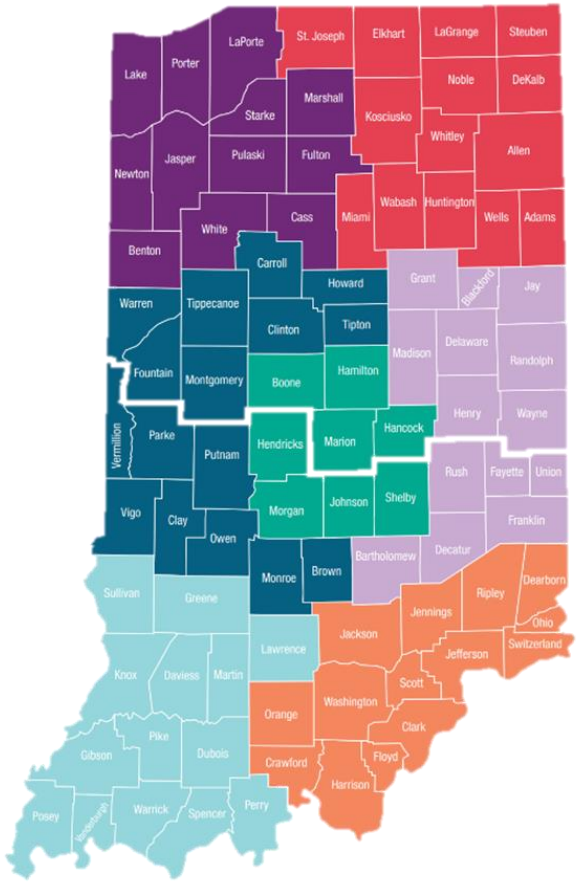


SCAN FOR A COPY OF THE HP ENGAGEMENT SPECIALIST MAP



SCAN ME

CARESOURCE.COM

Thank you for attending!

By taking a few moments to complete the event and session evaluations, you help us understand your experience and shape the future of our programs.

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IN-MED-P-4512307; Issue Date: 9/16/2025 OMPP Approved: 9/16/2025