



CareSource
Network Notification

Notice Date: May 1, 2020
To: Ohio Providers
From: CareSource
Subject: Provider Portal Quick Start Guide for Claims Attachments

There are multiple ways that you can upload documentation or attachments on the CareSource Provider Portal. This document provides instructions for submitting information for the following scenarios.

You can click the link to navigate directly to the relevant section of the document.

- [Submit a retro-authorization](#)
- [Submit medical records for denied claims](#)
- [Submit medical records proactively for claims](#)
- [File a claim dispute with supporting documentation](#)
- [File a claim appeal with supporting documentation](#)

In addition to this guide, please refer the following, as needed:

- [Payment Review Tool](#), to understand CareSource's policy for claim reviews such as readmissions, inpatient hospital claims with diagnosis-related group (DRG), high dollar claims, place of service validation and DRG.
- The Provider Manual that is available on CareSource.com for each plan, which outlines claim submission timely filing information. The Provider Manual may be found at **CareSource.com** > Providers > Tools & Resources > [Provider Manual](#).
- Appeal information, such as when and how to file a dispute or an appeal, is also located on **CareSource.com** > Providers > Provider Portal > [Provider Appeals](#).

SUBMIT A RETRO AUTHORIZATION

Retro authorizations will only be approved when the service meets **all** of the following requirements:

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

Unless the member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria must be met to qualify for a retro authorization review.

Guideline for submitting a retro authorization: If a member had an active coordination of benefits (COB) on the DOS, no prior authorization is required, as the rules of the primary insurance are followed.

To enter a retro authorization, complete the following steps:

1. From the **Providers** menu, select **Prior Authorization and Notifications**.
2. Click the **Medical (Inpatient & Outpatient)** tab.
3. Click the appropriate tab to enter the member's CareSource ID, Medicaid ID, or Member Info (name and date of birth).
4. Enter the **Start Date of Service** and click **Search**.
5. Click the **COB Information** tab and verify if the member has other insurance.

NOTES:

- The Portal may block retro authorizations from being submitted if the COB was not active on the DOS but is now active.
 - If the member has other insurance, select **Add COB Information**, then complete and submit the form.
6. If neither of the two scenarios above apply, click **Verified** to continue the retro authorization.
 7. Select the **Inpatient** or **Outpatient** authorization type.
 8. Complete the required form fields, then click continue.
 9. If prompted, complete clinical indications, upload supporting documentation and submit authorization.

SUBMIT MEDICAL RECORDS FOR DENIED CLAIMS

A **Document Upload** tab is available on the **Claims Detail** view when a claim is denied due to missing medical records. Use this option to upload documentation instead of submitting an appeal or corrected claim.

To upload documentation for a denied claim, do the following:

1. From the left hand **Claims** menu, click **Claim Information and Attachments**. Locate the claim using one of the search criteria available on the **Claim Information and Attachments** page.
2. Click the **View Details** link for the denied claim.
3. On the **Document Upload** tab, review the reason the claim was denied and then upload the appropriate documentation. The file size is limited to 100 MB.
4. Complete the required fields (marked with a red asterisk).
5. Add **Notes** if needed.
6. Click **Submit Documents**.

NOTES:

The screenshot shows the 'Claim Detail' page with the following information:

General Information			
Claim #:	142820000	Date Received:	9/25/2019
Adjusted From Claim #:	=	Total Amount Charged:	\$1,760.00
Adjusted To Claim #:	=	Total Patient Responsibility:	\$0.00
Original Claim #:	=	Total Amount Paid:	\$744.81
Patient Account #:	00000000000000000000	Processed Date:	10/16/2019
		Check Number:	00000000000000000000

Below the table, there is a 'Claim Detail' section with tabs for 'List View', 'Table View', 'Document Upload', and 'Attached Documents'. The 'Document Upload' tab is active, showing a 'Denial Reason: BSC - Disallow; consent form required' and instructions to upload a signed member consent form. It specifies that file sizes must be limited to 100 MB and lists supported file types: bmp, png, tiff, jpeg, bit, pdf, xls, xlsx, doc, and docx.

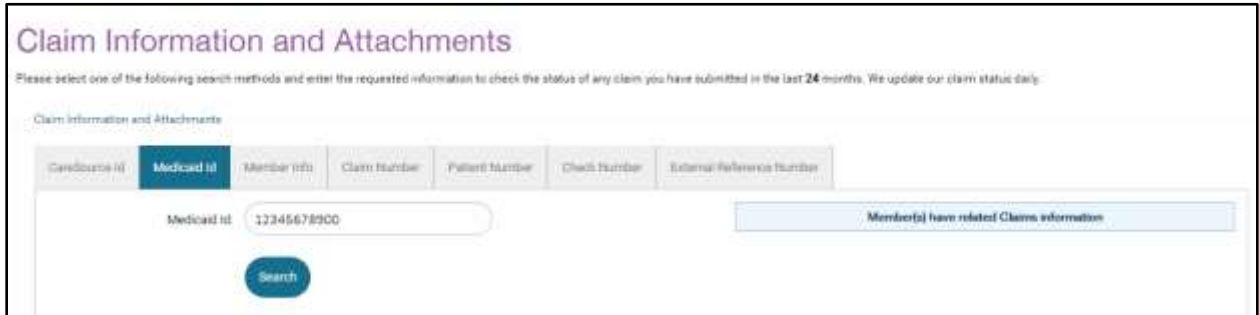
- Submitted documentation will be reviewed according to documented guidelines.
- The documents that are uploaded will be available on the **Attached Documents** tab approximately a half hour after they are uploaded.
- Submit records that directly correspond and support the billed services that were denied. Submitting an entire medical record versus documents related to a specific stay or visit could delay the processing turnaround time.

SUBMIT MEDICAL RECORDS PROACTIVELY FOR CLAIMS

If you need to submit medical records for a new claim, you can do so using the **Claim Information and Attachments** page. The attachments will be matched with member's corresponding claim so that the claim can be processed successfully.

To upload medical records, do the following:

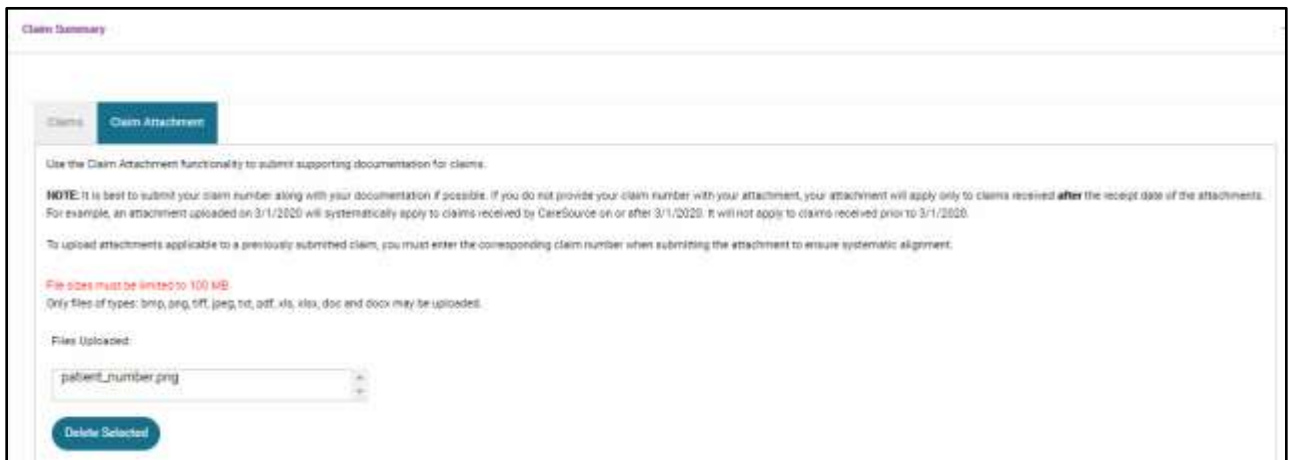
1. From the left hand **Claims** menu, click **Claim Information and Attachments** to perform a search to locate the specific member for whom you want to upload records.



2. In the **Claim Summary** section, click the **Claim Attachment** tab.

NOTES:

- a. If the member does not have existing claims, this tab opens by default.
- b. If you want to submit attachments for a denied claim, click the **View Details** link for the specific claim and follow the instructions to [Submit Medical records for denied claims](#).



3. Click **Choose File** to locate the attachment. The file size is limited to 100 MB.

Submit records that directly correspond and support the billed services. Submitting an entire medical record versus documents related to a specific claim could delay the processing turnaround time.

4. Enter the **Service Date** for the claim.

NOTES:

- The member must be eligible for the selected date of service to continue with the attachment.
- If you are including a claim number with the attachment, the date of service must match what is on the claim.
- If the claim is for a service with a date range, enter the first date that appears on the claim.

Claims **Claim Attachment**

Use the Claim Attachment functionality to submit supporting documentation for claims.

NOTE: It is best to submit your claim number along with your documentation if possible. If you do not provide your claim number with your attachment, your attachment will apply only to claims received **after** the receipt date of the attachments. For example, an attachment uploaded on 3/1/2020 will systematically apply to claims received by CareSource on or after 3/1/2020. It will not apply to claims received prior to 3/1/2020.

To upload attachments applicable to a previously submitted claim, you must enter the corresponding claim number when submitting the attachment to ensure systematic alignment.

File sizes must be limited to 100 KB.
Only files of types: bmp, png, tiff, jpeg, txt, pdf, xls, xlsx, doc and docx may be uploaded.

Files Uploaded:

patient_number.png

Delete Selected

Claim Attachment Form

Member CareSource ID: 1000000000

Service Date: * Required

Submission Reason: -- Select Reason -- * Required

Claim Number:

Provider Contact Email: * Required

Notes:

Cancel Submit Documents

5. Select the appropriate **Submission Reason**.
6. Enter the **Claim Number**, if available.
7. Enter your contact information and any applicable notes.
8. Click **Submit Documents**.

NOTE: If you submit documentation for a claim and do not indicate the specific claim number for which the documentation applies, the documentation will apply **only** to claims received **after** the receipt date of the medical records. For example, documentation uploaded on 1/6/2020 will systematically apply to claims received by CareSource on or after 1/6/2020. It will not apply to claims received prior to 1/6/2020. **To upload documentation applicable to a previously submitted claim, you must enter the corresponding claim number when submitting the attachment to ensure systematic alignment.**

FILE A CLAIM DISPUTE WITH SUPPORTING DOCUMENTATION

File a claim payment dispute for a claim underpayment, a partially or fully denied claim (please see below for a few exceptions), or for an adverse claim payment decision.

A claim number is required to submit your claim dispute through the Provider Portal. Any supporting documentation should also be attached.

NOTE: CareSource is currently unable to receive dental appeals or disputes through the Provider Portal. If you need to submit an appeal or dispute involving a dental claim, please mail or fax your submission.

The following should not be submitted as a dispute:

- If you are responding to a denied authorization that required medical necessity review, please submit an appeal.
- If you are submitting a request due to overpayment, please submit a claim recovery request.
- If your claim was denied due to a missing consent form, please upload the consent form.
- If your hospital claim was denied due to missing medical records, upload the medical records.

To submit a dispute, do the following:

1. From the left hand **Claims** menu, click **Disputes**.
2. Locate the claim for which you want to submit a dispute.
3. Complete the appropriate information and upload an attachment (up to 100 MB) if needed. Required fields are marked with a red asterisk. At a minimum, the dispute must include:
 - Sufficient information to identify the claims in dispute
 - A statement of why you believe a claim adjustment is needed (enter in the **Notes** field)
 - Pertinent documentation to support the adjustment

The screenshot shows a web form titled "Submit Dispute" with a "Check Status" link. The form contains the following elements:

- Claim ID:** 298246323988
- Dispute Type:** Please Select (dropdown menu)
- Issue Category:** Claim Dispute Medical
- Provider Contact Name:** (text input field with a red asterisk indicating it is required)
- Notes:** (text input field)
- Attachments:** A section with instructions: "Please select a file using Browse and click on Upload button for verification. Once all the files are uploaded, click Submit Dispute button to continue." It includes a "Choose File" button, a "No file chosen" label, and an "Upload" button. A red error message below reads: "File size must be limited to 100 MB".
- File Uploaded:** (text input field)
- Buttons:** "Cancel" and "Submit Dispute" buttons at the bottom.

4. Click **Submit Dispute**.

NOTES:

- You can return to the **Disputes** page to check status of your appeal using the **Claim ID** or **Dispute ID** that was generated when you submitted the dispute.
- Dispute acknowledgement and decision letters for Ohio Medicaid, Ohio Marketplace, Ohio MyCare, and Ohio Medicare Advantage claims, can be located on the **Provider Documents** page.

FILE A CLAIM APPEAL WITH SUPPORTING DOCUMENTATION

Review the reasons and timeframes for submitting an appeal below based upon the specific plan.

Submit an appeal for the following reasons	
Medicaid/MyCare/Marketplace	<ul style="list-style-type: none"> • Denied authorization – You will need member consent to appeal on their behalf. • Disagreement on underpaid or denied claim if after dispute timely filing or you do not agree with dispute decision.
Medicare Advantage/Dual Special Needs (DSNP)	<ul style="list-style-type: none"> • Denied authorization – provider will need member consent to appeal on their behalf. • Non-participating providers can appeal underpaid or denied claims. Per Centers for Medicare & Medicaid Services (CMS) guidelines, participating providers do not have claim appeal rights.
Timeframe to submit an appeal	
OH Medicaid and Marketplace	<ul style="list-style-type: none"> • Claim appeal – 365 calendar days from the date of service (DOS) or date of discharge. • Clinical appeal – 180 calendar days from the DOS, denial, or discharge. • Takeback response – 90 days from the date of recoupment to submit an appeal in response to a plan initiated takeback, or 365 days from the DOS (whichever is greater).
OH Medicare Advantage/MyCare/DSNP	<ul style="list-style-type: none"> • Claim appeal – 120 days from the DOS or date of discharge. <i>For a Medicare service, non-contracted providers (MyCare only): 180 calendar days from the remittance notification date.</i> • Clinical appeal – 60 days from the date of denial on authorization. • Takeback response – 90 days from the date of recoupment to submit a dispute in response to a plan initiated takeback, or 120 days from the DOS (whichever is greater).

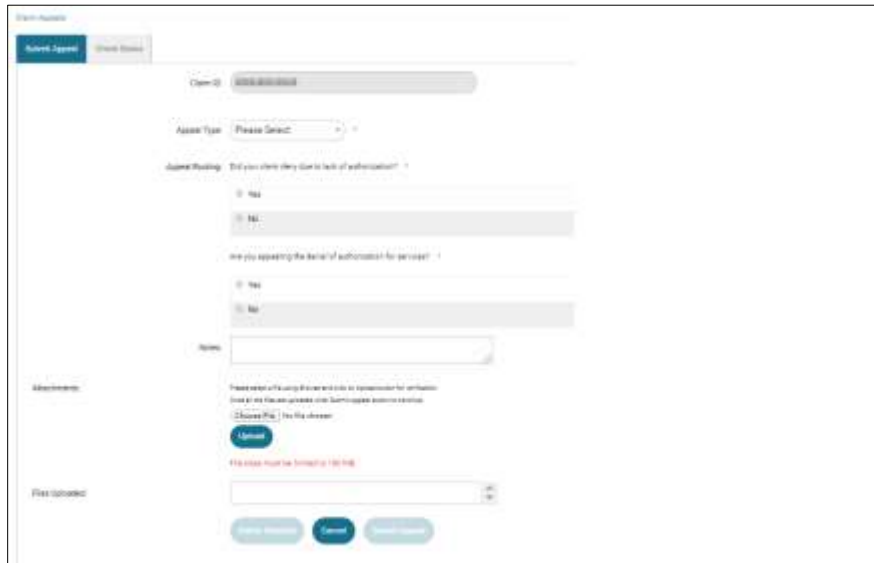
NOTE: CareSource is currently unable to receive dental appeals or disputes through the Provider Portal. If you need to submit an appeal or dispute involving a dental claim, please mail or fax your submission.

In addition to this guide, please refer the following, as needed:

- [Payment Review Tool](#), to understand CareSource’s policy for claim reviews such as readmissions, inpatient hospital claims with diagnosis-related group (DRG), high dollar claims, place of service validation and DRG.
- The Provider Manual that is available on CareSource.com for each plan, which outlines claim submission timely filing information. The Provider Manual may be found at **CareSource.com** > Providers > Tools & Resources > [Provider Manual](#).
- Appeal information, such as when and how to file a dispute or an appeal, is also located on **CareSource.com** > Providers > Provider Portal > [Provider Appeals](#).

To submit an appeal, do the following:

1. From the left hand **Claims** menu, click **Appeals**.
2. Locate the claim for which you want to submit an appeal.
3. Select the appropriate **Appeal Type**.
4. Complete the remaining required information (marked with a red asterisk).

The image shows a screenshot of a web application interface for submitting an appeal. At the top, there are two tabs: 'Submit Appeal' (active) and 'Track Status'. Below the tabs, there is a 'Claim ID' field with a value 'A000000000'. The 'Appeal Type' is set to 'Please Select'. There are two 'Appeal Reasoning' questions, each with 'Yes' and 'No' radio buttons and a text input field. The first question is 'Did you check every item on each of your bills?'. The second question is 'Are you appealing the denial of authorization for services?'. Below these is a 'Notes' text area. There is an 'Attachments' section with a 'Choose File' button and a 'File Selected' dropdown menu. At the bottom, there are three buttons: 'Submit Appeal', 'Cancel', and 'Back'. A red asterisk is visible next to the 'File Selected' field, indicating it is a required field.

5. Enter the reason for the appeal and any other applicable information in the **Notes** box.
6. You can upload an attachment, up to 100 MB, that is necessary for your appeal.
7. Click **Submit Appeal**.

NOTES:

- You can return to the **Appeals** page to check status of your appeal using the **Claim ID** or **Appeal ID** that was generated when you submitted the appeal.
- Appeal acknowledgement and decision letters for Ohio MyCare and Ohio Medicare Advantage claims can be located on the **Provider Documents** page.