



Claims

**2023 IHCP Works
Annual Seminar**

Agenda

About CareSource

Member Eligibility

Claim Submission

**Submitting Vision and Dental
Claims**

Claim Reminders

Claim Rejections

Claim Denials and Resolutions

**Provider Portal Claims
Dashboard**

Provider Payment Processing

Disputes and Appeals

**Important Updates and
Reminders**

**CareSource Health Partner
Contacts**




Member Eligibility



Eligibility Verification

Member Eligibility



INDIANA PROVIDER


Recipient Id	CareSource Id	Member Info	Multiple Recipient Ids	M
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Home / Member Search / Member Eligibility

MEMBER SEARCH

- Member Eligibility
- Coordination of Benefits
- Member File Upload

Recipient Id:

Date of Service: 

Search

Verify eligibility at every visit prior to rendering services.

Member Not Eligible

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

Recipient Id: [Redacted]

Date of Service: 7/31/2023

Search

Member is not eligible for service on the specified date

Member Information

Member has not consented to sharing sensitive health information. Because the member has not consented to sharing their health information, you may not be viewing the complete record. Members may grant consent by completing the Consent/HIPAA Authorization Form on www.caresource.com. They may also contact CareSource Member Services with questions or to obtain additional information.

Member Name: [Redacted] Member is not eligible

Address: [Redacted]

CareSource Id: [Redacted]

County: Blackford

Recipient Id: [Redacted]

Phone: [Redacted]

Case Number: [Redacted]

Date of Birth: [Redacted]

Gender: Male

Relationship to Subscriber: Subscriber/Insured

Member Eligible

Member Eligibility

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

Date of Service: 

[Search](#)

Member is eligible for service on the specified date



Member Information

Member has not consented to sharing sensitive health information. Because the member has not consented to sharing their health information, you may not be viewing the complete record. Members may grant consent by completing Consent/HIPAA Authorization Form on www.caresource.com. They may also contact CareSource Member Services with questions or to obtain additional information.

Member Name: [REDACTED]

CareSource Id: [REDACTED]

Recipient Id: [REDACTED]

Case Number: [REDACTED]

Gender: Female

Original Effective Date: 3/1/2021 12:00:00 AM

Program: [Indiana - State Health Plans - Healthy Indiana Plan \(HIP\)](#)



Address: [REDACTED]

County: HENDRICKS

Phone: [REDACTED]

Date of Birth: [REDACTED]

Relationship to Subscriber: Subscriber/Insured

Program Details: [Not a coordinated services member.](#)

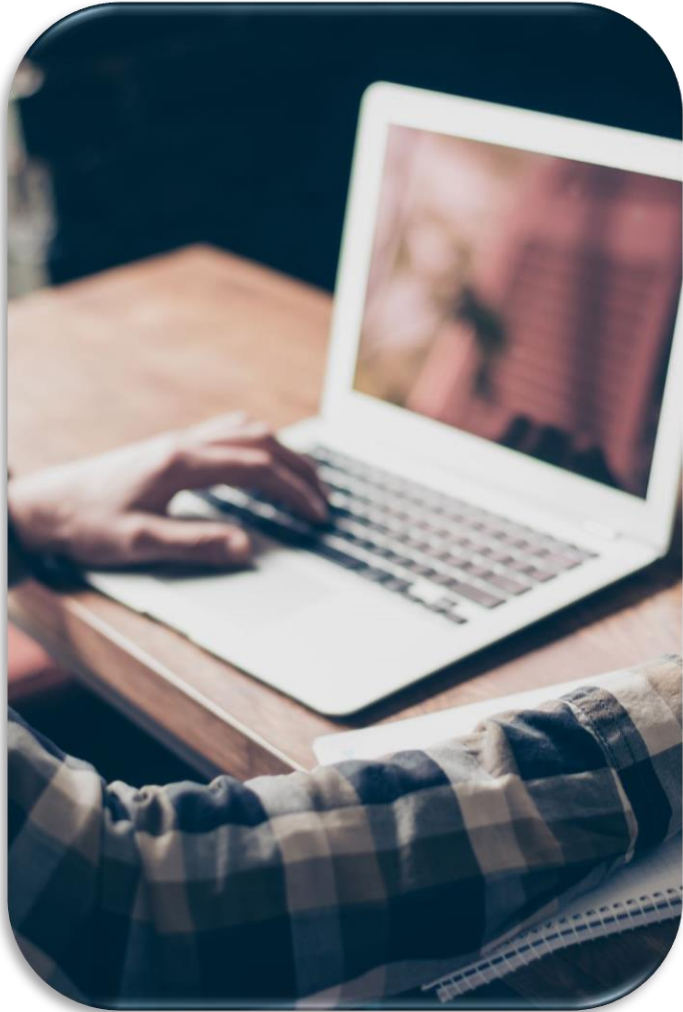
Member Eligibility Date Span Last Updated: 3/2/2022 12:42:40 PM

This member has COB on file. [Click here for more details.](#)



Claim Submission

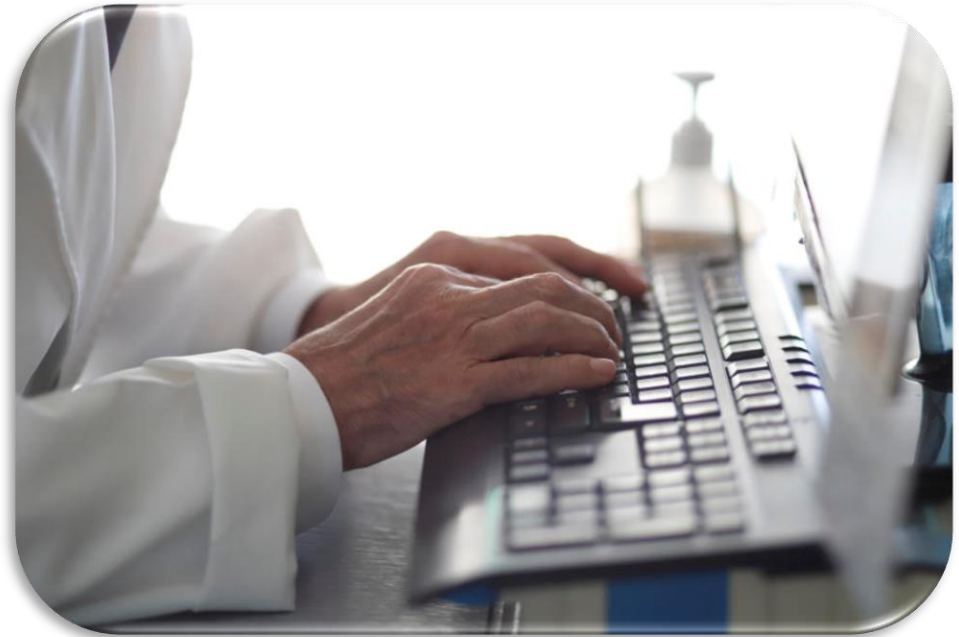
CareSource Claims Billing Methods



- Electronic claims submitted through a clearinghouse
- Claims data submitted directly via our Provider Portal
- Postal mail

Electronic Claims Submission

- Claim is transmitted to an EDI transaction
- EDI transaction sent to CareSource through Availity
- Received as the 837 file (also known as loop and segment or raw data)



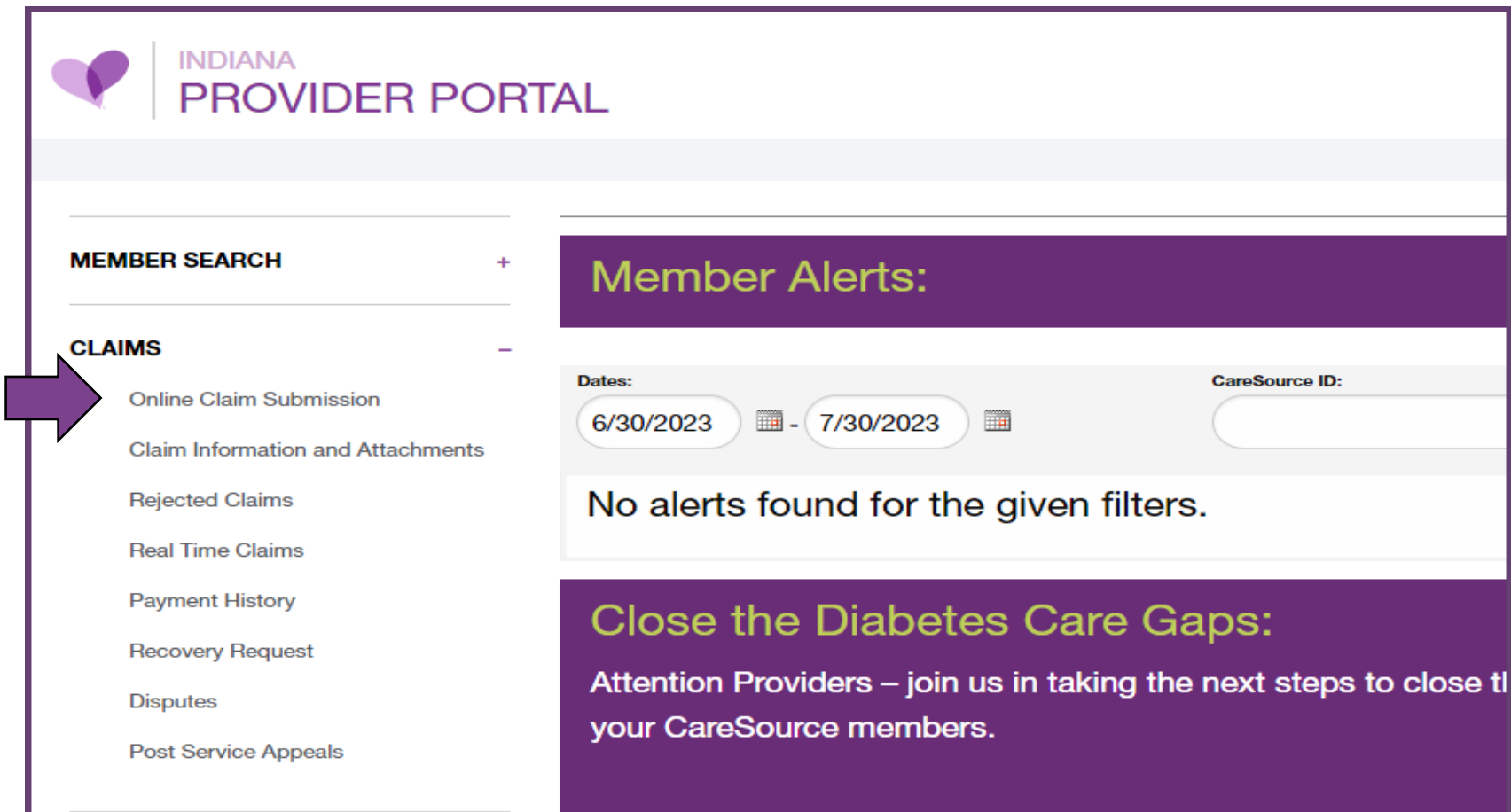
CareSource payer ID, **INCS1**

Availity's Client Services
1-800-282-4548

Portal Claim Submission



Under Claims, click on **Online Claim Submission**.



INDIANA PROVIDER PORTAL

MEMBER SEARCH +

CLAIMS -

- Online Claim Submission
- Claim Information and Attachments
- Rejected Claims
- Real Time Claims
- Payment History
- Recovery Request
- Disputes
- Post Service Appeals

Member Alerts:

Dates: 6/30/2023 - 7/30/2023

CareSource ID:

No alerts found for the given filters.

Close the Diabetes Care Gaps:
Attention Providers – join us in taking the next steps to close tl your CareSource members.

Create Online Claim



≡ CareSource

- Dashboard
- Document Status
- NewClaim
- Work Item
- Reports
- Help

CREATE HCFA CREATE UB CREATE DENTAL UPLOAD CLAIM

DOCUMENT STATUS

<input type="text"/>	<input type="text" value="DCN"/>	<input type="text" value="Submission Status to Payer"/>	<input type="text" value="LOB/Claim Type"/>	<input type="text" value="Incoming Mode"/>	<input type="text" value="Total Charges"/>
<input type="text"/>	<input type="text" value="To PCH Load Date"/>	<input type="text" value="PatientDOB (MM/DD/YYYY)"/>	<input type="text" value="InsuredDOB (MM/DD/YYYY)"/>	<input type="text" value="From DOS"/>	<input type="text" value="To DOS"/>
<input type="text"/>	<input type="text" value="Insured LastName"/>	<input type="text" value="Insured FirstName"/>	<input type="text" value="Patient LastName"/>	<input type="text" value="Patient FirstName"/>	<input type="text" value="Rejection Code"/>
<input type="button" value="Search"/>					<input type="text"/>

Document Number DCN Submission Status to Payer LOB/Claim Type Incoming Mode TotalCharges From PCH Load Date PatientDOB (MM/DD/YYYY) InsuredDOB (MM/DD/YYYY) From DOS

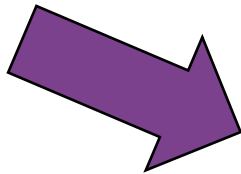
No data available in Workitem

entries

Online Claim Submission



25. FEDERAL TAX ID NUMBER 611764853 SSN <input type="radio"/> EIN <input type="radio"/>	26. PATIENT'S ACCOUNT NO. PATIENT ACCOUNT NO	27. ACCEPT ASSIGNMENT? Yes <input type="radio"/> No <input type="radio"/>	28. TOTAL CHARGE \$ \$ 0.00	29. AMOUNT PAID \$ \$ 0.00	30. BALANCE DUE \$ \$ 0.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <i>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</i> LAST NAME FIRST NAME MIDDLE INITIA SUFFIX CREDENTIAL MMDDCCYY Y	32. SERVICE FACILITY LOCATION INFORMATION <input type="checkbox"/> Ambulance FACILITY NAME FACILITY ADDRESS 1 FACILITY ADDRESS 2 FACILITY CITY FACILITY STATE FACILITY ZIP CODE EXT NPI Qualifier PIN FACILITY NPI FACILITY QUAL FACILITY PIN		33. BILLING PROVIDER INFO & PH # LAST NAME FIRST NAME MIDDLE NAME SUFFIX CREDENTIAL (or) IN 47129 8957 PROVIDER TELEPHONE NUMBER NPI Qualifier PIN QUAL PIN		



33. BILLING PROVIDER INFO & PH

LAST NAME	FIRST NAME
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Upload Claim Forms



Claim forms can also be uploaded to CareSource Provider Portal



The screenshot displays the CareSource Provider Portal interface. At the top left is the CareSource logo. Below it is a navigation menu with options: Dashboard, Document Status, NewClaim, Work Item, Reports, and Help. The main header contains four buttons: CREATE HCFA, CREATE UB, CREATE DENTAL, and UPLOAD CLAIM. Below the header is a search form titled 'DOCUMENT STATUS' with various input fields: DCN, Submission Status to Payer, LOB/Claim Type, Incoming Mode, To PCH Load Date, PatientDOB (MM/DD/YYYY), InsuredDOB (MM/DD/YYYY), From DOS, Insured LastName, Insured FirstName, Patient LastName, and Patient FirstName. A 'Search' button is located at the bottom right of the form. Below the search form is a table header with columns: Document Number, DCN, Submission Status to Payer, LOB/Claim Type, Incoming Mode, TotalCharges, From PCH Load Date, PatientDOB (MM/DD/YYYY), InsuredDOB (MM/DD/YYYY), and From DOS. The table content area is empty, displaying the message 'No data available in Workitem'.

Paper Claim Submission



To ensure optimal claims processing timelines:

- Use only original claim forms; do not submit claim forms that have been photocopied or printed from a website.
- Font should be 10-14 point with printing in ***black ink***.
- Do not use liquid correction fluid, highlighters, stickers, labels, or rubber stamps.
- Ensure printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- NPI, TIN, and taxonomy are required for all claim submissions.

Send all paper claim forms to CareSource at:

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



Paper Claim Notes

Detailed instructions for completing the CMS-1500 and the UB-04 are available in the IHCP provider reference module [“Claims Submission and Processing”](#) module.

CMS-1500 Notes:

- Rendering NPI – Box 24J
- Billing Provider NPI – Box 33a
- Group Taxonomy – Box 33b

UB-04 Note:

- Attending provider must be enrolled with IHCP.



Submitting Vision and Dental Claims



Vision Claims

Routine Vision Claims
Versant (Superior) Vision

Medical Vision Claims
CareSource



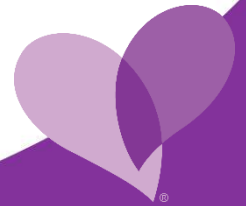
Dental Claims

SkyGen manages:

- Claims payment
- Prior Authorization
- Electronic Funds Transfer (EFT)
- Portal issues

CareSource manages:

- Member-related concerns such as claim issues, covered services, and patient eligibility
- Contracting with dental providers



Dental Claim Submission



Online:

<https://pwp.sciondental.com/PWP/Landing>

**Electronic Data Interchange (EDI) Payer
ID: INCS1**

Paper:

CareSource

Attn: Claims Department

P.O. Box 3607

Dayton, OH 45401-3607

The filing limit for participating providers is 90 days.

RETURNING USERS

Username *

Password *

LOGIN

Forgot your [user name](#) or [password](#)?

Claim Reminders



Timely Filing

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

For out-of-network providers, claims must be submitted within 180 calendar days of the date of service or discharge.

Claim Status



Additional information on the portal:

- Determine reason for payment or denial
- Check numbers and dates
- Procedure/diagnosis codes
- Claim payment date
- View and print remittance advice
- View status of claim disputes or appeals

Claim status is updated daily on the CareSource Provider Portal. You can view claims that were submitted for the previous 36 months.



Coordination of Benefits



Exceptions:

- ***Coordination of Benefits (COB)***: The claim and primary payer's explanation of payment (EOP) must be submitted to us within ***90 calendar days*** from the primary payer's EOP date. If the claim and primary insurance EOP are not submitted within the required time frame, the claim will be denied for timely filing.



Corrected Claims

60 calendar days from the date of EOP

UB-04

- Replacement/corrected claims require a Type of Bill with a Frequency Code “7” (field 4) and claim number in the Document Control Number (field 64)

CMS-1500

- enter a “7” in the left-hand side of Box 22 and the original claim number in the right-hand side of that box



Please note: If a corrected claim is submitted without this information, the claim will be processed as an original claim or rejected/denied as a duplicate.



Claim Rejections

Top Reasons for Rejected Claims

For CMS-1500 Claims:

One-To-One Match/NPI Rejections

Information that is submitted in boxes 24j and 33 – 33 a/b must match the provider and group enrollment with IHCP.

- Confirm provider listed in 24j is linked to group NPI in box 33a and is active for date of service of claim.
- Confirm address in Box 33 is **service address** for group NPI. Address must include Zip+4.
- Taxonomy code listed in 33b matches group NPI and is active.

Invalid Corrected Claim Number

- Wrong iteration of claim used
- No claim reference used



Portal Online Claims Submission Rejections

CareSource

Dashboard
Document Status
NewClaim
Work Item
Reports
Help

CREATE HCFA
CREATE UB
CREATE DENTAL
UPLOAD CLAIM

DOCUMENT STATUS

DCN
Submission Status to Payer
LOB/Claim Type
Incoming Mode
To PCH Load Date
PatientDOB (MM/DD/YYYY)
InsuredDOB (MM/DD/YYYY)
From DOS
Insured LastName
Insured FirstName
Patient LastName
Patient FirstName

Search

Document Number
DCN
Submission Status to Payer
LOB/Claim Type
Incoming Mode
TotalCharges
From PCH Load Date
PatientDOB (MM/DD/YYYY)
InsuredDOB (MM/DD/YYYY)
From DCN

No data available in Workitem

Claims submitted on the Portal that are rejected can only be found on the Provider Portal under claims submission.

- Claim can be found by using search fields.
- Rejected claims will show under the dark grey header.
 - To see reason for rejection you will need to scroll the far right.



Claims Denials and Resolutions

Coordination of Benefits (COB)

COB information has not been updated.

- Update COB information in CareSource Provider Portal, if incorrect.

Member has primary insurance.

- Submit claim to primary insurance.

Explanation of Payment (EOP) from primary was not included/attached to claim.

- Resubmit claim with EOP to CareSource as a corrected claim within 90 days of receipt of EOP.



Reminder: Verifying eligibility prior to appointments can help avoid COB denials.



Timely Filing Denials



Was this a corrected claim that was submitted as an original claim in error?

- Review claim type and resubmit claim if appropriate.

Was the primary payor's EOB dated within 60 days of claim submission?

- Review EOB date from primary payor.

Was this due to retro eligibility and provider was unable to submit claim timely?

- Dispute will need to be filed.



Invalid Rendering Provider NPI

KNP Incomplete denial reason

- Attending Provider NPI and/or taxonomy number
- Address in Box 33
- Billing Provider NPI and/or taxonomy number

Please note: If the provider treats a member prior to their effective date of the service location, claims will be denied as out-of-network.



Service Requires Authorization



Denial occurs when authorization was not present on claim or authorization was not requested

- Is the authorization number in Box 23 for professional or Box 50 for UB.
- Is the authorization number correct?

When claim details do not match what was requested on the authorization

- Do the units match what was requested?
- Do the Current Procedural Terminology (CPT) codes and diagnosis codes match what was submitted on authorization request?



Duplicate Claim

Denial occurs when claim was submitted after same claim was already processed.

- Has the claim already been processed/paid?

Denial occurs when a corrected claim is missing an original claim number.

- Does the corrected claim have a frequency code 7 and reference the most recent, processed claim number?



Unbundled Relationship



Occurs when CPT codes cannot be reimbursed when billed together

- Verify
 - NCCI Edits
 - Correct Coding Practices
 - CCI Edits
- Resolution Steps
 - Dispute
 - Appeal



Provider Portal Claims Dashboard



Claim Information

The screenshot shows the Indiana Provider Portal interface. At the top left is the logo, a stylized heart shape. To its right is the text "INDIANA PROVIDER PORTAL". Below this is a search bar labeled "MEMBER SEARCH" with a "+" icon and an "Edit" link. A red arrow points from the search bar area down to the "CLAIMS" menu item. The "CLAIMS" menu is a vertical list of options: "Online Claim Submission", "Claim Information and Attachments", "Rejected Claims", "Real Time Claims", "Payment History", "Recovery Request", "Disputes", and "Post Service Appeals". To the right of the menu is a "Member Alerts" section with a date range "3/7/2023 - 4/6/2023" and a calendar icon. Below the date range, it says "No alerts found". There is an "Edit" link above the "Member Alerts" section and another "Edit" link below it. A purple box with yellow text "Close the Disputes Attention Providers" is partially visible at the bottom right of the screenshot.

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 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.

Claim Information and Attachments

Recent Claims | **Claim Search** | Active Credit Balance

Search by: Recipient ID

Recipient Id: Recipient ID, CareSource ID, Member Info, Patient Number, Check Number, Claim Number, External Reference Number, All Claims

Claim Summary

Claims | Claim Attachment

Page(s): 1

Details	Claim Number	Status	Type	Received	DOS	Member ID	Servicing Provider
View Details		Pending	M	03/28/2023	03/22/2023		
View Details EOP		Processed	M	03/22/2023	03/20/2023		
View Details EOP		Processed	M	03/23/2023	03/20/2023		
View Details EOP		Processed	M	03/16/2023	03/10/2023		
View Details EOP		Processed	M	03/15/2023	03/08/2023		
View Details EOP		Processed	M	03/09/2023	03/06/2023		
View Details EOP		Processed	M	03/09/2023	03/06/2023		
View Details EOP		Processed	M	03/09/2023	03/03/2023		

Page(s): 1

Export Claims List: CSV



Recent Claims Dashboard

A new feature is now available on the Provider Portal, called Recent Claims, where you may see a consolidated view of recent claims.

This includes:

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

Information and Attachments

Recent Claims Claim Search Active Credit Balance

Recent Claims

Claims displayed below for the last 30 days from the date of service. Use the filter option to review additional claims.

Claims submitted in the past: 30 60 90 120

Denied - Documentation Required Denied - Other Pending Recovery Paid

Review the claim and attach appropriate documentation for claim review. Use the filter option to review additional claims.

Recipient ID

Page(s): 1

Claim Number	Member Name	Patient Number	Provider Name	Status	DOS	Action
				Processed	03/08/2023	Attach Required Documentation
				Processed	03/07/2023	Attach Required Documentation

Page(s): 1

Export Denied Claims Requiring Additional Documentation: [CSV](#)



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.

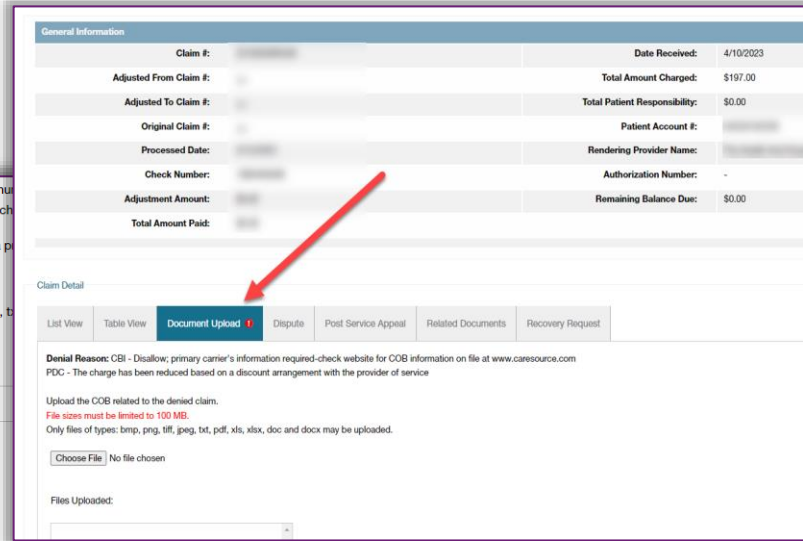
NOTE: It is best to submit your claim number and attach the attachments. For example, an attachment for a claim that has not been submitted.

To upload attachments applicable to a claim, click the Document Upload tab.

File sizes must be limited to 100 MB.
Only files of types: bmp, png, tiff, jpeg, t

Files Uploaded:

[Delete Selected](#)



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:

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:



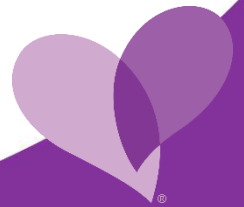
Provider Payment Processing



Provider Payment Processing

Payment methods offered by ECHO Health, Inc.:

- Electronic Funds Transfer (EFT)
- Electronic Remittance Advice (ERA)
- Virtual Card Payment
- Paper Check



Electronic Funds Transfer and Electronic Remittance Advice

EFT and ERA are the preferred methods of payments.

To register, please visit <https://enrollments.echohealthinc.com/>

You will need:

- Your CareSource Provider ID.
- Your practice's bank routing number and bank account number.

If already registered with ECHO, you will need:

- ECHO provider portal credentials or Tax Identification Number (TIN).
- An ECHO draft number and draft amount.





Virtual Card Payment

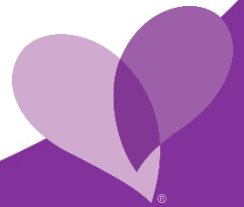
- Standard credit card processing and transaction fees apply.
- A unique credit card number will be assigned.
- Processing fees are based on your credit card processor's fees.



An open book is shown from a low angle, with the pages curled upwards to form a heart shape. The book is set against a dark, blurred background. The pages are a warm, yellowish-brown color, and the spine of the book is visible at the bottom.

Paper Check Payment

If your office would prefer to receive check payments, please call ECHO Support at 1-888-485-6233.



Disputes and Appeals

Claim Disputes

All disputes must be:

- Submitted in writing via the CareSource Provider Portal.
- May submit via the CareSource Provider Portal, fax (937-531-2398), or by paper to:
Claim Disputes Department
P.O. Box 2008
Dayton, OH 45401-2008
- Submitted within **60 days** after receipt of the EOP.
- 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.



Dental Claim Disputes

- The health partner must complete a claim dispute prior to requesting an appeal. The claim dispute form can be located within the [*Dental Health Partner Manual*](#) at [**CareSource.com**](http://CareSource.com).
- The dispute must be submitted within **60 days** after the health partner's receipt of the written determination of the claim.



Claim Appeals

- Paper appeal form can be found at CareSource.com
- May only submit appeal **after** completing dispute process
- Must be submitted within **60 days** of the resolution of the dispute
- May submit via the CareSource Provider Portal, fax (937-531-2398), or by paper to:
Claim Appeals Department
P.O. Box 2008
Dayton, OH 45401-2008

*****Timely filing appeals must include proof of original receipt of the appeal by fax or EDI for reconsideration.*****



Dental Claim Appeals

Health partners may only submit appeals after completing the claim dispute process as previously outlined.

Appeals must be submitted within **60 days** of the dispute decision.

- CareSource must issue a written decision within **45 days** of receipt of the written request for appeal.
- If the appeal is not resolved within the **45-day** time frame, the appeal will be determined as an approval.





Updates and Announcements

Member Billing

Not permitted:

- Balance billing a member for a Medicaid-covered service
- Billing a member in emergent situations

To charge a member:

- The service rendered must be determined to be non-covered by IHCP;
- The member has exceeded the program limitations for a particular service;
- The member must understand, before receiving the service, that the service is not covered under the IHCP, and that the member is responsible for the charges associated with the service;
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service.

Note: A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service. See the IHCP Provider Manual for more information



Updates and Announcements



Visit the **Updates and Announcements** page located on CareSource.com website for frequent network notifications.

Updates may include:

- Medical, pharmacy and reimbursement policies
- Authorization requirements

Updates & Announcements | Indiana – Medicaid | CareSource





Provider Communications Sign Up Form

The **sign-up** form:

<https://secureforms.caresource.com/ProviderCommunicationSignup>

The **unsubscribe** function at

<https://secureforms.caresource.com/ProviderCommunicationSignup/unsubscribe>



Provider Resources

Visit the CareSource website [Plan Resource](#) page to access the following resources:

- Printable health partner manual
- Printable orientation slides
- Formularies
- Covered benefits
- Quick reference guides
- And more

[CareSource Provider Portal](#)



Quarterly Friday Forums

- A Save the Date will be published on the Updates & Announcements page.
- Revenue cycle, contracting, credentialing, clinical operations, quality, or administrative staff are welcome to attend.
- Brief presentation covering updates.
- Live question and answer follows presentation.

Please reach out to your Health Partner Engagement Specialist for any topics you want to hear about.





Contacts

How to Reach Us

Provider Services	844-607-2831
Hours	Monday to Friday 8 a.m. to 8 p.m. (ET)
Member Services	844-607-2829
Hours	Monday to Friday 8 a.m. to 8 p.m. (ET)



Health Partner Engagement Team Contacts

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HEALTH PARTNER ENGAGEMENT SPECIALIST

**Brian Grcevich – Ancillary, Dental,
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Health Partner Engagement Specialists

Regional Specialists

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Parkview, Lutheran, St. Joseph
Regional Medical Center, Beacon

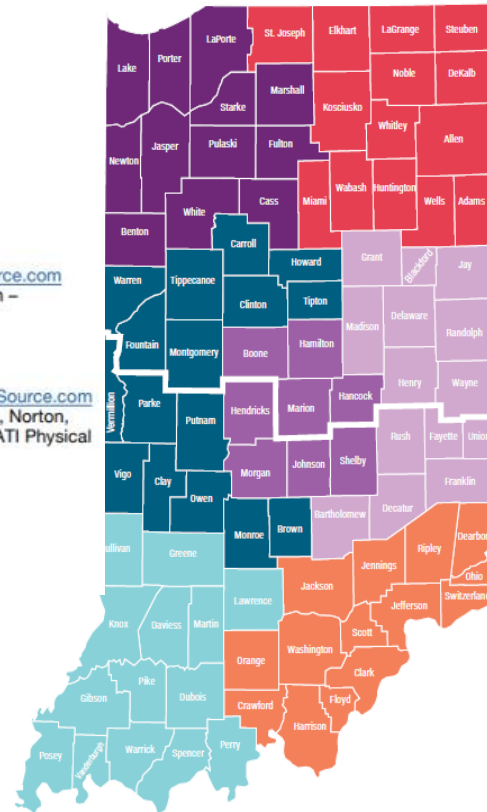
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Thank you!

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