

Primary Care Providers



Primary Care Provider (PCP) Concept

All CareSource members choose or are assigned to a Primary Care Provider (PCP) upon enrollment in the Plan. PCPs can help facilitate a medical home for members. This means that PCPs will help coordinate health care for the member, and provide additional health options to the member for self care or care from community partners.

Members select a PCP from our health plan's provider directory. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling Member Services.

To qualify as a PCP, a physician must have at least 50 percent of his or her practice in one of the following primary care areas:

- Family/general practice
- Internal medicine (providing care for patients 18 years of age and older unless specified otherwise)
- Pediatrics (providing care for patients up to age 18)

PCP Roles and Responsibilities

PCPs play an integral part in coordinating health care for CareSource members. PCPs provide:

- Availability of a personal physician to assist with coordination of a member's overall care, as appropriate for the member
- Continuity of the member's total health care
- Early detection and preventive health care services
- Elimination of inappropriate and duplicate services

PCPs are also responsible for:

- Identifying the member's health needs and taking appropriate action
- Providing phone coverage for handling patients' calls 24 hours a day, 7 days a week
- Maintaining a minimum of 20 hours per week per location in order to have members assigned to the location
- Following all referral and prior authorization policies and procedures as outlined in this manual
- Complying with the quality standards and credentialing policies of our health plan and the Michigan Department of Community Health as outlined in this manual

PCPs play an integral part in coordinating health care for CareSource members.

- Providing 30 days of emergency coverage to any CareSource patient dismissed from the practice
- Obtaining patient records from facilities visited by CareSource patients for emergency or urgent care if notified of the visit
- Before providing all services EXCEPT emergency services, providers are expected to verify member eligibility

Access Standards

CareSource has a comprehensive quality improvement program to help ensure our members receive the best possible health care services. It includes evaluation of the availability, accessibility and acceptability of services rendered to patients by participating health care providers.

Please keep in mind the following access standards for differing levels of care. Participating providers are expected to have procedures in place to see patients within these timeframes and to offer office hours to their CareSource patients that are at least the equivalent of those offered to Fee-For-Service (FFS) Medicaid patients and patients with commercial insurance coverage. Thank you for adhering to these standards.

Primary Care Providers (PCPs)

Patients with. . .	Should be seen. . .
Emergency needs	Immediately upon presentation (the same day)
Urgent care needs	No later than the end of the following working day after their initial contact with the PCP site (within 2 days)
Routine care needs	Within 21 days
Annual Physical	Within 90 days

Non-PCP Specialists

Patients with. . .	Should be seen. . .
Emergency needs	Immediately upon presentation (the same day)
Urgent care needs	No later than the end of the following working day after their initial contact with the PCP site (within 2 days)
Routine care needs (stable condition)	Within 21 days

For certain specialties with higher demand (such as dermatology, endocrinology and orthopedics), patients with routine care needs should be seen within 16 weeks.

For maternity care, the provider is requested to provide initial prenatal care appointments for enrolled pregnant members as follows:

- First trimester, within 14 days of first request
- Second trimester, within 7 days of first request
- Third trimester, within 3 days of first request
- High-risk pregnancies, within 3 days upon identification of high risk by the health plan or maternity care provider, or immediately, if an emergency exists

A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. It is expected that, if a provider is unable to see the member within the appropriate timeframe, CareSource will facilitate an appointment with a participating provider or a non-participating provider, if necessary.

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Providing Prenatal and Postpartum Care

Prenatal and Postpartum Care Documentation — To ensure accurate documentation of prenatal and postpartum care, please be sure to document the following in patient records:

- **OB assessment** — This consists of medical and pregnancy history, social history, living arrangements, support systems, involvement with the legal system and attitude toward pregnancy, date of last menstrual period, estimated due date and prenatal lab work.
- **Evidence of prenatal teaching** — This includes education on an ongoing basis with needs assessed at each appointment, and referral to other providers as appropriate. Teaching generally includes infant feeding, WIC, birth control, prenatal risk factors, dietary/nutrition information and childbirth procedures.
- **Physical examination** — This includes Pap smear, pelvic exam, breast exam, general health evaluation and risk assessment reviewed and adjusted accordingly.
- **Components of the postpartum checkup** — This includes documenting the pelvic exam, blood pressure, weight, breast exam, abdominal exam, and general health evaluation and risk assessment.

Well Child Care/EPSTD Program

Well Child/EPSTD is a child health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. All children of these ages who are CareSource members **must** receive a Well Child/EPSTD exam. It supports two goals: ensures access to necessary health resources, and assists parents and guardians in appropriately using those resources. For the complete listing of the American Academy of Pediatrics Preventive Health Guidelines visit www.aap.org.

*All children of these ages who are CareSource members **must** receive a Well Child/EPSTD exam.*

Well Child/EPSDT Exam Components

The screening component of the well child checkup includes a general health screening most commonly known as a periodic well child exam. The required Well Child/EPSDT screening guidelines, based on the American Academy of Pediatrics' recommendations for preventive pediatric health care include:

- Comprehensive health and developmental history
- Developmental/behavioral assessment
- Age appropriate unclothed physical examination
- Height and weight measurements and age appropriate head circumference
- Blood pressure for children 3 years of age and older
- Immunization review and administration
- Health education including anticipatory guidance
- Nutritional assessment
- Hearing, vision and dental assessments
- Blood lead testing for children under 6 years of age
- Interpretive conference and appropriate counseling for parents or guardians
- Objective testing for developmental/behavioral, hearing and vision screening must be performed in accordance with the Medicaid periodicity schedule
- Laboratory services for hematocrit, hemoglobin, urinalysis, hereditary/metabolic or other needed testing as determined by the physician must be provided
- Age appropriate screening, testing, and vaccinations

Well Child Exam Frequency

The recommended schedule for Well Child exams is as follows:

- Birth
- 3 to 5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 4 years
- Annually thereafter through age 20

PCPs receive a list of eligible CareSource members at the beginning of each month who have chosen or been assigned to the PCP as of that date.

Well Child/EPSDT Codes

Exams should be coded on claim forms using CPT codes 99381 through 99395, whichever is applicable. Correct codes are required for timely and accurate claims payment and documentation of services provided. Codes should be used along with appropriate ICD-9 diagnosis codes (V20.2 or V70. codes). When updating routine EPSDT status at the time of an acute care visit, the next-higher level E&M CPT code may be submitted if the appropriate ICD-9 code is also submitted as a secondary diagnosis.

Well Child/EPSDT Exam Referrals

If the PCP is unable to provide all of the components of the Well Child/EPSDT exam or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating provider within CareSource's provider network in accordance with CareSource's referral procedures. The member's medical record must indicate where the member was referred.

High Risk Children

Children at high risk should be tested according to the American Academy of Pediatrics (AAP) guidelines. Problems found or suspected during a well child visit must be diagnosed and treated as appropriate. Referrals must be made based on standards of good practice and AAP's recommendations for preventive pediatric health care or presenting need.

Blood Lead Level Testing

The Michigan Medicaid program requires that all children have at least one blood lead level test by the age of two. Filter paper testing is an accepted method to obtain blood lead levels and is covered by CareSource.

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Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during Well Child/EPSDT exams as needed. CareSource endorses the same recommended childhood immunization schedule that is recommended by the Center for Disease Control and approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The recommended schedule is included in this section of the manual. This schedule is updated annually and the most current updates can be found on www.aap.org.

Vaccines for Children Program

The federal Vaccines for Children (VFC) program makes designated vaccines available at no cost to health care providers to administer to children 18 and younger who are enrolled in Medicaid. CareSource members are eligible for these vaccines.

To bill CareSource for VFC administrations, please use V20.2 as the primary diagnosis code and include the correct procedure code for the vaccine administered. CareSource allows only one administration per VFC vaccine.

CareSource pays for the administration of the vaccine only when billed with an appropriate immunization and administration CPT Code.

For additional information on the VFC program, visit the VFC homepage at the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/vaccines/programs/vfc, or contact the immunization program at your local health department.

Immunization Codes

Please bill CareSource with the appropriate CPT vaccination codes, along with the appropriate ICD-9 vaccination codes and the appropriate administration code to receive reimbursement for administration of the vaccine.

Statewide Web-Based Immunization Registry

CareSource encourages all participating health care providers to take advantage of the statewide web-based immunization registry called Michigan Care Improvement Registry at www.mcir.org. The registry consolidates immunizations from multiple providers into one central record and provides reliable immunization history that is electronically accessible from multiple health care practice sites.

It also facilitates the introduction of new vaccine protocols and sends immunization reminder/recall notices automatically. The system is designed to provide immediate access to immunization history information, up-to-date recommended immunization schedules, fewer phone calls between providers to obtain and assess a child's immunization history, fewer missed opportunities, and quick, easy-to-print official immunization records for day care and school requirements.

You can find more information about immunizations at www.cdc.gov/vaccines/recs/acip.

Other EPSDT Covered Services

Vision screening — Vision screening is to be assessed by the provider at each EPSDT visit using the appropriate vision tests according to the periodicity schedule. Vision services must include at least diagnosis and treatment for defective vision, including glasses if appropriate. Referrals are to be initiated by the provider when the member fails the vision screening. Vision benefits are managed by VSP at **1-800-877-7195**.

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Hearing/speech screening — Newborns are to receive a hearing assessment as part of their complete newborn examination. Hearing screening is to be assessed at each EPSDT visit by the provider according to the periodicity schedule. Hearing services must include at least diagnosis and treatment for hearing defects, including hearing aids as appropriate. Speech screening for language development is to be assessed at each EPSDT visit. Referrals are to be initiated by the provider when a member fails the hearing or speech screening.

Behavioral health screening — Screening for mental health and substance abuse is to be assessed at each EPSDT visit. Mental health and substance abuse treatment services are covered under the EPSDT program. Behavioral health benefits are managed by Comprehensive Behavioral Health Care Services (CompCare) at **1-800-435-5348**.

Health education — Age-appropriate health counseling and education is to be provided at each EPSDT visit through the Anticipatory Guidance section. Anticipatory guidance is to assist member's parents or guardians in what to expect in terms of the member's development and information about the benefits of healthy lifestyles, accident and disease prevention.

Provision of EPSDT Services

- EPSDT screening requirements are to be conducted by the child's provider according to the timeframe identified on the periodicity schedule for all CareSource members under the age of 21.
- The EPSDT encounters will be submitted in accordance with the encounter reporting standards specified in the provider contracts.
- PCPs are contractually responsible to provide early and periodic screening, diagnosis and treatment services for all CareSource members, birth through 21 years in accordance with the EPSDT Periodicity Schedule.

The EPSDT providers will assume responsibility for:

- Documentation of the EPSDT screening services
- Referring members as necessary for follow-up, diagnosis and treatment
- Documentation in the child's medical record regarding the parent's decision to refuse to allow the child to participate in the EPSDT program
- Utilizing acute care visits to address missed opportunities. The provider is to assess the health and immunization status of the child during each office visit
- Having an office adequately equipped to provide EPSDT services. This will be monitored before credentialing and contracting by CareSource, and every three years thereafter. Providers who fail their site visit will be re-examined in six months for compliance

Education and Outreach

CareSource Care Management staff, in conjunction with the provider, will carry out the responsibilities of the EPSDT education and outreach program for eligible enrolled members under 21 years of age through mailings and computer analysis. Additional outreach activities as listed below will also target EPSDT recipients.

- All EPSDT providers will receive on-going education and training on current immunization recommendations through telephone calls, Provider Bulletins, letters of changes on immunization policy and direct contact with the CareSource medical director.
- All EPSDT providers will be informed of any changes in the federal and state regulations for the EPSDT program through phone calls or Provider Bulletins. Current immunization recommendations are available through a link on the CareSource website at www.caresource.com.

CareSource Care Management staff, in conjunction with the provider, will carry out the responsibilities of the EPSDT education and outreach program for eligible enrolled members under 21 years of age.

- Member education and outreach:
 - *General Mailing* – Within 10 days of notification of enrollment, each new member receives an enrollment packet that includes: a member handbook, EPSDT pamphlet, immunization booklet, ID card and a letter regarding information on the EPSDT program. This packet outlines how to obtain services and assistance with scheduling appointments, transportation services available, the importance of immunizations and a schedule to follow, and the benefits of preventive health care, emphasizing that EPSDT services are completely free of charge to members.
 - *Targeted Mailing*
 - EPSDT reminder postcards are sent monthly to the parents of each child between the ages of birth to 21 years due for an EPSDT visit according to the periodicity schedule.
 - Computerized monthly rosters are run on all members including those birth to 21 years of age in order to ascertain access to services such as EPSDT. These reports are based on claim’s information and identify members behind in an EPSDT visit.
 - *Care Management Outreach*
 - Care Management Health care specialists make calls to members reminding them of the importance of well child visits. The Healthcare Specialists offer to assist the member in making an appointment with their child’s PCP.
 - *Community Outreach*
 - CareSource coordinates with county health departments regarding involvement in health fairs and obtaining immunization records.
 - CareSource is working with the Michigan Care Improvement Registry to help ensure that all of Michigan’s children receive their immunizations.
 - *Direct PCP/Provider Interaction with Members*
 - PCPs/providers, in conjunction with CareSource, educate parents/guardians of the need to receive immunizations.
 - PCPs/providers educate parents/guardians on the importance of immunization and EPSDT visits by answering questions in the PCP/provider’s office during EPSDT visits.

You can find more information on EPSDT services on www.caresource.com.

Specialty Care Providers

Specialists are responsible for knowing which services need a referral from a member's PCP and/or a prior authorization from CareSource before services are provided. Please remember that only PCPs can issue referrals to additional specialists. Generally, specialist-to-specialist referrals are not allowed. However, there are exceptions for some cases. Specialists are also responsible for confirming a member's eligibility before providing services and for following claim submission guidelines. Please refer to the following sections of this manual for more information:

- Member Enrollment and Eligibility
- Covered Services and Exclusions
- Referrals and Prior Authorizations
- Claims Submissions

Access Standards

Please keep in mind the following access standards for differing levels of care. Participating providers are expected to have procedures in place to see patients within these timeframes. We appreciate your adherence to these standards.

Non-PCP Specialists

Patients with. . .	Should be seen. . .
Emergency needs	Immediately upon presentation
Persistent symptoms*	No later than 30 days after their initial contact with the specialist site
Routine care needs (stable condition)	Within 21 days

For certain specialties with higher demand (such as dermatology, endocrinology and orthopedics), patients with routine care needs should be seen within 16 weeks.

*A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. It is expected that, if a provider is unable to see the member within the appropriate timeframe, CareSource will facilitate an appointment with a participating provider or a non-participating provider, if necessary.

Medicaid

Prenatal/Obstetrical Services

Procedure codes — Global billing codes must be used for antepartum, delivery and postpartum care. Please use the following codes for these common pregnancy-related services:

Description	Code
Antepartum visit	Use the appropriate global billing codes 59425 & 59426 and include the OB dates of service on the claim. Include the postpartum visit and/or submit the postpartum visit progress note.
Childbirth preparation/Lamaze classes, non-physician provider	S9436
Childbirth refresher classes, non-physician provider	S9437
Baby parenting classes provided to pregnant women, non-physician provider	S9444
Infant safety classes provided to pregnant women, non-physician provider	S9447
Nutrition classes for pregnant women, non-physician provider	S9452
Medical nutrition counseling provided by a dietician	S9470
Physician providing nutrition services	Use appropriate office visit code with TH modifier
Delivery	59409, 59514, 59612, or 59620, as appropriate
Postpartum visit	59430 (do not include TH modifier)
Complete OB Package	59410, 59515, 59614, 59622, 59400, 59610, 59618

Providers of obstetrical services must include the LMP date and EDC date on the complete OB package, antepartum and/or delivery claim.

Prenatal and Postpartum Care Documentation — To ensure accurate documentation of prenatal and postpartum care, please be sure to document the following in patient records:

- **Evidence of prenatal teaching** — This includes education on infant feeding, WIC, birth control, prenatal risk factors, dietary/nutrition information and childbirth procedures.
- **Components of the postpartum checkup** — This includes documenting the pelvic exam, blood pressure, weight, breast exam and abdominal exam.

Vision Care Services

Optical vision services are provided through Vision Services Plan. Please contact a representative at Vision Services Plan (VSP) at **1-800-877-7195** for assistance. Also, review the Member Support Services and Benefits section, for details.

MDCH and CareSource cover low-vision services for Medicaid beneficiaries age 21 and older. This includes: low-vision eyeglasses, contact lenses, optical devices and other related low-vision supplies.

Medicare

Chiropractic Services

Procedure codes and benefit limits — Chiropractic radiographic services should be coded using the most current CPT procedure code. CareSource covers medically necessary chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine. The subluxation must be demonstrable on x-rays. Covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. A prior authorization is required for greater than 12 Medicare covered chiropractic visits per calendar year. Please see the Referrals and Prior Authorizations section in this manual for more information.

Vision Care Services

Optical vision services are provided by participating Specialists. Covered services include:

- A \$50 limit for eye wear every year
- Outpatient physician services for eye care
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens
- Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant

Podiatric Services

Procedure codes — The most current CPT codes should be used when submitting claims for podiatric services. Procedures performed must be within the scope of the provider's license. Covered services includes treatment of injuries and diseases of the feet (such as hammer toe or heel spurts). Routine foot care for members with certain medical conditions affecting the lower limbs.

Diagnosis codes — CareSource covers foot care prescribed for members that have systemic diseases which cause decreased circulation to the extremities and require professional foot care. Claims submitted for foot care must have the ICD-9-CM code clearly indicated on the form.

Benefit limits — Please remember that services related to flat feet are not covered. Please see the Referrals and Prior Authorizations section for more information. A prior authorization is required for greater than eight podiatry visits per calendar year.

Services requiring prior authorization:

- Extended benefit levels beyond established parameters
- Orthopedic (corrective) shoes and appliances

Prior authorization requests must include a plan of treatment. If you are in doubt about whether a service or procedure requires prior authorization from CareSource, please call our Medical Management Department. Please see the Referrals and Prior Authorizations section for more information about how to request prior authorization.

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Mental Health Care

All CareSource members (Medicaid and Medicare) must access their mental health benefits by calling **1-800-435-5348** prior to benefit utilization. CompCare staff will answer all calls. The member, family member, PCP, or other agencies/officials associated with the member may call to access the outpatient member mental health benefits. Care Management services are available 24 hours a day, 7 days a week to meet member needs.

Benefit limits — Mental health care / psychology visits are limited to 20 outpatient visits per year for Medicaid members.

Urgent/Emergent Mental Health Care

Urgent and emergent care is now handled by the member's local Community Mental Health Organization or its designee. However, if a member calls with an emergent or urgent need, Comprehensive Behavioral Healthcare Management Services will assist in the referral process to the appropriate agency/facility.

Routine Mental Health Care Medicaid/Medicare

When a member calls to utilize their outpatient mental health benefit, a care advocate or care manager will assess the member's need for treatment. Once determined what modality of treatment is needed, the care advocate/manager will usually authorize the initial evaluation and five additional sessions. The patient should receive the name of the provider, address, telephone number, and the authorization number. The member will be responsible for providing the facility with his or her demographics and authorization number. Comprehensive Behavioral Healthcare Management Services has provided information to its providers on the importance of communication with the member's PCP.

Medicaid

After Hours

CompCare staff are available 24 hours a day, 7 days a week. For after-hour calls, an answering service will screen calls for emergent and urgent status. **Please note:** CompCare does not manage the inpatient benefits for mental health or substance abuse. However, care managers are available to help the member/provider contact the appropriate agency. If a call is not emergent or urgent, the caller will be advised to call CompCare the next business day. The answering service will obtain a phone number from the patient and inform CompCare to call the member.

Medicare

After Hours

CompCare staff are available 24 hours a day, 7 days a week. For after-hour calls, an answering service will screen calls for emergent and urgent status. If a call is not emergent or urgent, the caller will be advised to call CompCare the next business day. The answering service will obtain a phone number from the patient and inform CompCare to call the member.

Access Standards — Behavioral Health (Medicare/Medicaid)

The care manager reviews presenting information to determine the urgency of service needs. All calls are classified as emergent, urgent or routine as follows:

- **Emergent** — The member is expressing suicidal or homicidal ideation. This care should occur within 2 hours of request for service.
- **Urgent** — The member has a significant psychiatric or substance abuse history, including outpatient treatment and/or hospitalizations, previous suicidal or homicidal ideation not currently present, evidence of psychosis and/or significant immediate crisis. This care should occur within 24 hours of request for service.
- **Routine** — The member is seeking outpatient services and is not presenting evidence of suicidal or homicidal ideation, psychosis or significant immediate medical crisis. This assessment should occur within 7 days of the request for service. **Any patients who presents medical complications should be referred to their PCP for additional assessment and appropriate referral.**

Preventive Health Guidelines/Clinical Practice Guidelines

CareSource adopts evidence-based preventive health guidelines and clinical practice guidelines relevant to our Medicaid and Medicare members to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. These guidelines are from recognized sources:

- Center for Disease Control (CDC) at www.cdc.gov
- United States Preventive Services Task Force (USPSTF) at www.ahrq.gov/CLINIC/uspstfix.htm
- American Academy of Pediatrics (AAP) at www.aap.org
- Michigan Quality Improvement Consortium (MQIC) at www.mqic.org
- National Guideline Clearinghouse (NGC) at www.guideline.gov

The guidelines are reviewed annually and updated as appropriate.

Guidelines are available on the CareSource website at www.caresource.com.

Preventive Care Guidelines include, but are not limited to:

- Immunizations, adult
- Immunizations, child
- Screenings, adult
- Screenings, child
- Screenings, women

Clinical Practice Guidelines include, but are not limited to:

- Acute Bronchitis Guideline
- Acute Pharyngitis in Children Guideline
- Adult Preventive Services Guideline (18 - 49 Years)
- Adult Preventive Services Guideline (50 - 65+ Years)
- Asthma Guideline (General Principles)
- Asthma Guideline (Children 0-4 Years)
- Asthma Guideline (Children 5-11 Years)
- Asthma Guideline (Youth 12 and Older and Adults)
- Childhood Overweight Prevention Guideline
- Childhood Overweight Treatment Guideline
- Chronic Kidney Disease Guideline
- Chronic Obstructive Pulmonary Disease Guideline
- Deep Venous Thrombosis Guideline
- Depression Guideline
- Diabetes Guideline
- Heart Failure Guideline
- Hypercholesterolemia Guideline
- Hypertension Guideline
- Low Back Pain Guideline
- Obesity Guideline
- Office-Based Surgery Guideline
- Osteoarthritis Guideline
- Osteoporosis Guideline
- Prevention of Unintended Pregnancy in Adolescents 12-17 years
- Prevention of Unintended Pregnancy in Adults
- Preventive Services for Children and Adolescents (Ages 2 - 21)
- Preventive Services for Infants and Children Birth-24 Months
- Routine Prenatal and Postnatal Care Guideline
- Substance Use Disorders Guideline
- Tobacco Control Guideline