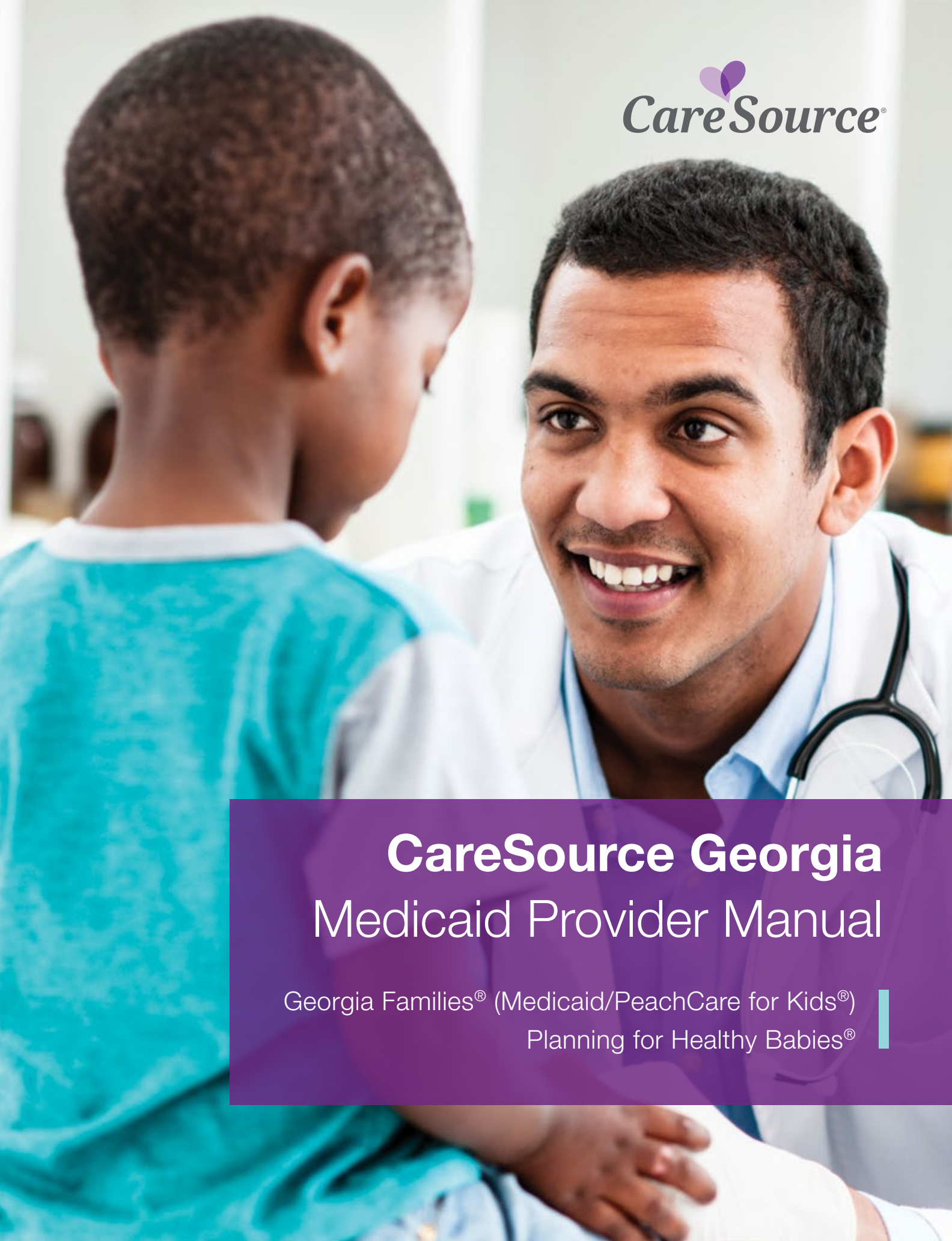

CareSource®

# CareSource Georgia
# Medicaid Provider Manual

Georgia Families® (Medicaid/PeachCare for Kids®)
Planning for Healthy Babies®

This content has been reviewed; however, changes and/or revisions occur frequently. Providers should check our website at **CareSource.com** for the most current version of this manual.

# Dear CareSource® Provider,

Welcome to CareSource and thank you for your participation. CareSource values you as a health partner, and we are actively working to make it easier for you to deliver quality care to our members.

The CareSource Provider Manual is intended as a resource for working with our plan. It communicates policies and information about our programs. This manual also outlines key information, such as claim submission and reimbursement processes, authorizations, member benefits and more to make it easier for you to do business with us. This manual is available on **CareSource.com** > Providers > Tools & Resources > Provider Manual, selecting Georgia Medicaid from the dropdown menu, or you may request a hard copy by calling Provider Services at **1-855-202-1058**.

CareSource communicates updates with our network regularly through network notifications available on the Updates & Announcements page on **CareSource.com** > Providers > Tools & Resources > Updates & Announcements, selecting Georgia Medicaid from the dropdown menu, and on our secure Provider Portal at **CareSource.com** > Login > Provider, selecting Georgia from the menu.

In an effort to better support our providers and offer an immediate response to questions, concerns and inquiries, we offer claim, policy and appeal assistance through our call center at **1-855-202-1058**. Our Provider Services call center can review your claim details and advise you of your rights as a provider to appeal or dispute. If you have questions or concerns, you may ask to speak to a member of our Provider Relations team by calling our toll-free number.

We know great health care begins with you. Together we can help attain better outcomes for our CareSource members.

Sincerely,

CareSource®

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# ABOUT US

## Welcome

Welcome and thank you for participating with CareSource.

At CareSource, we call health care providers our health partners. A “health partner” is any health care provider who participates in CareSource’s provider network. You may find “health partner” and health care provider used interchangeably in our manual, agreements and website.

We work together to ensure that our members – your patients – can improve their health and well-being. Because you’re our partner, we strive to make it simple for you to do business with us. This manual directs you to the solutions you need, whether that’s through convenient online self-service solutions, fast prior authorizations or hassle-free claims payments. It’s our strong partnership that allows us to work together to facilitate a high level of care and a respectful experience for our members.

We are a nonprofit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy.

As a managed health care entity (MCE), we improve the health of our members by utilizing a contracted network of high-quality participating providers. Preferred care providers (PCPs) within the network provide a range of services to our members and coordinate patient care by referring them to specialists when needed, ensuring that members have timely access to health care services and receive all appropriate preventive services.

CareSource also distributes the member rights and responsibility statements to the following groups upon their enrollment and annually thereafter:

- New members
- Existing members
- New providers
- Existing providers

# Plan Descriptions

## Georgia Families® Program Description

Georgia Families® is a partnership between the Georgia Department of Community Health (DCH) and Care Management Organizations (CMOs). Almost all who are eligible for Medicaid or PeachCare for Kids® must enroll in Georgia Families®. CareSource partners with Georgia Families® to deliver more efficient and effective health care services to our members.

The goals of the Georgia Families® program are to:

- Continually and significantly improve the quality of health and services
- Offer care coordination to members
- Enhance access to health care services
- Achieve budget predictability and cost containment
- Create system-wide performance improvement
- Improve efficiency for all
- Improve health outcomes of our members
- Establish member/provider relationships
- Establish a climate of contract accountability
- Slow the growth rate of Medicaid programs to enhance existing programs
- Expand and strengthen member responsibility and engagement

For more information, visit www.dch.georgia.gov.

## PeachCare for Kids® Program Description

PeachCare for Kids® is a program that provides health care coverage to uninsured children in the state of Georgia. In order to be eligible, a child must:

- Be under the age of 19
- Not have health insurance
- Have a family income level less than or equal to 247 percent of the federal poverty limit

Each child who participates in the program enrolls in a CMO and has a primary care provider (PCP).

PeachCare for Kids® covers the following health benefits:

- Primary care services
- Preventive care
- Specialist care services
- Dental care
- Vision
- Hospitalization

- Emergency room services
- Prescription medications
- Behavioral health care

### Planning for Healthy Babies® Program Description

Planning for Healthy Babies® (P4HB®) is an 1115 demonstration program that provides family planning services to women who are not otherwise covered under Medicaid or who have lost Medicaid benefits.

The goals of P4HB® are to:

- Improve Georgia's very low birth weight (VLBW) and low birth weight rates
- Reduce the number of unplanned pregnancies
- Provide family planning to low-income women
- Increase child spacing intervals through effective contraceptive use
- Provide access to inter-pregnancy health care services for women with a previous VLBW infant

CareSource contracts with the state of Georgia's Department of Community Health to provide benefits for Planning for Healthy Babies®.

### Georgia Families® Service Areas

CareSource serves Georgia Families® members state-wide.

## About Us

We founded CareSource on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a nonprofit, we are mission-driven to provide quality care to our members. We offer process efficiencies and value-added benefits for our members and participating providers.

At CareSource, our mission is one we take to heart. In fact, we call our mission our "heartbeat." It is the essence of our company, and our unwavering dedication to it is the hallmark of our success.

## Vision & Mission

**Our vision** is transforming lives through innovative health and life services.

**Our mission** is making a lasting difference in our members' lives by improving their health and well-being.

## Our Services

- Provider relations
- Provider services
- Member eligibility/enrollment information
- Claim processing
- Credentialing/recredentialing
- Delegated credentialing and recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory/compliance
- Special investigations for fraud, waste and abuse
- Member services, including a member call center with CareSource as well as our benefit managers:
  - Pharmacy: Express Scripts, Inc.
  - Dental: SkyGen
  - Vision: EyeMed
  - Hearing: TruHearing
  - Fitness: American Specialty Health

In addition to the above, our care management programs include the following:

- High-risk case management
- Onsite case management (clinics and facilities)
- High emergency department utilization focus (targeted at members with frequent utilization)
- CareSource24® (nurse advice line)
- Health home care
- Maternal and child health
  - Dedicated neonatal intensive care unit (NICU) care management nurses
  - Outreach programs in partnership with community agencies to target members at greatest risk for preterm birth or complications
- Disease management
- Behavioral health and substance use disorder (SUD)

# The CareSource Foundation

Since 2006, the CareSource Foundation has awarded more than $25 million to nonprofits that are working to eliminate poverty, provide much-needed services to low-and moderate-income families, encourage healthy communities, develop innovative approaches to address critical health issues, and enhance the lives of a diverse array of children, adults and families. We are so proud of our partnerships and ultimately, of the impact we are able to make together.

# Compliance & Ethics

At CareSource, we serve a variety of audiences – members, providers, government regulators, community partners and each other. We serve them best by working together with honesty, respect and integrity. Our corporate compliance plan, along with state and federal regulations, outline the personal, professional, ethical and legal standards we must all follow.

Our CareSource Corporate Compliance Plan is an affirmation of CareSource's ongoing commitment to conduct business in a legal and ethical environment. It has been established to:

- Formalize CareSource's commitment to honest communication within the company and within the community
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state and federal laws and regulations
- Implement a system for early detection and reporting of noncompliance with laws, regulations or CareSource policy

This allows us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties and criminal sanctions.

CareSource's Corporate Compliance Plan is a formal company policy that outlines how everyone who represents CareSource must conduct himself or herself. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as providers, consultants and vendors. All providers are required to review and comply with CareSource's corporate compliance plan, located at **CareSource.com** > About Us > Legal > Corporate Compliance.

## General Compliance and Ethics Expectations of Providers

- Act according to the standards of our compliance plan.
- Notify us about suspected violations or misconduct.
- Contact us if you have questions.

For questions about provider expectations, please call Provider Services at **1-855-202-1058**.

If you suspect potential violations, misconduct or non-compliant conduct which impacts CareSource or our members, please leverage one of the following methods to communicate the issue to CareSource:

- Ethics and Compliance Hotline: 1-844-784-9583 or CareSource.ethicspoint.com
- Compliance Department: helpdesk4gf@dch.ga.gov

Any issues submitted to the Ethics and Compliance Hotline may be submitted anonymously.

The CareSource Corporate Compliance Plan is posted for your reference on **CareSource.com** > About Us > Legal > Corporate Compliance.

Please let us know if you have questions regarding the CareSource Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

## Accreditation

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our Ohio, Indiana and Georgia Medicaid plans and our Ohio, Indiana, Kentucky and West Virginia Health Insurance Marketplace plans. NCQA is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement. Visit www.ncqa.org/ for more information.

# COMMUNICATING WITH CARESOURCE

CareSource communicates with our network providers through a variety of methods including phone, fax, mail, our website at **CareSource.com**, provider portals, newsletters, network notifications and in person through our provider orientation process.

## Hours of Operation

| **Provider Services** | | |
|---|---|---|
| Georgia Families® | Monday to Friday | 7 a.m. to 7 p.m. Eastern Time (ET), excluding state holidays |

| **Member Services** | | |
|---|---|---|
| CareSource24® | Available 24 hours a day, seven days a week, 365 days a year | |
| Georgia Families® | Monday to Friday | 7 a.m. to 7 p.m. ET, excluding state holidays |

| **Provider Services** | | |
|---|---|---|
| Phone: **1-855-202-1058** | Monday to Friday | 7 a.m. to 7 p.m. ET |

### Holiday Hours

Representatives are available by telephone Monday through Friday, except on observed holidays. Please visit **CareSource.com** > Providers > Contact Us for the holiday schedule or contact Provider Services for more information.

## Phone

Our interactive voice response (IVR) system will direct your call to the appropriate professional for assistance. We also provide telephone based self-service applications that allow you to verify member eligibility.

| | |
|---|---|
| Provider Services | **1-855-202-1058** |
| Prior Authorizations | **1-855-202-1058** |
| Pharmacy | **1-855-202-1058** |
| Georgia Medicaid Management Information System (GAMMIS) Centralized Prior Authorization | **1-800-766-4456** |
| Claims | **1-855-202-1058** |
| Member Services | **1-855-202-0729** |
| CareSource24 – Nurse Advice Line | **1-844-206-5944** |
| Fraud, Waste & Abuse Hotline | **1-855-202-1058** |
| TTY for the Hearing Impaired | **1-800-255-0056 or 711** |

Please visit **CareSource.com** > Members > Members Overview > Contact Us, selecting Georgia Medicaid, for the holiday schedule or contact Provider Services for more information.

# CLAIMS

## Claims Information

In general, CareSource follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. These can be found at **CareSource.com** > Providers > Provider Policies. It is critical that all addresses and phone numbers on file with CareSource are up to date to ensure timely claims processing and payment delivery. You can email ProviderMaintenance@CareSource.com to update this information. For expedited claims processing and payment delivery, please ensure addresses and phone numbers on file are up to date.

Claims must be submitted within 180 calendar days of the date of service or discharge. We will not pay a claim with incomplete, incorrect or unclear information. If this happens, providers have 180 calendar days from the date of service or discharge to submit a corrected claim. Corrected claims should not be submitted through appeal.

## Claim Submission Process

### Timely Filing

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

CareSource accepts electronic and paper claims. We encourage providers to submit claims electronically to take advantage of the following benefits:

- Faster claim processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claim status
- Minimal staff and cost

### Information to Include in Claims

- Patient (member) name.
- Patient address.
- Insured's ID number – Be sure to provide the complete CareSource member ID number of the patient.
- Patient's birth date – Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service – Use standard CMS (HCFA) location codes.
- ICD-10 diagnosis code(s).
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable.
- Units, where applicable (anesthesia claims require minutes).
- Date(s) of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI).
- Federal tax ID number or physician Social Security Number – Every provider practice (e.g., legal business entity) has a different tax ID number.
- Signature of physician or supplier – The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

## Electronic Funds Transfer

CareSource has partnered with ECHO Health, Inc. to deliver provider payments. ECHO offers three payment options:

1. Electronic fund transfer (EFT) – preferred
2. Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

*Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.

Visit our Claims webpage at **CareSource.com** > Providers > Provider Portal > Claims, selecting Georgia from the dropdown menu, for additional information about getting paid electronically and enrolling in EFT.

Simply complete the enrollment form and fax it back to ECHO Health, CareSource's EFT partner, at **440-835-5656**. ECHO Health will work directly with you to complete your enrollment in EFT.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) thorough a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the CareSource Provider Portal.

# Claim Processing Guidelines

If the claim is submitted after the timeline allotted, then the claim will receive denial for timely filing.

- Providers have 180 calendar days from the date of service or discharge or 90 days from the EOP date to submit a clean claim. If the claim is not submitted within this time frame, the claim will be denied for timely filing.
- If you do not agree with the decision of a claim, you can ask us to review the claim again. Please see the Grievance and Appeals section of this manual for additional information.
- If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment within 90 calendar days of the primary carrier's EOP, but not more than 12 months from the date of service or discharge. Claims that were filed within this time frame with a primary carrier, with no response from the carrier despite all reasonable actions taken, must be filed not more than 12 months from the date of service or discharge indicating no response was received.
- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 12 months from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.
- There will be times when a member is hospitalized for a longer period of time. The provider will be able to submit interim bills, which CareSource will pay at 30 percent of the billed charges submitted. When the patient is discharged, the provider will be required to submit a final bill, which includes the entire bill from date admitted to date discharged. CareSource is not able to determine correct payment unless the full, final bill is submitted. The provider will have 180 calendar days from the date of discharge to submit the complete bill. If this information is not submitted within the timely filing guidelines, the claim will be denied and previous payments will be recouped.
- All claims for newborns must be submitted using the newborn's CareSource ID number. Do not submit newborn claims using the mother's ID number; the claim will deny. Claims for newborns must include the birth weight. The same timely filing guidelines apply for newborns. Newborns receiving retroactive eligibility are subject to timely filing requirements. If retroactive eligibility delays the claim submission, a dispute may be needed.
- For prenatal or delivery services, the last menstrual period date is required on claims. Participating providers may estimate the last menstrual period date based on the gestational age of the child at birth.
- Claims indicating the provided services were the result of an injury will be considered as a case of possible subrogation. Any third-party liability will be determined. CareSource will pay the provider for all covered services. Then, we will pursue recovery from any third parties involved.
- When processing a claim for emergency health care services, CareSource considers, at the time that the claim is submitted, at minimum, the age of the patient, the time and day of the week the patient presented for services, the severity and nature of the presenting symptoms, the patient's initial and final diagnosis and any other criteria prescribed by DCH, including criteria specific to patients under 18 years of age.

# Electronic Claim Submission

## Submitting Claims Through the Provider Portal

Providers may submit claims through the secure, online Provider Portal. Online submission saves you money by eliminating the costs associated with printing and mailing paper claims. Using the portal for claims submission also provides additional benefits:

- Improves accuracy by decreasing the opportunities for transcription errors and missing or incorrect data
- Allows tracking and monitoring of claims through a convenient online search tool

CareSource also partners with Availity to offer electronic claim submission and real-time transactions at no charge through the Availity Portal at www.availity.com. To sign up, you can use the Availity Portal Registration Guide available on the Claims webpage at **CareSource.com** > Providers > Provider Portal > Claims, selecting Georgia Medicaid from the dropdown menu.

## Who Can Submit Claims Via the Portal?

CareSource's traditional providers, community partners and delegates, and health homes all may submit claims through the Provider Portal.

## What Types of Claims Can Be Submitted?

- Professional medical office claims
- Institutional claims
- Behavioral health claims

## Submitting Claim Attachments on the Provider Portal

CareSource providers may submit claims attachments on the provider portal to make processing the claim faster and easier. Supporting Documentation can be uploaded on the on the Claim Information and Attachments page, under the Claims section of the left hand menu on the portal. Attachment size is limited to 100MB.

To upload documentation, do the following:

- If you have the claim number, search for the claim. After locating the claim, click **View Detail**, and then upload the documentation using the **Document Upload** tab.
- If you do not have the claim number, search for the member record. After searching for the member, enter the correct date of service for the claim you have submitted. Select the appropriate reason for submitting documentation, and then upload your attachments.

Enter your contact information before submitting your attachments.

## Clearinghouse

**CareSource prefers electronic claim submission.** CareSource currently accepts electronic claims through Availity. Please contact Availity to begin electronic claims submission.

- Phone: 1-800-282-4548
- Website: www.availity.com

Please provide the clearinghouse with the CareSource payer ID number: GACS1.

## File Format

CareSource accepts electronic claims in the 837 ANSI ASC X12N (005010X ERRATA version) file format for professional and hospital claims.

## 5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This was in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format. All trading partners and payers should be 5010 compliant.

- 837 Health Care Claim/Encounter
- 276/277 Health Care Claim Status Request and Response
- 835 Health Care Claim Payments/Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 278 Health Care Services Review (Prior Authorization Requests)
- 834 Benefit Enrollment and Maintenance
- 820 Group Premium Payment for Insurance Products
- NCPDP Version D.0

Please include the full physical address for billing 5010 transactions. P.O. boxes are no longer accepted for the billing address. However, a P.O. Box or lock box can be used for the pay-to address (Loop 2010AB).

## Procedure & Diagnosis Codes

HIPAA specifies that the health care industry use the following code sets when submitting health care claims electronically.

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM). Available from the U.S. Government Printing Office at 202-512-1800, 202-512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at www.ama-assn.org/practice-management/cpt-current-procedural-terminology.
- HCFA Common Procedure Coding System (HCPCS). Available at www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/%20MedHCPCSGeninfo/%20http://www.cms.hhs.gov/default.asp%20.

- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org/en.
- National Drug Codes (NDC). Available at www.fda.gov/.

**Note:** CareSource also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. Local or proprietary codes are no longer allowed.

## National Provider Identifier and Tax ID Numbers

Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting through the clearinghouse.

**Please note:** On paper claims, the NPI number should be placed in the following box(es) based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

## Location of Provider Information on Professional Claims

On 837P professional claims (005010X222A1), the provider NPI should be in the following location:

- Medicaid: 2010AA Loop – Billing provider name
- Medicare: 2310B Loop – Rendering provider name
- 2010AA Loop – Billing provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing provider NPI
- 2310B Loop – Rendering provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Rendering provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

### Institutional Claims

On 837I institutional claims (005010223A2), the billing provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing provider NPI

The billing provider TIN (Tax Identification Number) must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

On all electronic claims, the RID number should go on:

- 2010BA Loop – Subscriber name
- NM109 = Member ID (RID) number

On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI 24J and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

## Corrected Claims

We will not pay a claim with incomplete, incorrect or unclear information. If this happens, providers have 180 calendar days from the date of service or discharge to submit a corrected claim. Corrected claims should not be submitted through appeal.

**Correcting electronic HCFA 1500 claims:**
EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF*F8* with the most recent claim number for which the corrected claim is being submitted.

**Correcting electronic UB-04 claims:**
EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF *F8* with the most recent claim number for which the corrected claim is being submitted.

**Note:** When billing corrected claims, providers must use the **most recent claim number** in the original claim ID (segment REF*F8) or the claim will be rejected.

# Paper Claims

**For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.**

## Paper Claim Submission Guidelines

Paper claim forms are only encouraged for services that require clinical documentation or other forms to process. If you submit paper claims, please submit on one of the following claim form types:

- CMS 1500
- AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental Claim Form
- CMS 1450 (UB-04)

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare & Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA).

We cannot accept handwritten claims or SuperBills. Claims that have been modified must be submitted using a new claim form; correction made to a previously submitted claim using white-out or erasable ink, may not be processed.

Detailed instructions for completing each form type are available at the websites below:

- CMS 1500 Form Instructions: www.nucc.org
- UB-04 Form Instructions: www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

Please note: On paper claims, the NPI number should be placed in the following box(es) based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
  - Three data elements are used for the standard NPI crosswalk to establish a one-to-one match: billing
- NPI, billing taxonomy code, billing provider service location zip code +4 on file in CoreMMIS
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

Please send all paper claim forms to CareSource at the following address:

CareSource
Attn: Claims Department
P.O. Box 803
Dayton, OH 45401

CareSource uses an optical/intelligent character recognition (OCR/ICR) system to capture claim information, which increases efficiency, improves accuracy and results in faster turnaround time. We cannot accept handwritten claims or superbills.

CareSource also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. Local or proprietary codes are no longer allowed.

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code – F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC, or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

Include the following on claims that require (NDC):

- NDC and unit of measure: pill, milliliter (cc), international unit or gram
- Quantity administered: the number of NDC units
- NDC unit price: detail charge divided by quantity administered
- HCPCS codes that will require NDCs on professional claims: submitted on the 837P format

## Tips for Submitting Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.

CareSource uses an optical/intelligent character recognition (OCR/ICR) system to capture claims information, which increases efficiency, improves accuracy and results in faster turnaround time.

To ensure optimal claims processing timelines:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.
- When submitting paper claims, know we require the most current form version as designated by CMS, NUCC and the ADA.
- Do not submit handwritten (including printed claims with any handwritten information) claims or SuperBills. They will not be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Ensure fonts are 10 to 14 point (capital letters preferred) with printing in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.

- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- It is recommended that you submit your 12-digit CareSource Provider ID, located in your welcome letter, in conjunction with your required NPI number.
- Submit NPI, GNPI (if applicable) and federal TIN or physician SSN for all claim submissions.

## Paper Claim Address

Please send all paper claim forms to CareSource:

CareSource
Attn: Claims Department
P.O. Box 803
Dayton, OH 45401

## Claim Status

Provider Portal at **CareSource.com** > Login > Provider, selecting Georgia.

Claim status is updated daily, and you can check claims that were submitted for the previous 24 months. You can search by member ID number, member name and date of birth or claim number.

You can find the following claim information on the Provider Portal:

- Claim history available up to 24 months from the date of service
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date
- Dental claim information
  - Must log in to Skygen portal for dental claims viewing: https://pwp.sciondental.com/PWP/Landing
- Vision claim information

Claims in a pending status have been entered into our system but have not yet been processed completely. CareSource, not the provider, is responsible for resolving pended claims. Please do not resubmit pended claims as this may further delay processing.

## Member Billing Policy

Providers may not bill members for any covered services, with the exception of copayments. In addition, providers may not refuse to provide services if a member cannot pay the copayment. However, a provider may, upon accepting a patient as a Medicaid/PeachCare for Kids® member, charge the member for non-covered services.

In order to charge the member for non-covered services, the provider must obtain written acknowledgement that the member is assuming financial responsibility prior to the service being rendered.

Providers may not charge members for services which CareSource denied on the basis of lack of medical necessity or lack of compliance to contractual terms. Providers may not bill members for missed appointments. A member may not be billed for medically necessary emergency services.

## Code Editing

CareSource uses clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately and efficiently.

CareSource's code editing software finds any coding conflict or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need for additional information from the provider.

CareSource's code editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

## Explanation of Payment

Explanation of Payments (EOPs) are statements of the status of your claims that have been submitted to CareSource and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated, depending on your claim submission activity. Providers who receive EFT payments may elect to receive an electronic remittance advice (ERA) and can access it on the CareSource Provider Portal.

### Information Included on EOPs

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

# Hospital Statistical and Reimbursement Report (HS&R)

An HS&R report is a summary of Medicaid claims submitted and paid to a hospital for a specific period of time, usually by the hospital's fiscal year end (FYE). The primary use of the report is capturing data for survey completion and calculating various Reimbursement payments and settlements. A written Hospital Statistical and Reimbursement Report (HS&R) request can be received by the CareSource Georgia Regulatory Department via email or mail.

Submit your email request to: GA_HS&R_Reports@CareSource.com.

Submit your written request to:

CareSource, Georgia
C/O Regulatory Department - HS&R Request
600 Galleria Parkway, Suite 400
Atlanta, GA 30339

The HS&R written request should include the following information:

- Facility/Institution Name
- Provider Medicaid ID Number
- Period Service Dates (From – Through)
- Period Paid Dates (From – Through)
- Requestor Contact Information, including email

All HS&R requests to CareSource will be made available within thirty (30) days of receipt of a written request. The data extract report will adhere to the specifications provided by the Department of Community Health (DCH). The report will be distributed to the requestor via email or mail.

Should you have questions or need assistance with your HS&R Request, please feel free to contact CareSource's Regulatory Department by calling 678-214-7400 or via email at GA_HS&R_Reports@CareSource.com.

# Coordination of Benefits

## Coordination of Benefits Information

CareSource collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately.

While we try to maintain information as accurately as possible, we rely on numerous sources of information that are updated periodically, and some information may not always be fully reflected on our Provider Portal. Please ask CareSource members for all health care insurance information at the time of service.

In general we are required to comply with the federal regulations that Medicaid programs serve as the payer of last resort.

### Searching Coordination of Benefits on the Provider Portal

Providers may search for COB on the Provider Portal by:

- Member number
- Case number
- Medicaid number/MMIS number
- Member name and date of birth

You can check COB information for members who have been active with CareSource within the last 12 months.

Claims involving COB will not be paid until an EOB/EOP or EDI payment information file is received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (i.e., $0 balance) must still be submitted to CareSource for processing due to regulatory requirements.

### Coordination of Benefit Overpayment

If a provider receives a payment from another carrier after receiving payment from CareSource for the same items or services and it is determined the other carrier is primary, then this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the provider, or the provider can issue refund checks to CareSource for any overpayments. Providers should not refund any money received from a third party to a member.

## Out-of-Network Claims

Nonparticipating providers may submit claims to CareSource using the Non-Participating Provider Profile Form located on our Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Georgia Medicaid from the dropdown menu. Please be sure to attach your W-9 form when you submit this online form. CareSource is unable to process claims without this information.

## Coding & Reimbursement Policies

CareSource strives to be consistent with all DCH, federal regulations and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code or code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims.

Accordingly, we accept only HIPAA compliant code sets (HCPCS, CPT, ICD-10, and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored, as would be any aspect of a provider contract.

In addition, the Center for Medicare and Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed. Finally, generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the listed links for details:

- Georgia Medicaid: www.mmis.georgia.gov/portal/PubAccessProviderInformation/FeeSchedules/tabid/56/BMLUsed/20160127/Default.aspx

CareSource uses coding industry standards, such as the AMA CPT manual, CCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPCS code or modifier usage

CareSource seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that will review, upon request, any claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review will take into consideration all the previously mentioned DCH, Medicare, CCI and national commercial standards when considering the appeal.

In order to ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the CareSource appeals team to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

CareSource maintains reimbursement policies. To view medical, reimbursement, administrative and pharmacy policies, visit **CareSource.com** > Providers > Tools & Resources > Provider Policies.

# CONTRACTING & CREDENTIALING

## Provider Contracting

Providers must enroll in the Medicaid/PeachCare for Kids® program by submitting an application and supporting documentation to the Georgia Medicaid Management Information System (GAMMIS) portal at www.mmis.georgia.gov/portal. If you need assistance, please contact a DXC Provider Relations Representative at 1-800-766-4456.

To contract with CareSource, providers may complete the New Health Partner Contract Form available at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Georgia Medicaid from the dropdown menu, or call our Provider Services department at **1-855-202-1058**. After we receive your request:

- CareSource reviews the provider request and begins building the provider's contract.
- CareSource coordinates with the CVO to confirm the credentialing status of the provider.
- CareSource refers new providers who are not Medicaid providers to GAMMIS to complete the credentialing process.
- Upon receipt of notice that the CVO has completed the credentialing process, CareSource electronically sends the contract to the provider.

## Georgia Families® Credentialing

The Georgia Department of Community Health (DCH), through its fiscal agent, DXC Technologies, uses a centralized credentialing verification organization (CVO) to perform credentialing and recredentialing functions for providers enrolled or seeking to enroll in the Georgia Families® network. The CVO:

- Performs primary source verification
- Checks federal and state databases
- Obtains information from Medicare's Provider Enrollment Chain Ownership System (PECOS)
- Checks required medical malpractice insurance
- Confirms Drug Enforcement Agency (DEA) numbers, etc.

A credentialing committee renders a decision regarding the provider's credentialing status. Applications that contain all required credentialing materials at the time of submission receive a decision within 51 calendar days. Incomplete applications that do not contain all required credentialing documents are returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing decision.

## Credentialing/Recredentialing

CareSource will not conduct its own credentialing and will accept the CVO's credentialing determination. CareSource cannot appeal the CVO's credentialing decision or require providers to submit supplemental or additional information for purposes of conducting a second credentialing process. CareSource will not pay for claims for dates of service prior to the credentialing approval date.

CareSource will include in our network only those providers who:

- Have been appropriately credentialed by the CVO;
- Maintain a current license; and
- Have appropriate locations to provide covered services to our members.

CareSource will not include any providers in our network who:

- Have been excluded by the United States Department of Health and Human Services
- Have been excluded by the Office of Inspector General
- Are on Georgia's list of excluded providers

CareSource monitors the exclusions list monthly and immediately terminates any provider found to be excluded. We notify any impacted members, per contractual requirements.

## Accreditation Standards for Providers

The DCH recognizes the Joint Commission's accreditation/certification programs to provide quality oversight for certain provider types. To view a list of current state accreditation requirements, visit www.jointcommission.org > Accreditation > Accreditation Top Spots > State Recognition, then select Georgia from the map.

## Delegation of Credentialing/Recredentialing

For Independent Physician Associations (IPAs) and/or Preferred Hospital Organizations (PHOs), CareSource may also enter into agreements to delegate credentialing if the entity that wants to be delegated meets the following requirements:

- Is NCQA-accredited for these functions,
- Utilizes an NCQA-accredited CVO, and/or
- Successfully passes a pre-delegation audit demonstrating compliance with NCQA, federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed using the most current NCQA and regulatory requirements.

Delegates must be in good standing with state and CMS requirements. Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

## Reconsideration and Appeals of Credentialing/Recredentialing Decisions

If the committee maintains the original decision, an appeal may be made consistent with provisions of the CareSource Fair Hearing Plan unless an exception applies. Any appeal request must be submitted in writing and received by CareSource within 30 calendar days of the date the provider is notified of the reconsideration decision.

Appeals may be sent to:

CareSource
Attn: Vice President/Senior Medicaid Director
P.O. Box 8738
Dayton, OH 45401-8738

Applying providers may submit additional documents for reconsideration by the credentialing committee to the address above. An application rejection due to the provider's failure to submit a complete application is not subject to reconsideration or appeal.

If you would like to review the CareSource Fair Hearing Plan, please visit CareSource.com/documents/fhp.

# COVERED SERVICES & EXCLUSIONS

This section describes some of the services and exclusions to benefits that are provided to our CareSource members. CareSource requires all covered services to be medically necessary. Covered services may require copayments and/or prior authorization. To check whether a procedure code requires prior authorization, visit **CareSource.com** > Providers > Provider Portal > Prior Authorization and use the Procedure Code Lookup Tool.

In addition, for Medicaid children under age 21, CareSource covers medically necessary services to correct or ameliorate physical and behavioral health disorders and defects or conditions identified during Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings or preventive visits, regardless of whether the services are included under the State plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.

Covered services and exclusions for CareSource members can be found at **CareSource.com**.

## Medicaid and PeachCare for Kids®

For the most comprehensive and up-to-date list of CareSource covered benefits, please review our member handbook at **CareSource.com** > Plans > Medicaid > Plan Documents, selecting Georgia from the dropdown menu.

| | Medicaid | | | PeachCare for Kids® | | | |
|---|---|---|---|---|---|---|---|
| **Type of Service** | **Copayment*** | **Limits** | **PA Required** | **Copayment***** | **Limits** | **PA Required** | **Additional Comments** |
| Allergy Testing and Treatment | $3 | N/A | No | $3 or cost-based | N/A | No | $3 copayment applies if service performed in outpatient facility setting |
| Ambulance Services | $0 | N/A | Yes | $0 | N/A | Yes | Prior authorization is required on fixed wing transports and ambulance transportation with a HR modifier. |
| Anesthesia | $0 | N/A | No | $0 | N/A | No | |
| **Behavioral Health** | | | | | | | |
| Inpatient Facility | $12.50 | Up to age 21 | Yes | $12.50 | N/A | Yes | |
| Outpatient Facility | $3 | N/A | Yes | $3 | N/A | Yes | IOP or PHP requires a prior authorization after 30 visits. Prior authorization is required for applied behavioral analysis. |
| Psychological Testing | $3 | Up to age 21 | Yes | $3 or cost-based | N/A | Yes | A $3 copayment applies if the service is performed in an outpatient facility setting. Prior authorization is required for applied behavioral analysis. |
| Dental Services | $0 | Adults | No | $0 | Preventative | No | Adult services of two teeth cleanings per year, annual x-rays and simple tooth extractions.<br><br>Preventive services include teeth cleaning, x-rays and simple extractions. |

| | Medicaid | | | PeachCare for Kids® | | | |
|---|---|---|---|---|---|---|---|
| **Type of Service** | **Copayment*** | **Limits** | **PA Required** | **Copayment***** | **Limits** | **PA Required** | **Additional Comments** |
| **Diagnostic Services** | | | | | | | |
| Diagnostic Surgery | $3 | N/A | No | $3 | N/A | No | A $3 copayment applies if service performed in outpatient facility setting. |
| Diagnostic Radiology | $3 | N/A | No | $3 | N/A | No | A $3 copayment applies if service performed in outpatient facility setting. |
| Diagnostic Lab/ Pathology | $3 | N/A | No | $3 | N/A | No | A $3 copayment applies if service performed in outpatient facility setting. |

| | Medicaid | | | PeachCare for Kids® | | | |
|---|---|---|---|---|---|---|---|
| **Type of Service** | **Copayment*** | **Limits** | **PA Required** | **Copayment***** | **Limits** | **PA Required** | **Additional Comments** |
| Durable Medical Equipment | $0 | N/A | Yes | $2 | N/A | Yes | Prior authorization is required on the following durable medical equipment: Powered or customized wheelchairs, manual wheelchair rental over three months, all miscellaneous codes, continuous positive airway pressure (CPAP), insulin pumps and continuous glucose monitors (CGMs), cranial orthotics, food supplements/ nutritional supplements/ enteral feeds – greater than 30 cans per month or greater than one can per day, speech generating devices, defibrillators, bone growth stimulation, implantable cardioverter-defibrillator (ICD), implanted spinal cord stimulators (SCS), chest compression vest and intrapulmonary percussive ventilation (IPV), pneumatic artificial voicing systems, standing frames, stretching devices for the treatment of joint stiffness and contracture, wheel mobility devices, UV light therapy, prosthetic and orthotic devices > $1200, contact lens including the fitting fee and hearing aids. Copayments apply. |
| Education/ Training | $0 | N/A | No | Cost-based | N/A | No | |

| | Medicaid | | | PeachCare for Kids® | | | |
|---|---|---|---|---|---|---|---|
| Type of Service | Copayment* | Limits | PA Required | Copayment*** | Limits | PA Required | Additional Comments |
| Emergency Room | $3 | N/A | No | $0 | N/A | No | A copayment applies if the condition is not an emergency medical condition. |
| Emergent/Urgent Care | $0 | N/A | No | $0 | N/A | No | |
| Family Planning | $0 | N/A | No | $0 | N/A | No | |
| Federally Qualified Health Center/Rural Health Center | $2 | N/A | No | $2 | N/A | No | Limits apply as necessary, based on the services provided. |
| Habilitative Services | $0 | Up to age 21 | No | Cost-based | Up to age 21 | No | |
| Hearing Aids | $0 | Up to age 21 | Yes | $0 | N/A | Yes | |
| Home Health Services | $0 | N/A | Yes | $3 | N/A | Yes | Prior authorization is required for home health aides, private duty nursing, skilled nurse visits and social worker visits. |
| Hospice Care | $0 | N/A | No | $0 | N/A | No | |
| Inpatient Hospital | $12.50 | Respite care limited to five days | Yes | $12.50 | N/A | Yes | |
| Skilled Nursing Facility | $0 | N/A | Yes | $0 | N/A | Yes | |
| Office Visits | $0 | N/A | Yes | Cost-based | N/A | Yes | Prior authorization is required for pain management services. |
| Oral Maxillofacial Surgery | $0 | N/A | | Cost-based | N/A | | |
| Orthotics/ Prosthetics | $0 | N/A | Yes | $3 | N/A | Yes | Prior authorization required for items exceeding $1,200. |
| Outpatient Hospital | $3 | N/A | No | $3 | N/A | No | |

| | Medicaid | | | PeachCare for Kids® | | | |
|---|---|---|---|---|---|---|---|
| **Type of Service** | **Copayment*** | **Limits** | **PA Required** | **Copayment***** | **Limits** | **PA Required** | **Additional Comments** |
| Pharmacy | Preferred = $.50<br><br>Non-Preferred = Cost-Based | N/A | May be required | Preferred = $.50<br><br>Non-Preferred = Cost-Based | N/A | May be required | Some members are exempt from copays. See Pharmacy Copay Requirements for more details. |
| Podiatry | $0 | N/A | No | Cost-based | N/A | No | |
| Preventive Services | $0 | N/A | No | $0 | N/A | No | Immunizations that are covered under the Vaccines for Children (VFC) program are limited to administration of the vaccine only. |
| Physical Therapy/ Occupational Therapy/Speech Therapy | $0 | Up to age 21 | Yes | Cost-based | N/A | Yes | |
| Inpatient Facility | $12.50 | N/A | Yes | $12.50 | N/A | Yes | |
| Outpatient Facility | $3 | N/A | No | $3 | N/A | No | |
| Ambulatory Surgery Center | $3 | N/A | No | $3 | N/A | No | |
| Transportation – Non-Emergency | $0 | N/A | No | $0 | 12 one-way trips | No | DCH provides trips to Medicaid members and CareSource provides trips for PeachCare for Kids® members. |
| Vision | $0 | Eye exam and $75 allowance for hardware or contacts | Yes | Cost-based | N/A | Yes | Prior authorization is required for contacts lens and fitting. |

# Abortion, Sterilization and Hysterectomy Procedures

CareSource covers abortions, hysterectomy and sterilizations in very limited circumstances. Please review the information below for specific information. Providers are required to maintain documentation of all sterilizations, hysterectomies and abortions, as consistent with requirements in 42 CFR 441.200 and 42 CFR 441.208 and 42 CFR 441.250 through 42 CFR 441.259. CareSource will not accept documentation for informed consent completed or altered after the service was rendered.

## Abortion

Abortion services are covered in the following circumstances without prior authorization:

- This patient suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place this woman in danger of death unless an abortion is performed.
- The pregnancy is the result of rape.
- The pregnancy is the result of incest.

Abortion or abortion-related services are not covered when performed for family planning purposes. CareSource will cover treatment of medical complications resulting from elective abortions and treatments for spontaneous, incomplete or threatened abortions and for ectopic pregnancies.

Before reimbursement for an abortion can be made:

- The provider performing the abortion must certify that one of the three circumstances above has occurred.
- The certification must be made on the Georgia Department of Medical Assistance Certification of Necessity for Abortion (DMA-311)*. The certification form must be attached to the claim.
- The provider's signature must be in the physician's own handwriting.
- All certifications must contain the patient's name, address and Medicaid ID number.

## Sterilization

Sterilization procedures are covered if the following requirements are met:

- The member is at least 21 years of age at the time of the informed consent.
- The member is mentally competent and not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.
- Sterilization is the result of a voluntary request for services by a member legally capable of consenting to such a procedure.
- The member is given a thorough explanation of the procedure. In instances where the individual is blind, deaf or otherwise handicapped or unable to understand the language of the consent, an interpreter must be provided for interpretation.

- The procedure is scheduled at least 30 calendar days before, but not more than 180 calendar days, after the consent is signed, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form).

These requirements are applicable to all sterilizations when the primary intent of the sterilizing procedure is fertility control.

For hysterectomies, the following additional requirements must also be met:

- A hysterectomy is only rendered for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental retardation.
- Prior to the hysterectomy, the member must be informed orally and in writing that she will be permanently incapable of reproducing.
- The hysterectomy is not being performed for the purpose of cancer prophylaxis.
- The Hysterectomy Form (DMA-276)* must be completed and attached to the claim.

**Note:** A hysterectomy is not a covered service for Planning for Healthy Babies® (P4HB®) members.

### *Informed Consent Requirements*

- Informed consent is not obtained while the individual to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness.
- The hysterectomy is not being performed for the purpose of cancer prophylaxis.
- The Informed Consent for Voluntary Sterilization Form (DMA-69)* must be completed and attached to the claim.
- Informed consent is obtained on the Georgia Families® Sterilization Request Consent Form prior to the hysterectomy, regardless of diagnosis or age.

* These forms can be found on the GAMMIS portal at www.mmis.georgia.gov/portal. Select Provider Information and then Forms for Providers.

## Annual Wellness Exams for Adults

All adults are eligible to receive a wellness exam from a PCP at the earliest opportunity upon enrollment with CareSource. Members may receive an annual wellness exam consisting of the following:

- Routine physical exam by the PCP or OB/GYN.
- Screening which consists of the following, as appropriate:
  - Abdominal aortic aneurysm ultrasound (AAA)
  - Alcohol misuse
  - Blood pressure for adults

- Bone mass measurements
- Cardiovascular disease
- Cholesterol for adults
- Depression for adults
- Diabetes
- Hepatitis B
- Human immunodeficiency virus (HIV)
- Obesity
- Colorectal
- Electrocardiogram (ECG or EKG)
- Lung
- Mammogram
- Pap smear
- Prostate
- Sexually transmitted infections (STIs)
- Tobacco/smoking
- Vision exam for members age 21 and over

Please visit our website at **CareSource.com** > Providers > Education > Patient Care and visit the Health Care Links page for up-to-date clinical and preventive care guidelines.

# Behavioral Health

## Behavioral Health Overview

Behavioral health is critical to each member's overall health, and CareSource provides behavioral health benefits to our Medicaid members. CareSource ensures that all members have access to behavioral health resources and that behavioral health is integrated across all interventions. Behavioral health providers (BHPs) are expected to assist members in accessing emergent, urgent and routine behavioral services as expeditiously as the member's condition requires.

Members may self-refer to behavioral health services within our provider network without a referral from their primary care provider (PCP).

If you have questions about the SUD incentive program, please call Provider Services at **1-855-202-1058**.

## Screening & Evaluation

CareSource requires that PCPs and specialists have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs and specialists may provide clinically appropriate behavioral health services within the scope of their practice.

CareSource provides training to network PCPs on how to screen for and identify behavioral health disorders, CareSource's referral process for behavioral health services and clinical coordination requirements for such services. Training includes coordination, quality of care and new models of behavioral health interventions. Training may be found at **CareSource.com** > Providers > Education > Patient Care, then going to the Behavioral Health page.

BHPs may provide physical health care services within their scope of practice. Behavioral health providers are required to use DSM-5 multi-axial classification when assessing the member for behavioral health services. Behavioral health providers are required to document the DSM-5 diagnosis and outcome of assessment information in the member's medical record.

## Care Management

CareSource members have access to specialty behavioral health Care Managers for assistance in obtaining both routine and higher complexity health care services.

PCPs can contact CareSource for assistance in facilitating specialty behavioral health services for our members. We can assist members and PCPs with provider referrals and with making appointments for members in need of therapy and/or psychiatric services.

## Coordination of Care

CareSource requires that behavioral health providers refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so.

CareSource encourages communication and care coordination between PCPs and behavioral health providers to achieve optimal health for our members. Communication is necessary to ensure continuity of care and member safety.

CareSource encourages behavioral health providers to send initial and at least quarterly status reports to PCPs, with the member's or the member's legal guardian's consent.

CareSource requires every provider to ask and encourage members to sign a consent permitting release of substance use disorder information to CareSource and to the PCP or BHP. The consent form can be found on **CareSource.com** > Providers > Tools & Resources > Forms.

42 CFR Part 2, better known as Part 2, requires Part 2 providers to obtain written consent from the member before releasing information related to substance use disorder services. This type of release of information also requires the provider to include a "Prohibition on Redisclosure" statement. CareSource contractually requires that physical and behavioral health providers document and reciprocally share the following information for each member:

- Primary and secondary diagnoses
- Findings from assessments
- Medication prescribed
- Psychotherapy prescribed
- Any other relevant information

CareSource ensures members' Behavioral Health Profiles are sent to their respective PCP on file each quarter (or more frequently if clinically indicated). The Behavioral Health Profile is a summary report of a member's physical and behavioral health treatment received during the previous reporting period. Information about substance abuse treatment and HIV/AIDS is only released when the member's consent has been obtained.

The intent of the Member Profile is for coordination of care between physical and behavioral health to better serve members. Thorough and timely sharing of patient information is essential to addressing patients' care plan needs to support positive health outcomes.

CareSource is required to notify both the BHP and PCP when a member has an inpatient behavioral health admission or receives emergency treatment within five days for all behavioral health conditions. However, if the member has a substance use disorder (SUD) diagnosis, we must have their consent to notify the PCP and BHP.

CareSource facilitates coordination of care between BHPs and PCPs. CareSource requires that BHPs refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent.

CareSource assures that behavioral health services are integrated with physical health care services and that behavioral health services are part of the treatment continuum of care. CareSource has developed protocols:

- To address the needs of members in an integrated way, with attention to the physical health and chronic disease contributing to behavioral health,
- For providers to provide a written plan and evidence of ongoing increased communication between the PCP, the managed care plan (MCP) and the BHP, and
- To coordinate management of utilization of behavioral health care services with Medicaid Rehabilitation Option (MRO) and 1915(i) services and services for physical health.

## Continuity of Care

CareSource requires that all members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. If a member misses an outpatient follow-up appointment or continuing treatment, CareSource requires the behavioral health provider to notify CareSource through the Provider Portal and the care manager contact the member within three business days of notification of the missed appointment to reschedule.

# Covered Services and Exclusions

## Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check that the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Provider Services at **1-855-202-1058**.

Covered services may require prior authorization. Please visit **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization for the most up-to-date list of services that require prior authorization. Prior authorization requirements for members enrolled with CareSource are determined and enforced by CareSource.

## Planning for Healthy Babies®

There are three components to the Planning for Healthy Babies® Program (P4HB®):

- **Family Planning:** If a member meets eligibility requirements, this component covers family planning and family planning related services.
- **Inter-pregnancy Care:** If a member meets eligibility requirements, this component covers family planning and additional services for women who have delivered a VLBW baby.
- **Resource Mother:** If a member currently receives Medicaid and delivered a VLBW baby on or after Jan. 1, 2011, this component offers specially trained Resource Mothers who provide support and information on parenting, nutrition and healthy lifestyles.

Refer to the Member Enrollment, Eligibility & Payment Responsibility section for eligibility requirements.

## *Family Planning Services*

Women enrolled in P4HB® are eligible for the following family planning and related services:

| Services | Notes/Limitations |
|---|---|
| Family planning initial or annual exams (one per year) | • Included services: Initial comprehensive and annual examinations<br>• Excluded services: Infertility assessment services, including infertility review, education, physical examination, appropriate lab testing and counseling and referral related to infertility |
| Follow-up family planning or related service visits | • Services are generally performed as part of, or as follow-up to, a family planning service for contraception or for a family planning related problem identified/diagnosed during a routine/periodic family planning visit.<br>• Follow-up visits occur after the initial or annual examination and include services outlined in sections 901.2 and 901.3 of the DCH Family Planning and Family Planning Waiver Services Policies and Procedures Manual.<br>• Follow up service visit examples include:<br>- Contraceptive services and supplies clearly provided or performed for the primary purpose of family planning<br>- Procedures or services clearly provided or performed for the primary purpose of family planning<br>- Periodic or inter-periodic contraceptive management<br>- Patient education and counseling<br>- Rescreening for an abnormal Pap test<br>- Screening or rescreening for a sexually transmitted disease (STD)<br>- Colposcopy (and procedures done with/during a colposcopy)<br>- A Loop Electrosurgical Excision Procedure (LEEP)<br>- Treatment/drugs for sexually transmitted infections (STIs) **except** for HIV/AIDS and hepatitis, when the STIs were identified/diagnosed during a routine/periodic family planning visit<br>- Treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders and urinary tract infections<br>- Treatment of major complications such as:<br>- A perforated uterus due to an intrauterine device insertion<br>- Severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage<br>- Surgical or anesthesia-related complications during a sterilization procedure |

| Services | Notes/Limitations |
|---|---|
| Family planning lab tests | Lab tests may be performed to address family planning problems when those problems are identified during a family planning visit:<br>• Pregnancy tests<br>• Pap tests<br>• STI tests |
| Screening, treatment and follow up for STIs except HIV/AIDS and hepatitis | • Antibiotic treatment for STIs<br>• Treatment for limited infections identified during a routine family planning visit |
| Tubal ligation (sterilization) | • Sterilizations are covered when provided in a family planning setting and when the P4HB® participant:<br>- Is at least 21 years of age at the time consent is obtained<br>- Is mentally competent<br>- Voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Clinic Services (includes the completion of all applicable documentation)<br>- Is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility<br>• In addition, at least 30 calendar days, but not more than 180 calendar days, must have passed between the date of informed consent and the date of sterilization.<br>• An interpreter must be provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a participant who is visually impaired, hearing impaired or otherwise disabled.<br>• A hysterectomy is not considered a covered service for P4HB® participants. |
| Pharmacy services | Prescriptions for family planning related services, folic acid and multivitamins with folic acid. |
| Vaccinations | • Coverage includes hepatitis B, tetanus-diphtheria (Td) and combined tetanus, diphtheria and pertussis (TdAP) vaccinations for P4HB® participants ages 18 to 20.<br>• There is no coverage under the P4HB® program for the Human Papilloma Virus (HPV) vaccine. |
| Nonemergency Transportation | P4HB® Family Planning members can receive 12 one-way trips to covered appointments. |
| Abortions or abortion-related services | This is not a covered service for P4HB® participants. |

## Inter-Pregnancy Care Services

In addition to the family planning services listed above, women who give birth to a VLBW baby on or after Jan. 1, 2011, and do not receive Medicaid or are losing Medicaid coverage, are eligible for Inter-pregnancy Care services:

| Services | Notes/Limitations |
|---|---|
| Primary care | PCP coordinates care for the participant and makes referrals to in-network and out-of-network specialty care as needed. |
| 5 office/outpatient visits | Per year |
| Management and treatment of chronic diseases | Including but not limited to asthma, diabetes, and hypertension |
| Substance abuse treatment (detoxification and intensive outpatient rehabilitation) | Participants can self-refer to an in-network provider for an initial mental health or substance abuse visit but prior authorization may be required for subsequent visits.<br><br>Participants may receive detoxification and intensive outpatient rehabilitation services only. |
| Case Management/Resource Mother Outreach | See below. |
| Limited Dental | For a list of benefits, contact Member Services. |
| Prescription drugs (non-family planning) | IPC enrollees have limited prescription drug coverage. Our online Preferred Drug List (PDL) can be found on **CareSource.com** > Providers > Education > Pharmacy > Georgia P4HB. |
| Nonemergency medical transportation | DCH provides nonemergency medical transportation to all Georgia Medicaid members. Women enrolled in the IPC component will have access to non-emergency medical transportation. |

### *Resource Mother Services*

Women served under the IPC component of the P4HB® program and women enrolled in other Medicaid programs who have delivered a VLBW baby on or after Jan. 1, 2011, have access to case management including a Resource Mother (RM). The Resource Mother mentors women who give birth to VLBW babies and provides information regarding parenting, nutrition and healthy lifestyles, in addition to the following services:

- Meet with P4HB® participants over the phone or in person to encourage them to adopt healthy behaviors, including healthy eating and smoking cessation
- Support compliance with primary care medical appointments including assistance with nonemergency transportation arrangements
- Consult with physicians, nurses, social workers and case managers about problems identified and assist in the development of an appropriate action plan

- Support P4HB® participants' compliance with medications to treat chronic health conditions including assisting the P4HB participant with obtaining needed medications and reinforcing the need for medication compliance
- Assist the P4HB® participant with the coordination of social services support for family and life issues
- Assist P4HB® participants in locating and utilizing community resources including legal, medical, financial assistance and other referral services (including Women, Infants and Children [WIC] programs) to make sure the baby receives regular well-baby check-ups and immunizations
- Provide peer and emotional support needed to meet the health demands of the VLBW baby

### *Benefit Limits*

| Services | Notes |
|---|---|
| Initial and annual comprehensive family planning visits* | • Only one initial or annual comprehensive visit is available per member per 12 months.<br>• The initial or annual comprehensive visit cannot be billed on the same date of service with a general comprehensive medical visit.<br>• Providers should use CPT codes 99204 (for new patient) or 92215 (for an established patient) when conducting the initial or annual comprehensive visit.<br>• The FP modifier must be used with either of these codes. |
| Brief medical visit* | • This is a follow-up visit that occurs after the initial or annual comprehensive visit.<br>• It typically consists of 10 minutes of face-to-face time with the patient.<br>• Providers should use CPT code 99212 (for an established patient) when conducting the brief medical visit.<br>• The FP modifier must be used with this code. |
| Comprehensive medical visit* | • This is a follow-up visit that occurs after the initial or annual comprehensive visit.<br>• It typically consists of 15 to 25 minutes of face-to-face time with the patient.<br>• Providers should use CPT codes 99213 (for an established patient; typically a 15 minute visit) or 99214 (for an established patient; typically a 25 minute visit) when conducting the comprehensive medical visit.<br>• The FP modifier must be used with either of these codes. |
| *Providers cannot bill for an initial exam or the annual exam on the same date of service with the comprehensive medical visit or brief medical visit. | |
| Supply visit | • The purpose of the supply visit is to allow the patient to obtain additional contraceptives and counseling if indicated.<br>• This typically consists of five minutes spent performing or supervising these services.<br>• The presenting problems are minimal.<br>• The visit may not require the presence of a physician.<br>• Providers should use CPT code 99211 when conducting this office visit.<br>• The FP modifier must be used with this code. |

| Services | Notes |
|---|---|
| Implantable contraceptive capsules | • Physicians, nurse practitioners, midwives and physicians' assistants will be reimbursed for the insertion and removal of implantable contraceptive capsules only after their training requirements have been completed.<br>• Staff training should be conducted according to the manufacturer's guidelines.<br>• Documentation of training must be maintained in the provider's personnel or training record.<br>• The insertion, management and removal of the capsule must be accomplished according to the manufacturer's recommendations.<br>• Providers should use the codes below with the FP modifier when billing for this service.<br>- J7307 Etonogestrel (Implanon/Nexplanon) Implant System – Modifier FP<br>- 11981 Insertion, Implantable Contraceptive Device – Modifier FP<br>- 11976 Removal, Implantable Contraceptive Capsule – Modifier FP<br>• Insertions are limited to one within a three-year period.<br>• The insertion or removal may be billed in conjunction with one of the above-mentioned visits. |
| Intrauterine devices | • Physicians, nurse practitioners, midwives and physicians' assistants will be reimbursed for the insertion and removal of intrauterine devices only after their training requirements have been completed.<br>• Staff training should be conducted according to the manufacturer's guidelines.<br>• Documentation of training must be maintained in the provider's personnel or training record.<br>• The insertion, management and removal of these devices must be accomplished according to the manufacturer's recommendations.<br>• Providers should use the codes below with the FP modifier when billing for this service.<br>- J7296- Levonorgestrel-releasing intrauterine –contraceptive, 19.5 MG (5 year Kyleena) – Modifier FP<br>- J7297 Liletta IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 3 year - Modifier FP<br>- J7298 Mirena IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 5 year – Modifier FP<br>- J7300 Paragard / Intrauterine Copper Contraceptive – Modifier FP<br>- J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System (Skyla), 13.5MG-Modifier FP.<br>- J7307-Etonogestrel contraceptive implant system, including implant and supplies (Nexplanon) – Modifier FP<br>- 58300 Insertions, Intrauterine Device – Modifier FP |

| Services | Notes |
|---|---|
| Injectable contraceptives | • The Depo-Provera injection may be billed with any type of visit code.<br>• Coverage is limited to one injection every three months or one every 12-13 weeks.<br>• Providers should use the code below with the FP modifier when billing for this service.<br>- J1050 Medroxyprogesterone Acetate 1 mg (Injection) – Modifier FP<br>• The provider must bill the appropriate units administered to the patient (1 mg = 1 unit). |
| Other contraceptive methods | • Oral contraceptives are available as a pharmacy benefit.<br>• Providers should use the codes below with the FP modifier when billing for Other Contraceptive Methods services.<br>- 57170 Diaphragm or Cervical Cap Fitting with Instructions – Modifier FP<br>- A4267 Contraceptive Supply, Condom, Male, – Modifier FP<br>• Condoms may be billed with any type visit code. |
| Pregnancy test | • The pregnancy test may be billed through the Family Planning program only when the test is family planning related under the following circumstances:<br>- It is performed at the time family planning services are initiated for an individual.<br>- It is performed at a visit after the initiation of family planning services where the patient may not have used the particular family planning method properly or where the patient is having an unusual response to the method.<br>- It is performed during the infertility evaluation.<br>• Providers should use CPT code 81025 with the FP modifier when billing for the urine pregnancy test. |
| **NOTE:** Please Use the FP modifier for all Family Planning related laboratory services. | |

## Emergency Services

CareSource provides reimbursement for medically necessary emergency services when rendered by a qualified provider, in accordance with the provider's contract with CareSource or in accordance with the Department of Community Health's fee-for-service reimbursement rates for providers that do not have a contract with CareSource, less any applicable percentage.

CareSource reimburses for all medically necessary emergency services that are provided to stabilize the member. After a member's condition is stabilized, providers must notify CareSource as soon as reasonably possible in order for CareSource to issue any needed authorization.

CareSource will not:

- Deny or inappropriately reduce reimbursement for a provider's provision of emergency care services for any evaluation, diagnostics or treatment provided to a member who needs emergency medical assistance, or
- Reimburse emergency care services contingent upon on the member or provider providing any notification, either before or after receiving emergency services.

## Post-Stabilization Services

Post-stabilization services are covered services that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition. Notification of all emergent inpatient admissions should be provided within 24 hours after admission. Post-stabilization care services are defined by 42 CFR 438.11.

### Participating Providers

Prior authorization is not required for coverage of post-stabilization services when these services are provided in an emergency department or for services in an observation setting by a participating provider. Please call **1-855-202-1058** for any questions related to post-stabilization services.

### Non-Participating Providers

All non-participating providers require prior authorization. To request authorization for services, please submit your request through the Georgia Medicaid Management Information System (GAMMIS).

## EPSDT Overview

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit includes a comprehensive array of preventive, diagnostic and treatment services for Medicaid eligible infants, children and adolescents under age 21. The EPSDT benefit is also available to PeachCare for Kids® members up to 19 years of age.

The EPSDT benefit is designed to assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible. The goal of the EPSDT benefit is to ensure that individual children get the health care they need when they need it. The EPSDT benefit also covers medically necessary diagnostic services.

The program provides reimbursement for preventive health services, interperiodic visits, developmental screenings, brief emotional/behavioral assessments, hearing and vision screenings, and immunizations under the EPSDT benefit.

## Exam Components

The exam is a general health assessment and is composed of the following required screening components:

- A comprehensive health, psychosocial and developmental history;
- Documentation of vital signs;
- An unclothed comprehensive physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination);
- Assessment of growth and nutritional status, including BMI percentile documentation;
- Assessment of immunization status and provision of appropriate immunizations. Use the Advisory Committee on Immunization Practices (ACIP) schedules;
- Screening for vision, hearing, lead poisoning and development, as per AAP guidance (blood lead test is required, per federal mandate);

- Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance;
- Oral health screening, preventive counseling and referral to a dentist for ongoing dental care;
- Screening for and if suspected, reporting of child abuse and neglect;
- Anticipatory guidance (health education); and
- Referrals/follow-ups where appropriate based on history and exam findings.

## Exam Frequency

CareSource's recommended schedule for HealthWatch exams is as follows:

- Birth
- Three to five days
- One month
- Two months
- Four months
- Six months
- Nine months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- after 30 months, one exam per year until age 21

The American Academy of Pediatrics (AAP) Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule is the periodicity schedule used for EPSDT visits and services. The schedule is available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

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. The list also includes indicators for patients who appear not to have had their initial preventive HealthWatch exam and/or who do not comply with the EPSDT periodicity schedule. Initial HealthWatch exams are to be completed within 90 days of the initial effective date of membership for new enrollees. You can find this list on our Provider Portal.

Initial preventive health exams are to be completed within 24 hours of birth for all newborns and within 90 days of the initial effective date of membership for new enrollees. PCPs are required to contact members via phone/mail to encourage them to schedule and keep their preventive health appointment.

## EPSDT Referrals for Further Diagnosis and Treatment

If the PCP is unable to provide all of the components of the preventive health 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.

## Documentation/Billing

In order to receive proper payment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/ HealthWatch services, you must use the appropriate preventive medicine CPT codes, diagnosis codes and EPSDT referral indicators. CareSource requires the appropriate referral field indicators to be populated on EPSDT claims. Claims missing this information, or submitted with invalid combinations of this information, may be rejected or denied.

**(Use 99381-99385 for a new patient and use 99391-99395 for an established patient.)**

| Age | Preventive Visit Code | HIPAA Modifier |
|---|---|---|
| Birth – 11 months | 99381 or 99391 | EP |
| 12 months – 4 years | 99382 or 99392 | EP |
| 5 years – 11 years | 99383 or 99393 | EP |
| 12 years – 17 years | 99384 or 99394 | EP |
| 18 years – 20 years | 99385 or 99395 | EP |

## PCP Preventive Visit ICD-10 Codes

| ICD-10 Code | At this Age |
|---|---|
| Z00.100 | 0 – 7 days |
| Z00.111 | 8 – 28 days |
| Z00.121 or Z00.129 | 29 days through 14 years |
| Z00.121 or Z00.129<br>Z00.00 or Z00.01 | 15 years through 17 years |
| Z00.00 or Z00.01 | 18 years through 20 years |
| Z02 – Z02.89 | 0 through 20 years |

| Screening | Timing | CPT Code | HIPAA Modifier | ICD-10 Diagnosis Code |
|---|---|---|---|---|
| Developmental Screen | 9, 18 and 30 months | 96110 | EP | Z00.121 or Z00.129<br>Z02 – Z02.89 |
| Autism Screening | 18 and 24 months | 96110 | EP, UA or<br>EP, UA, HA | Z00.121 or Z00.129<br>Z02 – Z02.89 |
| Brief Emotional/ Behavioral Assessment | Annually ages 12 years – 20 years | 96127 | EP | Z00.121 or Z00.129<br>Z00.00 or Z00.01<br>Z02 – Z02.89 |
| Alcohol, Tobacco or Drug Use Assessment | Annually ages 11 years – 20 years | 96160 | EP | Z00.121 or Z00.129<br>Z00.00 or Z00.01<br>Z02 – Z02.89 |
| Maternal Depression Screening | By one month<br>2 month<br>4 month<br>6 month | 96161 | EP | Z00.121 or Z00.129<br>Z00.00 or Z00.01<br>Z02 – Z02.89 |

| Screening | Timing | CPT Code | HIPAA Modifier | ICD-10 Diagnosis Code |
|---|---|---|---|---|
| Blood Lead Level Screening | 12 months<br>24 months | 36415 or 36416 | | Z13.88 |
| | 36-72 months* | 83655** | EP, 90 or<br>EP, 91 | |

* If no record of previous blood lead level test

** Bill in addition to 36415 or 36416 if specimen is sent to the Georgia Public Health Laboratory (GPHL)

| Referrals | |
|---|---|
| **Box 24 of claim** | |
| NU | No follow up needed |
| AV | Available, Not Used: Patient refused referral. |
| S2 | Under Treatment: Patient is currently under treatment for health problem and has a return appointment. |
| ST | New Services Requested: Referral to another provider for diagnostic or corrective treatment/scheduled. |

**For more information about the EPSDT program, visit the EPDST webpage at Medicaid.gov > Medicaid > Benefits > Early Periodic Screening, Diagnostic and Treatment.**

## Immunization

All members under 21 years of age shall be provided access to all vaccines in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

Providers must administer immunizations obtained through the Vaccines for Children (VFC) program for all members 18 years of age and younger. CareSource will not reimburse costs for vaccines obtained outside the VFC program when provided to children under age 18.

Immunizations are an important part of preventive care for children and should be administered during HealthWatch exams as needed.

P4HB® participants ages 19 and 20 shall receive hepatitis B, tetanus-diphtheria (Td) and combined tetanus, diphtheria and pertussis vaccinations according to the ACIP guidelines as needed.

Vaccines, flu vaccines and pneumococcal vaccines can be obtained at the retail pharmacy for those members ages 19 and older. Some vaccines require a prescription. CareSource pays for the administration of the vaccine only when billed with an appropriate immunization and administration CPT code.

## Immunization Codes

Please bill CareSource with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. Please refer to the code tables located on the CMS website at www.cms.gov/Medicare/Coding/ICD10. You can also get CMS coding guidelines at www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf.

To view the most recent list of VFC-covered vaccine codes, please refer to the Department of Community Health "Part II Policies and Procedures for EPSDT (Health Check) Services" Appendix C at www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/EPSDT%20Services%20Health%20Check%20Program_%2020200624201407.pdf. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

## Vaccine Schedule

Immunizations are an important part of preventive care for children and should be administered during preventive health exams as needed.

CareSource endorses the same recommended childhood immunization schedule that is 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 updated annually, and the most current updates are located on www.aap.org.

## Vaccines for Children Program

The federal Vaccines for Children (VFC) program makes designated vaccines available at no cost to VFC participating health care providers to administer to children under the age of 18 who:

- Are eligible for Medicaid and/or PeachCare for Kids®
- Uninsured
- Underinsured
- Or American Indian/Alaskan native

CareSource encourages providers to participate with the VFC program. Vaccines administered to children under the age of 18 must be obtained through the VFC program, which supplies vaccines to program participating providers at no cost. CareSource will not reimburse costs for vaccines obtained outside the VFC program. CareSource will pay for the administration of the vaccine only.

This program is administered by the Georgia Department of Public Health.

For more information about the Georgia VFC program and how to enroll and obtain vaccines, please contact:

Immunization Program
2 Peachtree St. NW, 13-276
Atlanta, GA 30303

**Email:** DPH-gavfc@dph.ga.gov

**Phone:** 1-800-848-3868 or 404-657-5013/5015

## Statewide Web-Based Immunization Registry

Participating providers must report all immunizations to the statewide web-based immunization registry, the Georgia Registry of Immunization Transactions and Services (GRITS), found at www.grits.state.ga.us/production/security_ui.showLogin.

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. The system is designed to save time and money, reduce paperwork and provide quick and efficient tracking of immunizations. It also ensures that all persons in Georgia receive appropriate, timely immunizations to lead healthy, disease-free lives.


# PHARMACY

## Pharmacy Coverage

CareSource covers all medically necessary Medicaid-covered prescription drugs and medical supplies.

## Pharmacy Partner

The following Georgia Medicaid members are exempt from copayments:

- Members under age 21
- Pregnant women
- Nursing facility residents
- Members enrolled in breast and cervical cancer programs
- Hospice care members
- American Indian or Alaska Natives

Many PeachCare for Kids® members are required to pay copayments for their children that are cost-based. However, copays are not required for PeachCare for Kids® members who are:

- Under the age of 6
- Foster children
- Alaskan natives
- American Indians

## Medical Supplies/Durable Medical Equipment

To support member access and convenience, other select medical supplies, such as wound care supplies and enteral feeds, may be filled through the retail pharmacy for a limited period of time (up to 30 days) until you coordinate delivery with a DME provider.

## Medications Administered in Provider Setting

CareSource covers many medications that are administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center.

Please note, prior authorization requirements exist for many injectable medications.

## Network Pharmacies

Our Pharmacy Directory gives members a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website for a complete list of network pharmacies at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions > Find A Pharmacy.

## Preferred Drug List/Formulary

CareSource uses a Preferred Drug List (PDL), along with evidence-based guidelines, to ensure health care services and medications meet the standards of excellent medical practice. Some drugs on the PDL require a prior authorization before CareSource will cover it.

The online formulary contains information about prior authorizations, quantity limits and step therapy protocols for most drug classes. This may be found online at **CareSource.com** > Providers > Tools & Resources > Drug Formulary. The PDL contains information about prior authorizations, quantity limits, step therapy protocols and therapeutic interchanges for most drug classes.

To learn more about how to use our pharmaceutical management procedures, please visit our website's Pharmacy page at **CareSource.com** > Provider Overview > Education > Patient Care > Pharmacy.

CareSource updates PDLs on a quarterly basis and communicates updates online on the Drug Formulary Changes page located at **CareSource.com** > Providers > Tools & Resources > Drug Formulary > Drug Formulary Changes.

## Step Therapy

Certain medications on the Drug Formulary are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a first step formulary medication be tried and failed prior to the approval of a step two formulary medication. A reasonable clinical trial of the step one drug is defined to include appropriate use for labeled or compendia-supported indications, titration of the step one drug (where appropriate) and supporting evidence (such as provider notes or lab results) to show the step one drug has failed. Step two drugs are formulary medications which may require the member to pay higher cost share and may be more costly to the plan. Step therapy is designed to preserve best practice and protect our member's financial medication burden.

## Quantity Limits

Quantity limits are also placed on many medications, based on normal manufacturers' recommended dosing frequencies and safety considerations.

## Generic Substitution/Therapeutic Exchange

Generic substitution occurs when a pharmacy dispenses a generic version rather than a prescribed brand-name product. Generic drugs are usually priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Members and providers can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic interchange).

In the online PDL, boldface type indicates generic availability. However, not all strengths or dosage forms of the generic name in boldface type may be generically available. In most instances, when a generic product becomes available, the brand-name version will become non-formulary and replaced with its generic equivalent. However, the PDL document is subject to state-specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

A list of preferred drugs is available at **CareSource.com** > Provider Overview > Tools & Resources > Drug Formulary. This site also includes other information about the CareSource pharmacy program.

## Specialty Pharmacy Program

Please visit our Pharmacy webpage at **CareSource.com** > Providers > Education > Pharmacy, selecting Plan from the dropdown menu, to see more details about the Specialty Pharmacy program.

## Prior Authorization

A prior authorization is when CareSource requires that a drug be pre-approved in order for it to be covered under the member's health benefit. CareSource processes prior authorization requests within 24 hours of receipt, unless additional information is required from the prescriber, in accordance with Georgia Medicaid regulations. If we need additional information in order to make a decision on the authorization request, we will contact the prescriber every 24 hours up to a final disposition within 72 hours of receipt of the request.

The Prior Authorization staff adheres to the Georgia Department of Community Health regulations and determines medical necessity for formulary exception requests based on drug-specific prior authorization criteria or standard non-formulary prescription request criteria.

Providers can submit prior authorization requests electronically, by phone or fax. To ensure timely review, providers are required to submit pertinent medical/drug history, prior treatment history, along with any other necessary supporting clinical information with the request.

Access our Pharmacy webpage at **CareSource.com** > Providers > Education > Pharmacy, selecting Georgia Medicaid from the dropdown menu, for instructions to obtain a prior authorization.

### Online

Visit **CareSource.com** > Login > Provider. Alternate methods include phone, fax or mail.

### Fax

1-866-930-0019

### Phone

1-844-607-2831

## Synagis Prior Authorization

CareSource's Medical Policy for administration of Synagis follows the American Academy of Pediatrics (AAP) guidelines for Respiratory Syncytial Virus (RSV), which may be found at www.aappublications.org. CareSource will review according to the guidelines in determining payment authorization for Synagis immunization. Consistent with epidemiologic findings, CareSource considers "RSV season" to be November 1 through March 31.

Coverage for the RSV season will end March 31 with a possible extension if RSV is still in the community. Requests for Synagis injections can be submitted on our secure Provider Portal.

## Lock-In Program (LIP)

The CareSource Lock-In Program (LIP) helps reduce member fraud and abuse by restricting the providers and medications available to the member. The LIP is a regulatory requirement. It is the policy of CareSource to take appropriate steps to control fraud, abuse and overutilization of medical and pharmacy services by placing or continuing members in the (LIP) which monitors and educates members with the goal of developing positive behavior changes.

The CareSource LIP team monitors complaints and referrals regarding potential fraud, member abuse, provider abuse or overutilization. The LIP team responds to any complaint or data finding by conducting a utilization review of the member.

A member utilization review includes a review of medical and pharmacy claims to identify if the member utilized Medicaid services at a frequency or amount that exceeds utilization criteria and to determine if the member should be placed in the LIP.

LIP members are restricted to receiving Medicaid services from designated providers, including:

- One or more controlled substance prescribers who will serve as the sole prescriber and manager of controlled substances for the lock-in member; and
- One pharmacy who will serve as the sole establishment to fill the member's prescriptions

## Eligibility

Potential Lock-In members are scored based on the likelihood that they are engaging in behaviors of abuse or unnecessary use of prescription or non-prescription drugs including, but not limited to:

- Drug therapy that does not correlate with either the primary or secondary diagnosis in claim data
- Prescriptions filled at two or more pharmacies per month, or more than five pharmacies per year
- More than three controlled substances per month
- The number of prescriptions for controlled substances exceeds 10 percent of the total number of prescriptions filled by the member
- More than two hospital emergency room visits per year and the recorded diagnosis is not consistent with an emergency medical condition
- Duplicate therapy from different physicians
- Prescriptions from pharmacies or physician visits located outside the member's county of residence
- Purchases of drugs of abuse without utilizing Medicaid prescription benefits
- Diagnosis of narcotic poisoning or drug abuse
- Greater than 120mg MED (morphine equivalent dose) per day

Members may be **excluded** from the Lock-In program if:

- They utilize Medicaid services at a frequency or amount which is medically necessary to treat a complex, life threatening medical condition as determined by the Lock-In Coordinator or with the assistance of a Medical Director and Pharmacist
- The Lock-In Coordinator, in collaboration with Pharmacy, Behavioral Health and/or Care Management staff, determines that not enrolling a member in the Lock-In program is in the best interest of the member

## Enrollment

Upon identifying a member for the Lock-In program, CareSource will:

1. Send a written notification to the member including:
    - The reason for enrolling the member in the Lock-In program
    - A description of the Lock-In program
    - The effective date of Lock-In program enrollment
    - Identification of the member's designated provider(s) and/or pharmacy
    - Information relating to the member's right to an appeal
    - Information on how to contact CareSource for more information about the Lock-In program
2. Enroll the member in the Lock-in program.
3. Refer the member to Care Management for management, education and reinforcement of appropriate medication use.

CareSource will enroll the member in the Lock-In program within 30 days of sending the written notification, except for a member who requests an appeal relating to a lock-in determination.

## Changing Designated Providers

The member has 30 days from the date of the initial notification of enrollment to select designated provider(s), otherwise the CMO will select the designated provider(s). The designated controlled substance provider(s) will be the designated provider(s) of a Lock-In member for up to 12 months.

A Lock-In member may not transfer to another pharmacy, PCP or care management program while enrolled in the Lock-In program within a 12-month period except as indicated below.

- The designated provider contacts CareSource requesting a release from serving as the member's designated provider. The provider will continue to serve as the member's designated provider until a comparable designated provider is selected.
- A member contacts CareSource to request a change, or CareSource requires an alternative selection of a designated provider under the following circumstances:
  - The designated provider's office or location is no longer accessible to the member for one or more of the following reasons:
    - Relocation or closing of the designated provider's office.
    - Relocation or incapacity of the member.
  - The designated provider is no longer an eligible provider.
  - The designated provider chooses to not, or no longer, provide services to the member.
  - The medical or prescription needs of the member are not available from the current designated provider.
  - The medical or prescription needs of the member require a designated provider with a different specialty.
- The CareSource Lock-In staff or the care manager determines that it is in the best interest of the member to change the designated provider.

## Annual Review Process

CareSource will annually assess the needs for each Lock-In member. Members enrolled in the Lock-In program will either be disenrolled or re-enrolled for an additional 12-month period.

Prior to consideration for disenrollment from the Lock-In program, CareSource will conduct a utilization review to measure the effectiveness of the member's enrollment in the Lock-In program. CareSource will provide the Lock-In member with written notification, which includes the findings of the utilization review and the decision to maintain enrollment or discharge the member from the Lock-In program.

# GRIEVANCES & APPEALS

CareSource provides members with reasonable assistance in completing forms and taking other procedural steps for both grievances and administrative reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability.

## Member Grievances

Members have the right to file a grievance at any time. A provider cannot file a grievance on behalf of a member.

Any time a member informs us that they are dissatisfied with CareSource or one of our providers, it is a grievance. A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the following:

- Quality of care or services provided
- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the enrollee's rights, regardless of whether remedial action is requested
- A dispute of an extension of time proposed by CareSource to make an authorization decision

Members are encouraged to call or write to CareSource to let us know of any complaints regarding CareSource or the health care services they receive. Detailed grievance and appeal procedures are explained in the member handbook. Members can contact CareSource at **1-855-202-0729** (TTY: 1-800-255-0056 or 711) to learn more about these procedures.

## Time Frames & Requirements for Member Grievances

State and federal agencies require us to comply with all requirements, which include aggressive resolution time frames.

CareSource will acknowledge receipt of a grievance within ten business days of receipt.

CareSource investigates all grievances. As a CareSource provider, we may contact you to obtain documentation. If the grievance is about a provider, we call the provider's office to gather information for resolution.

CareSource ensures that the individuals who make decisions on grievances that involve clinical issues are health care professionals, under the supervision of CareSource's Medical Director, who have the appropriate clinical expertise in treating the member's condition or disease and who were not involved in any previous level of review or decision-making.

CareSource has procedures to ensure all members are notified of the grievance resolution in their primary language.

CareSource responds to all other grievances as soon as possible, but no later than 90 calendar days from receipt.

If members are not satisfied with our response to a grievance, they can ask us to reconsider it by sending us a letter within 180 days.

## Member Appeals

A member appeal is a request for reconsideration of an adverse benefit determination. CareSource notifies members in writing when an adverse benefit determination has been made. This can include:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or part, of payment for a service
- Failure to provide services in a timely manner
- Failure of CareSource to act within the appropriate time frame
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities

Members have the right to appeal an adverse benefit determination if they contact CareSource within 60 calendar days from the date on their adverse benefit determination notice. Members can contact CareSource at **1-855-202-0729** (TTY: 1-800-255-0056 or 711) to learn more about appeal procedures.

## Submissions

A member, the member's authorized representative, or a provider acting on behalf of the member with the member's written consent, may file an appeal orally or in writing.

Appeals will be expedited when a provider indicates, or CareSource determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

CareSource will provide the member, the member's authorized representative, or provider acting on behalf of the member with the member's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing, and to examine the member's case file, including medical records and any other documents and records considered during the appeal process. CareSource will inform the member of the limited time available to provide this in case of an expedited review.

CareSource will ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making and who are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:

- An appeal of a denial that is based on lack of medical necessity
- An appeal that involves clinical issues

## Notification of Resolution or Adverse Action

CareSource will respond to the appeal in writing as expeditiously as the member's health condition requires, but not later than 30 calendar days of when it was received for a standard appeal or within 72 hours for an expedited appeal.

CareSource will verbally notify the provider/facility of the appeal resolution or adverse action if the member is in an inpatient setting and will send written notification to both the provider and member on the same business day of the decision.

## Extensions

A member or the authorized representative can verbally request that CareSource extend the time frame to resolve a standard or expedited appeal up to 14 calendar days. CareSource may also request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days if CareSource demonstrates to the DCH satisfaction that there is a need for additional information and that the delay is in the member's best interest. CareSource will immediately give the member written notice of the reason for the extension and the date that a decision must be made.

## Administrative Law Hearings

CareSource members can request an Administrative Law Hearing if they have exhausted CareSource's internal appeal process and CareSource has upheld its decision. A provider can request an Administrative Law Hearing on behalf of a member.

Members must request an Administrative Law Hearing within 120 calendar days of the date of CareSource's notice to uphold its decision in response to a member's appeal. CareSource will comply with the decisions reached as a result of the Administrative Law Hearing.

## Continuation of Benefits

CareSource will continue the member's benefits while an appeal or Administrative Law Hearing is pending:

- If the member or the member's authorized representative files, the appeal within the required time frame
- If the appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- If the services were ordered by an authorized provider
- If the original period covered by the original authorization has not expired
- If the member requests the extension of benefits

Providers may not request the continuation of benefits on behalf of a member. Required time frames for filing are on or before the later of the following:

- Within ten calendar days of CareSource mailing the notice of adverse benefit determination (the appeal decision)
- The intended effective date of CareSource's proposed adverse benefit determination

If, at the member's request, CareSource continues or reinstates the member's benefits while the appeal or Administrative Law Hearing is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the appeal or request for the administrative law hearing
- The member fails to request an Administrative Law Hearing and the continuation of benefits within ten calendar days after CareSource sends the notice of adverse benefit determination
- An administrative law judge issues a hearing decision adverse to the member
- The time period or service limits of a previously authorized service have been met

## Final Resolutions

If the final resolution of an appeal is averse to the member and upholds CareSource's appeal decision, CareSource may recover from the member the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

If CareSource or the administrative law judge reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, CareSource will authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires.

If CareSource or the administrative law judge reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, CareSource will pay for those services.

## Provider Complaints

CareSource provides several opportunities for you to request review of claim or authorization denials. Provider Services Call Center Specialists are available to help review your claims and advise of next steps when calling 1-855-202-1058. Actions available after a denial include:

Providers are permitted to submit complaints to CareSource regarding CareSource's policies, procedures or any aspect of CareSource's administrative functions. All provider complaints should be clearly documented. Matters pertaining to claim payment or denials must be submitted through the applicable dispute or appeals processes.

Providers have 30 calendar days from the date of the incident to file a provider complaint:

CareSource
Attn: Provider Grievances – Georgia
P.O. Box 2008
Dayton OH 45401-2008

CareSource strives to resolve all provider complaints within 30 days.

We ensure that CareSource executives with the authority to require corrective action are involved in the provider complaint process.

CareSource will thoroughly investigate each Georgia Families® provider complaint using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying CareSource policies and procedures.

### Peer-to-Peer Consultations

Providers are notified of their right to a peer-to-peer conversation in the notification that is distributed to communicate a medical necessity decision. You have five business days from the receipt of this letter to request a peer-to-peer consultation and only one per denied service/procedure is allowed. We will schedule the consultation within one business day or within a reasonable time frame at the provider's request.

If a denial is upheld through a peer-to-peer consultation, the provider can request a clinical appeal. Review the Provider Appeals section below for further instruction on how to submit a clinical appeal. If a denial is upheld on appeal, a peer-to-peer consultation is no longer an option. In addition, the following adverse decisions are not eligible for peer-to-peer consultations:

- Retroactively denied services/procedures (denied for timely filing reasons)
- Administratively denied services/procedures

## Claim Payment Disputes

If you believe your claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. If you have new information to be considered for your claim, you should submit a corrected claim. Corrected claims should not be submitted through the claim dispute process.

Requests for adjustment for underpayment or overpayment may be submitted through the claim payment dispute process. You do not need to submit an appeal for this type of review. If your claim has been denied, in whole or in part, an appeal should be submitted. Review the Provider Appeals section in this manual.

Request for review of a claim denial should be submitted as an appeal. Claim payment disputes must be submitted in writing. The dispute must be submitted within three (3) months of the date of payment.

At a minimum, the dispute must include:

- Sufficient information to identify the claim(s) in dispute
- A statement of why you believe a claim adjustment is needed
- Pertinent document to support the adjustment

Incomplete requests will be returned with no action taken. The request must be resubmitted within all necessary information within ten (10) calendar days of the date on the letter notifying you of the incomplete request.

## Payments disputes can be submitted to CareSource through the following methods:

- **Provider Portal:** https://providerportal.CareSource.com/GA
- **Fax:** 937-531-2398
- **Mail:** CareSource
  Attn: Provider Appeals Department
  P.O. Box 2008
  Dayton, OH 45401

CareSource will render a Payment Dispute decision within fifteen (15) calendar days of receipt. If the decision is to uphold the original claim adjudication, providers will receive a letter including the right to request an Administrative Law Hearing. If the dispute is approved, payment will reflect on the Explanation of Payment (EOP).

## Provider Appeals

Providers may submit a claim appeal to request reconsideration of a claim denial or a clinical appeal for a medical necessity decision.

If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. Refer to the Claims Submission section of this manual for more information regarding corrected claims. You do not need to file an appeal in this situation. If you have new information to be considered for your claim, you should submit a corrected claim. Corrected claims should not be submitted through the appeal process.

You have 30 calendar days from the date the adverse action, denial of payment, remittance advice or initial review determination was mailed to you to submit a claim appeal. If the appeal is not submitted in the required time frame, it will not be considered You will be notified of the dismissal in writing.

After receiving a letter from CareSource denying coverage, the provider or the member can submit a clinical appeal. Providers must have a member's written consent to file an appeal on behalf of a member and to appeal pre-service issues. The consent must be specific to the service being appealed, is only valid for that appeal and must be signed by the member. You can use the Consent for Provider to File an Appeal on Patient/Member's Behalf form, available on our Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Georgia Medicaid from the dropdown menu. The appeal must be submitted within 60 calendar days of the notice of adverse benefit determination.

The appeal request should include all grounds for appeal and be accompanied by supporting documentation and an explanation of why you disagree with our decision.

## Submissions

CareSource allows providers to consolidate appeals of multiple claims that involve the same or similar coverage issues, regardless of the number of individual members or claims included in the bundled appeal.

Providers may submit appeals through our secure Provider Portal or in writing:

- Provider Portal: **CareSource.com** > Login > Provider, Georgia. Georgia. Click the Claims Information and Attachments > Claim Appeals option.
- Writing: Use the **Provider Claim Appeal Request Form** available on our Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Georgia Medicaid from the dropdown menu.
- Please include:
  - Member's name and CareSource member ID number
  - Provider's name and ID number
  - Code(s) and why the determination should be reconsidered
  - For a timely filing appeal, proof of original receipt of the appeal by fax or Electronic Data Information (EDI)
  - For a clinical edit denial, all the supporting documentation as to the justification of reversing the determination

CareSource
Attn: Provider Appeals – Georgia
P.O. Box 2008
Dayton, OH 45401-2008
Fax: 937-531-2398

## Resolutions

Appeals may be reviewed by the CareSource Appeals staff, Medical Directors, Claims staff, Provider Relations staff and any department that may have reason to assist in resolving a grievance or appeal.

If the outcome of the review of the claim appeal is averse to the provider, CareSource will provide a notice of adverse action. The notice of adverse action will state that you may request an Administrative Law Hearing in accordance with O.C.G.A. § 49-4-153, O.C.G.A. § 50-13-13 and O.C.G.A. § 50-13-15.

If the appeal is approved, payment will show on your Explanation of Payment (EOP).

Providers who have exhausted CareSource's appeals process for a denied or underpaid claim or group of claims bundled for appeal have the option to either:

- Pursue the administrative appeals process described in O.C.G.A. § 49-4-153(e)
- Select binding arbitration by a private arbitrator who is certified by a nationally-recognized association that provides training and certification in alternative dispute resolution as described in O.C.G.A.§ 33-21A-7

If CareSource and the provider are not able to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this code shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 calendar days of being selected, unless CareSource and the provider mutually agree to extend this deadline. All costs for arbitration, not including attorney's fees, shall be shared equally by the parties.

## Administrative Law Hearings

CareSource requires exhaustion of the provider appeal process prior to requesting an Administrative Law Hearing.

If you have new information to be considered for your claim, you should submit a corrected claim. Corrected claims should not be submitted through the claim dispute process, the appeals process, or the administrative law hearing process.

A request for an Administrative Law Hearing must include the following information:

- A clear expression by the provider that he or she wishes to present his or her case to an Administrative Law judge
- Identification of the action being appealed and the issues that will be addressed at the hearing
- A specific statement of why the provider believes CareSource's action is wrong
- A statement of the relief sought

The Department of Community Health has delegated its authority to receive Administrative Law Hearing requests to CareSource. Providers can send requests for Administrative Law Hearings through the Provider Portal or mailing to CareSource within 30 calendar days of the date of the appeal decision:

CareSource
Attn: Administrative Law Hearing Request – Georgia
P.O. Box 2008
Dayton, OH 45402
Fax: 937-531-2398

## Definitions

For purposes of this section, the following definitions apply:

**Adverse Benefit Determination** means our denial, reduction, or termination of a Health Care Service, in whole or in part, based on any of the following:

- A determination that the member is not eligible for Benefits under the Plan;
- A determination that a health care service is not a covered service;
- A determination that the health care service does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational Services;
- The imposition of an exclusion or other limitation on benefits that would otherwise be covered;
- A determination not to issue the member coverage, if applicable to the Plan; or
- A determination to rescind coverage under the Plan regardless of whether there is an adverse effect on any particular benefit at that time.

**Appeal (or internal appeal)** means the review by the Plan of an Adverse Benefit Determination, as required in this section.

**External Review** means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted by an Independent Review Entity (IRE).

**Final Internal Adverse Benefit Determination** means an adverse benefit determination that has been upheld by the Plan at the completion of the internal appeals process described in this section.

**Independent review entity (IRE)** means an entity that conducts independent External Reviews of Adverse Benefit Determinations pursuant to this section.

# Fair Hearing Plan

A Provider subject to an Action proposed by or issued by Plan shall have the rights set forth in this Fair Hearing Plan. This Fair Hearing Plan applies only to Actions, as defined herein. Prior to the issuance of an Action, the Provider will have the opportunity to take corrective action. Following the issuance of a Notice of Action by Plan, the levels of appeal available to the Provider are as follows:

Level 1 Meeting with CMO or Designee

Level 2 Provider Fair Hearing Panel

Level 3 Review by the Board of Trustees

Except as set forth in Section 11(8) herein, Provider under review for failing to meet standards for quality or utilization in the delivery of health care service will generally retain his or her status as a Participating Provider during the Provider's appeals under the provisions of this Fair Hearing Plan.

## I. DEFINITIONS

Action. An action of Plan affecting the ability of Provider to provide services to individuals enrolled with Plan, including but not limited to rejection of the Provider's application for participation or summary suspension or termination of the Provider's Provider Agreement on the basis of Provider's failure to meet Plan's standards for quality or utilization in the delivery of health care services. Exclusions are set forth in Section II, herein.

Board. The Plan's Board of Trustees.

Board Decision. The decision issued by the Board, which may include affirmance, modification, or reversal of the PFHP Decision.

CEO. The Chief Executive Officer of Plan. Duties assigned to the CEO hereunder may be assigned to his or her designee.

CMO. The Chief Medical Officer of Plan. Duties assigned to the CMO hereunder may be assigned to his or her designee.

CMO Decision. The decision issued by the CMO or his or her designee following a meeting with the Provider, which may include affirmance, modification, or reversal of the Action.

Notice of Action. A written notice of an Action issued by Plan to Provider, which shall include the nature of the Action and the Provider's appeal rights.

Participating Provider. A health care professional or facility that has been credentialed or approved by Plan and entered into a Provider Agreement with Plan, to provide services to individuals enrolled with Plan in accordance with Plan requirements.

PFHP. The Provider Fair Hearing Panel.

PFHP Decision. The decision of the PFHP, which may include affirmance, modification, or reversal of the CMO Decision.

Plan. The entity within the CareSource Family of Companies that, through contracts with its Participating Providers, provides or arranges for the provision of medical services to its enrollees. This includes CareSource, CareSource Indiana, Inc. and CareSource Kentucky Co.

Provider. A health care professional or facility that is the subject of a proposed Action or an Action.

Provider Agreement. The contract between Provider and Plan for the provision of services by Provider to individuals enrolled with Plan, including but not limited to contracts titled "Provider Agreement" and "Group Practice Services Agreement."

## II. PROPOSED ACTION, NOTICE OF ACTION AND EXCLUSIONS

### A. PROPOSED ACTION AND NOTICE OF ACTION

Prior to finalizing an Action, Plan will give Provider notice of the reason or reasons for the Action and an opportunity to take corrective action, if appropriate. When necessary, Plan will develop a performance improvement plan in conjunction with Provider. If the Provider declines to participate in a performance improvement plan or agrees to participate but fails to comply, in the reasonable determination of Plan, Plan may finalize the Action. If Plan finalizes the Action, the CMO or his or her designee will send a Notice of Action via certified mail, return receipt requested, to the Provider. The Notice of Action will include information regarding the Provider's further appeal rights. The procedures set forth in this Section II(A) shall not apply to a Provider whose participation has been summarily suspended in accordance with Section 11(8).

### B. EXCLUSIONS

This Fair Hearing Plan shall not apply, and the Provider shall have none of the rights set forth herein under any of the following circumstances:

1. the Provider Agreement is terminated without cause pursuant to the terms of the Provider Agreement;
2. the health care needs of Plan's enrollees are being met and no need exists for the Provider's continued services; or
3. Plan determines that the Provider docs not otherwise meet the terms and conditions of the Provider Agreement.

Nothing in this Fair Hearing Plan will be construed as precluding Plan from summarily suspending a Provider's participation for the following reasons: the Provider's conduct presents an imminent risk of harm to an enrollee or enrollees; there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating Provider's field; or a governmental action has impaired the participating Provider's ability to practice.

The rejection of a Provider's application for participation with Plan due to the Provider's failure to submit a complete application does not constitute an Action for purposes of this Fair Hearing Plan.

## III. MEETING WITH CHIEF MEDICAL OFFICER OR DESIGNEE

A Provider for whom an Action has been taken has a right to request an informal meeting with the CMO or his or her designee to discuss the Action. The Provider must request such a meeting, in writing, within thirty (30) days of receipt of the Notice of Action. The request must be addressed to the CMO and must be hand delivered or sent via certified mail, return receipt requested. The request must be received by the CMO within the thirty (30) day period.

### A. NOTICE OF MEETING

Upon receipt of a Provider's request for a meeting, the CMO or his or her designee will schedule the meeting. In no event will the meeting be scheduled for later than thirty (30) days after the Provider's request for a meeting is received, unless otherwise agreed to by the parties or, at the sole discretion of the CMO, for good cause. Promptly after the meeting is scheduled, the CMO or his or her designee will send a notice to the Provider, via certified mail, return receipt requested, of the date, time and place of the meeting.

### B. MEETING PROCEDURE

During the meeting, the CMO or his or her designee and the Provider will discuss the reason or reasons for the Action. This is an informal meeting and not a hearing. The following procedural requirements apply:

1. Personal presence will be required. Failure of the Provider to appear at the meeting, without good cause, will constitute a waiver of the right to a meeting and a voluntary acceptance of Action involved;
2. Representation of the Provider by legal counsel or any other individual is not permitted, unless such representation is approved in advance of the meeting by the CMO or his or her designee; and
3. The Provider may submit any documents or other evidence or a written statement to the CMO or his or her designee either before or during the meeting.

### C. TIMING AND NOTICE OF DECISION

No later than fourteen (14) days after the meeting, the CMO or his or her designee will make a decision regarding the Action. The CMO or his or her designee will report the CMO Decision to the Chairperson of the Board. The CMO or his or her designee will, within seven (7) days after making the report to the Chairperson of the Board, send notice via certified mail, return receipt requested, to the Provider, of the CMO Decision and the Provider's further appeal rights.

## IV. PROVIDER FAIR HEARING PANEL

Following the procedures set forth in Section III above, the Provider may appeal the Action by requesting a hearing with the Provider Fair Hearing Panel ("PFHP"). The Provider must request such a hearing, in writing, within thirty (30) days of receipt of the CMO Decision. The request must be addressed to the CEO and must be hand delivered or sent via certified mail, return receipt requested. The request must be received by the CEO within the thirty (30) day period. Failure to file such a request within the required time period shall constitute the Provider's complete and final waiver of any right to a meeting, hearing and/or any appellate review of the Action.

### A. NOTICE OF HEARING

Upon receipt of a Provider's request for a hearing, the CEO or his or her designee will promptly arrange for and schedule the hearing. Promptly after the hearing is scheduled, the CEO or his or her designee will send a notice to the Provider, via certified mail, return receipt requested, of the date, time and place of the hearing.

### B. COMPOSITION OF THE PROVIDER FAIR HEARING PANEL

The hearing will be conducted by the PFHP, composed of not less than three (3) members selected by the CEO. The PFHP will be composed of Participating Providers with comparable or higher levels of education and training than the Provider and not otherwise involved in Plan's network management. If possible, a representative of the Provider's specialty will be a member of the PFHP. No one who has participated in the case or circumstances giving rise to the hearing, and no one in direct economic competition or professionally associated with the Provider will be appointed to the PFHP. Knowledge of the matter involved will not preclude any individual from serving as a member of the PFHP.

The CEO or his or her designee will designate one of the PFHP members as the Chairperson. The names of the PFHP members will be promptly communicated to both parties, both upon the initial appointments and in the event of any subsequent substitute appointments. Within five (5) days of receiving the list of names, the Provider may object to any PFHP member. The objection must be in writing stating the basis of the objection. The decision as to whether to replace any PFHP member will be at the sole discretion of the CEO or his or her designee.

### C. HEARING PROCEDURE

1. **Appearances.** The personal presence of the Provider is required. If the Provider fails to appear without good cause, as determined by the PFHP, the Provider will be deemed to have completely and finally waived his/her rights to the hearing and any appellate review. Both the Provider and Plan are entitled to have legal counsel, or any other person, represent them at the hearing. The PFHP may also have separate legal counsel to advise it regarding the procedures herein. If a party is represented by an attorney or anyone else, that attorney or person will be responsible for presenting the case. If the Provider will be represented by legal counsel or any other person, the Provider will notify Plan of such representation, in writing, at least fourteen (14) days in advance of the hearing.
2. **Presiding Officer.** The Chairperson of the PFHP will preside at the hearing. The presiding officer will determine the order of procedure and will make all rulings on procedure, including postponements and recesses, and the admissibility of evidence. The presiding officer may, in his or her sole discretion, call a pre-hearing conference in order to make decisions regarding exhibits, objections, or any other procedural matters as chosen by the presiding officer.

3. **Attendance of PFHP Members.** A majority of the PFHP must be present throughout the hearing and the PFHP deliberations. If a member is absent from any part of the proceedings, the member will not be permitted to participate in the deliberations or decision of the PFHP.
4. **Rights of Parties.** During the hearing, each of the parties will have the right:
    a. to call and examine witnesses;
    b. to introduce exhibits;
    c. to cross-examine any witness on any matter relevant to the issues;
    d. to rebut any evidence; and
    e. to submit a written statement at the close of the hearing.

    Oral evidence will be taken only on oath or affirmation administered by a person entitled to notarize documents.
5. **Procedure and Evidence.** The following rules of procedure and evidence will apply to the hearing:
    a. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of their affairs will be admitted regardless of the admissibility of such evidence in a court of law. Each party will, prior to or during the hearing, be entitled to submit memoranda that will become part of the hearing record. State and Federal Rules of Evidence do not apply to the hearing. It is the intent of this section that evidentiary disputes be resolved in favor of admissibility, with the PFHP deciding the appropriate weight to be accorded all evidence.
    b. If requested by either party or at the direction of the presiding officer, copies of the exhibits to be introduced and the names of the witnesses to be called will be exchanged by the parties no later than seventy-two (72) hours before the hearing is scheduled to begin. Additional exhibits and witnesses can only be introduced or called upon a showing of good cause.
    c. If the Provider does not testify in his/her own behalf, the Provider may be called and examined as if under cross-examination by the Plan representative or the members of the PFHP.
    d. In reaching a decision, the PFHP may take official notice before the submission of the matter for decision of any generally accepted technical or scientific matter relating to the issues under consideration. Parties present at the hearing will be informed of the matters to be noticed and those matters will be noted in the hearing record. Any party will be given the opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noted matters by evidence or by written or oral presentation of authority. The manner of such refutation will be determined by the PFHP.
    e. It will be the obligation of the Plan representative to present appropriate evidence in support of the Action. The Provider will thereafter have the burden of proving by clear and convincing evidence that the Action was arbitrary or capricious.
6. **Record.** A record of the hearing will be kept by a court reporter, and a copy thereafter may be obtained by the Provider upon payment of reasonable charges associated with the preparation thereof.

7. **Deliberation and Adjournment.** Upon conclusion of the presentation of oral and written evidence, the hearing will be closed, unless the PFHP permits the parties to submit final written statements. The PFHP will thereupon, at a time convenient to itself within twenty-one (21) days after the later of hearing closure or the submission of written statements, conduct its deliberations outside of the presence of the parties. The conclusion of deliberations will constitute adjournment of the PFHP.

### D. TIMING AND NOTICE OF DECISION

Within seven (7) days of adjournment of the PFHP, the PFHP Decision will be sent to the Chairperson of the Board, the CEO and the CMO. The Chairperson of the Board will, within seven (7) days of receipt of the PFHP Decision, send notice via certified mail, return receipt requested, to the Provider, of the PFHP Decision and the Provider's further appeal rights.

## V. REVIEW BY THE BOARD OF TRUSTEES

Following issuance of the PFHP Decision, the Provider may request that the Board review the PFHP Decision. Such a request must be addressed to the Chairperson of the Board and must be hand delivered or sent via certified mail, return receipt requested. The request must include a brief statement of the grounds for appeal. If such request for Board review is not received by the Chairperson of the Board within fourteen (14) days of the date of the PFHP Decision, the PFHP Decision will thereupon become final and immediately effective. The Provider has the burden of proving by clear and convincing evidence that the PFHP Decision was arbitrary or capricious. Within thirty (30) days after its receipt of the request for review, the Board will affirm, modify, or reverse the PFHP Decision. The Board Decision will be final and conclusive of the matter. The Board Decision will be in writing, and the Board will deliver copies thereof to the Provider, to the Chairperson of the PFHP, in person or by certified mail, return receipt requested.

## VI. ADOPTION AND AMENDMENT OF FAIR HEARING PLAN

This Fair Hearing Plan will be effective upon adoption by Board. In the event of any conflict between this document and any other Plan rule, policy or agreement, the provision(s) of this Fair Hearing Plan will prevail. This Fair Hearing Plan may be amended by a majority vote of the Board, at any meeting of the Board at which a quorum is present. Proposed changes must be provided to each Board member at least seven (7) days before the meeting.

### A. COMPUTATION OF DAYS

Any reference to "days" throughout means calendar days. In computing any period of time pursuant to this policy, the day of the act or event from which the period of time begins to run will not be included. The last day of the period so computed will be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday.

# MEMBER ENROLLMENT & ELIGIBILITY

## Enrollment & Eligibility

The Georgia Department of Community Health (DCH) is solely responsible for member enrollment, including auto-assignment to a CMO, disenrollment, education on enrollment options and outreach activities to those eligible to enroll in a CMO. DCH has implemented potential open enrollment and auto-assignment processes in order to enroll all Georgia Families® members with selected CMOs.

Once eligible to participate in Georgia Families®, members may select CareSource as their CMO health plan.

## Eligibility Verification

Providers are expected to verify member eligibility each time a service is rendered.

Providers may use the Provider Portal to verify member eligibility. Upon logging in to the Provider Portal, providers will be able to view member eligibility with:

- 24 months of history
- Member span information
- Multiple member look-up (up to 500)

You can also verify eligibility on the GAMMIS portal at www.mmis.georgia.gov or by calling Provider Services at **1-855-202-1058** and using our interactive voice response system.

## Member ID Cards

The member ID card is used to identify a CareSource member. However, having a member ID card does not guarantee eligibility or benefits coverage. Please verify member's eligibility prior to each service rendered.

You can use our secure Provider Portal or call Provider Services to check member eligibility.

### Provider Services

Call Provider Services at **1-855-202-1058** and follow the prompts.

### Provider Portal

Click on “Member Eligibility” on the left, which is the first tab. Make sure to enter the full 11-digit member ID number for the person, and if a dependent, include the dependent suffix.

Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification.


CareSource Georgia Families

**Member ID:** <123455676>
**Member:** <Mary Doe>
**Primary Care Provider:**
<John Doe
12345 Main Street
Atlanta, Georgia 30307
1-404-555-1213>
<PCP After Hours: 1-404-123-1234>

**Medicaid ID:** <123456789101>
**Effective Date:** <07/01/2017>
**Dental Home:**
<Jill Doe
12345 Main Street
Atlanta, Georgia 30307
1-404-555-1213>

**Member Services:** 1-855-202-0729 (TTY:1-800-255-0056 or 711)

## New Member Welcome Kits

Each household receives a new member kit, a welcome letter and an ID card for each person in the family who has joined CareSource. The new member kits are mailed separately from the ID card and new member welcome letter.

### New Member Kit Elements

- A Member Handbook, which explains plan services and benefits and how to access them
- A quick start guide for how to get started with CareSource
- Information on how to access or request a health assessment survey
- CareSource’s Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA)
- Other preventive health education materials and information, including how to select a PCP and how to complete an initial health screening

**Please Note:** Members will receive a Provider Directory only if they requested one at the time of enrollment or if they return a request postcard included in new member kits that indicates they would like a printed copy. The Provider Directory lists participating CareSource providers and facilities within a certain radius of the member’s residence. As the contents of the printed directory are subject to change, we encourage members to call CareSource or the provider directly to confirm they are in network.

Members are referred to the Provider Directory, which lists providers and facilities participating with CareSource. A current list of providers can be found at any time on CareSource’s website, **CareSource.com** > Members > Tools & Resources > Find a Doctor.

# Newborn Enrollment

When a mother gives birth, the newborn child will automatically be enrolled into the mother's health plan starting on the baby's date of birth.

The mother will have the choice up to 90 days from the baby's date of birth to make a one-time change. If no change is made, the baby will stay on the mother's health plan until the next year.

The birth of a baby is a qualifying event for the mother to request disenrollment and to be assigned to a different health plan.

# Eligibility

## Georgia Families Eligibility

The following Georgia Families® eligibility categories are required to enroll in Medicaid or PeachCare for Kids®:

- **Low Income Families** – Adults and children under age 19 who meet the standards based on Modified Adjusted Gross Income (MAGI) converted Aid to Families with Department Children (AFDC)
- **Transitional Medicaid** – Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the income limit
- **Pregnant women** – Pregnant women with family income at or below 220 percent of the federal poverty level who receive Medicaid through the Right from the Start Medicaid (RSM) program
- **Children (RSM)** – Children less than 19 years of age whose family income is at or below the appropriate percentage of the federal poverty level for their age and family
- **Newborns** – A child born to a woman who is eligible for Medicaid on the day the child is born
- **Women eligible due to breast and cervical cancer** – Women less than 65 years of age who have been screened through Title XV Center for Disease Control (CDC) screening and have been diagnosed with breast or cervical cancer
- **Refugees** – Individuals, as defined under O.C.G.A. § 38-3-3, including but not limited to those who have the required Immigration and Naturalization Service (INS) documentation showing they meet a status of asylees, Cuban parolees/Haitian entrants, Amerasians or human trafficking victims

The following recipients are excluded from enrollment in Georgia Families®, even if the recipient is otherwise eligible for Georgia Families® per the categories above:

- Recipients eligible for Medicare
- Recipients that are members of a federally recognized Indian Tribe
- Recipients that are enrolled in fee-for-service Medicaid through Supplemental Security Income (SSI) prior to enrollment in Georgia Families®
- Medicaid children enrolled in the Children's Medical Services program administered by the Georgia Department of Public Health
- Children enrolled in the Georgia Pediatric Program (GAPP)
- Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act

- Individuals enrolled in a hospice category of aid
- Individuals enrolled in a nursing home category of aid
- Individuals enrolled in Community Based Alternatives for Youths (CBAY)

## PeachCare for Kids Eligibility

PeachCare for Kids® is the Children's Health Insurance Program (CHIP) in Georgia. Children meeting the following requirements are eligible for services under PeachCare for Kids®:

- Less than 19 years of age
- Family income that is less than 247 percent of the federal poverty level
- Not eligible for Medicaid or any other health insurance program

## Planning for Healthy Babies® Eligibility

The Planning for Healthy Babies® Program (P4HB®) is an 1115 Medicaid Demonstration Waiver that expands the provision of family planning services to women who are Georgia residents, who do not qualify for other Medicaid benefits, any other insurance coverage, or who have lost Medicaid coverage for any reason and who meet specific eligibility criteria. Eligible P4HB® participants will be enrolled in one of three components of the P4HB® family planning waiver program:

- Family Planning component: family planning and family planning related services for eligible participants for the duration of the waiver
- Inter-pregnancy Care component: family planning and additional services for women who have delivered a very low birth weight (VLBW) (<1500 grams or 3.3 pounds) baby
- Resource Mother Outreach: inclusive of a specially trained case manager to women on traditional Medicaid plans who have delivered a VLBW baby

Enrollees who meet the following requirements are eligible to enroll in P4HB®:

- Be a US citizen or person with qualified proof of citizenship
- Be ages 18 through 44 years
- Be a Georgia resident
- Be able to become pregnant
- Not be eligible for any other Medicaid program or managed care program
- Meet family gross income requirements of no more than 200 percent of the federal poverty level (FPL)
- If losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum, not otherwise be eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Women who no longer meet the eligibility criteria outlined for the P4HB® program will be disenrolled from the P4HB® program. These include women who:

- Become pregnant
- Receive a sterilization procedure and complete all necessary follow-up
- Move out of the state
- Become incarcerated

- Change income status
- Become unable to become pregnant
- Women who have aged out

Women who participate in the Inter-pregnancy Care (IPC) program will be disenrolled after two years of participation. They may transition to the Family Planning component if deemed eligible following their IPC participation.

Redeterminations of eligibility for the P4HB® Program are conducted at least every 12 months.

Providers are encouraged to refer women who have delivered a VLBW infant to the P4HB® program to determine if they would be eligible to participate in the Inter-pregnancy Care or Resource Mother Outreach program components.

Members can apply for the P4HB® program online at https://medicaid.georgia.gov/programs/all-programs/planning-healthy-babies or can pick up an application at their local:

- Public Health Department
- Division of Family and Children Services Office

## Payment Responsibility

Many Georgia Medicaid and PeachCare for Kids® members pay a small part of their health care costs via copayments. Providers collect copayments and may not refuse to provide services if members cannot make the copayment. However, a provider may, upon accepting a patient as a Medicaid or PeachCare for Kids® member, charge the member for non-covered services. In order to charge the member for non-covered services, the provider must obtain written acknowledgement that the member is assuming financial responsibility prior to the service being rendered. Please see the Member Billing section on page 19.

The following Georgia Medicaid members do not have to pay copayments:

- Children under age 21
- Pregnant women
- Nursing facility residents
- Hospice care members
- Members enrolled in breast and cervical cancer programs
- American Indians and Alaska Natives

The following PeachCare for Kids® members do not have to pay copayments:

- Children under age 6
- Children in foster care or hospice care
- Children who are American Indians or Alaska Natives

Some copayments are a set amount and other copayments are cost-based.

# Copayments

## Set Amount Copayments

Georgia Medicaid members who have copays have a set copay amount for some care settings, like:

- $2 for most services received at a Federally Qualified Health Center or Rural Health Center
- $3 for services received at an outpatient facility or surgery center
- $3 for emergency room visits (This fee is waived for emergency medical conditions.)
- $12.50 for inpatient care per admission

## Cost-Based Copayments

Some PeachCare for Kids® copayments are cost-based, like provider office visits. This means the amount owed depends on the cost of the service.

All PeachCare for Kids® copayments are limited to no more than 5 percent of the family's income. For example, if a covered service costs $25, a PeachCare for Kids® member would pay a $1 copay for that service. Members may owe between $.50 to $3 per service, based on the range below.

| Category of Service | Copayment (Amount Member Pays) |
|---|---|
| Ambulatory Surgical Centers/Birthing | $3 |
| Durable Medical Equipment (RR) | $1 |
| Durable Medical Equipment (NU) | $3 |
| Federally Qualified Health Centers | $2 |
| Free-Standing Rural Health Clinic | $2 |
| Home Health Services | $3 |
| Hospital-Based Rural Health Center | $2 |
| Inpatient Hospital Services | $12.50 |
| Oral Maxillofacial Surgery | Cost-Based |
| Orthotics and Prosthetics | $3 |
| Outpatient Hospital Services | $3 |
| Pharmacy – Preferred Drugs | $.50 |
| Pharmacy – Non-Preferred Drugs | Cost-Based |
| Physician Assistant Services | Cost-Based |
| Physician Services | Cost-Based |
| Podiatry | Cost-Based |
| Vision Care | Cost-Based |

### Cost-Based Copayment Schedule

| Cost of Service | Copayment (Amount Member Pays) |
|---|---|
| $10 or less | $.50 |
| $10.01 to $25 | $1 |
| $25.01 to $50 | $2 |
| $50.01 or more | $3 |

## Disenrollment

We understand that members may choose to select a different health plan from the CMO to which they were assigned by DCH. For various reasons, including reenrolling with a previous CMO with which the member has a historical relationship, a member may choose to change CMO. We support this decision by our members and provide judgement-free disenrollment assistance and referral to DCH.

If we choose to disenroll a member based on DCH-approved criteria, CareSource will provide DCH with documentation of at least three interventions made over a period of 90 days that occurred through treatment, case management and care coordination to resolve the issue.

### Reasons for Disenrollment

DCH or its agent will process all CMO disenrollment requests. This includes:

- Disenrollment due to nonpayment of the PeachCare for Kids® premiums
- Loss of eligibility for Georgia Families® due to other reasons
- All disenrollment requests Georgia Families® members, P4HB® participants or CareSource submits via telephone, surface mail, internet, facsimile and in person

### Disenrollment Initiated by the Member

A member may request disenrollment or a change in CMO enrollment without cause during the 90 calendar days following the date of the member's initial enrollment with the CMO or the date DCH or its agent sends the member notice of the enrollment, whichever is later. A member may request a change in CMO enrollment without cause every 12 months thereafter.

A member may request disenrollment or a change in CMO enrollment for cause at any time. The following constitutes cause for requesting disenrollment:

- The member moves out of the CMO's service region.
- The CMO does not, because of moral or religious objections, provide the covered service the member seeks.
- The member needs related services to be performed and not all related services are available within the network. The member's or participant's provider or another provider has determined that receiving related services from in-network and out-of-network providers would subject the member to unnecessary risk.
- The member requests to be assigned to the same CMO as family member(s).
- The member's Medicaid category of eligibility changes to a category ineligible for Georgia Families®, and/or the member otherwise becomes ineligible to participate in Georgia Families®.

Other reasons for disenrollment initiated by the member, pursuant to 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the contract or lack of providers experienced in addressing the member's health care needs. DCH or its agent will make the determination of these reasons.

## Disenrollment Initiated by CareSource

CareSource may request disenrollment if:

- The member's utilization of services is fraudulent or abusive.
- The member is placed in a long-term care nursing facility, state institution or intermediate care facility for individuals with intellectual disabilities.
- The member's Medicaid eligibility category changes to a category ineligible for Georgia Families®, and/or the member otherwise becomes ineligible to participate in Georgia Families®. Disenrollment due to member eligibility will follow the normal monthly process. Disenrollments will be processed as of the date that the member eligibility category actually changes and will not be made retroactive, regardless of the effective date of the new eligibility category. Note that an exception is when members become eligible and enrolled in any retroactive program (such as SSI) after the date of an inpatient hospitalization.
- The member has died, been incarcerated or moved out of state, thereby becoming ineligible for Medicaid.
- The P4HB® participant no longer meets the eligibility criteria for the demonstration.
- The inter-pregnancy care (IPC) P4HB® participant has reached the end of the 24 months of eligibility for the IPC component of the demonstration.
- The P4HB® participant becomes pregnant while enrolled in the demonstration.
- The P4HB® participant becomes infertile through a sterilization procedure.

Prior to requesting disenrollment of a member, CareSource will document at least three interventions over a period of 90 calendar days that occurred through treatment, case management and care coordination to resolve any difficulty leading to the request. CareSource will provide at least one written warning to the member, certified return receipt requested, regarding implications of his or her actions. This notice will be delivered within ten business days of the member's action.

# MEMBER SUPPORT SERVICES

CareSource provides a wide variety of support and educational services to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

## Member Services

Members access Member Services by calling our toll-free number at **1-855-202-0729** Monday through Friday from 7 a.m. to 7 p.m. Eastern Time (ET) and telling our interactive voice response system (IVR) what their question is regarding.

### Holiday Hours

Representatives are available by telephone Monday through Friday, except on certain holidays. Please check the website for holiday hours.

# Care Coordination and HIPAA

Care coordination is an approach to health care in which all of a patient's needs are coordinated with the assistance of a primary point of contact. Strong care coordination improves partnerships between the patients/members (patients), providers and CareSource.

The Code of Federal Regulations (CFR) § 438.208 allows providers to legally share patients' information with CareSource for care coordination purposes.

- Contract requirements: Contracts between CareSource and providers require providers to follow federal and state requirements and cooperate with the health plans' quality care delivery guidelines.
- HIPAA-required validation questions: If the identification of the caller is in question, the provider can ask HIPAA-approved validation questions such as date of birth, address or Medicaid ID number.
- Communication among treating providers: Physical and behavioral health providers are required to coordinate care, including sending status reports to each other.

Per 45 CFR 164.506, a covered entity may, under certain circumstances, use or disclose protected health information without the written consent of the member.

- In general, a provider may share a patient's protected health information with CareSource for purposes of care coordination and obtaining appropriate health or community-related services without a patient's consent.
- CareSource may share a member's protected health information without the member's consent in cases of transition from one CMO to another CMO for the purpose of coordinating member treatment or care (e.g., during Medicaid open enrollment period when a Medicaid recipient chooses a different CMO during an active course of treatment).

# Sign & Language Interpretation Assistance

## Non-Hospital Providers

CareSource offers sign and other language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. We can also provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services are available at no cost to the member or provider. As a provider, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately.

Providers who have 24-hour access to health care-related services in their service area or via telephone must provide members with 24-hour language interpreter services, either through in-person or telephone interpreter services.

To arrange services, please contact our Provider Services at **1-855-202-1058**. To request a sign language interpreter, five business days' notice is needed before the scheduled appointment, while any other language interpreter services require four business days' notice before the scheduled appointment. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

### Hospital Providers

CareSource requires hospitals, emergency rooms and skilled nursing facilities, at their own expense, to offer sign and other language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking proficiency. We can provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services should be available at no cost to the member. You are also required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. If you do not have access to interpreter services, contact Provider Services at **1-855-202-1058.** We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

## Telemedicine/Telehealth

Telehealth technology makes health care more accessible, cost-effective, and can increase patient engagement. CareSource wants to support your telehealth program by covering select telehealth services you provide to our members.

If you do not have a telehealth program or if you need help servicing your patients during busy times, CareSource has partnered with Teladoc® to provide the convenience of telemedicine to all of our members over the age of two. Teladoc physicians can consult, diagnose and also prescribe medications when appropriate (DEA controlled substances excluded) and provide treatment for non-emergency conditions like allergies, asthma, sore throat, cold and flu, ear infection, pink eye, UTI, skin inflammation, joint aches and pains and sinus infections. CareSource will continue to encourage our members to engage with their PCP first, but much like using retail clinics or urgent care as a way to meet medical needs, we are providing another access point through Teladoc.

Members can connect to Teladoc by:

- Downloading the Teladoc app to a smart phone.
- Visiting www.Teladoc.com/CareSource
- Calling 1-800-Teladoc (1-800-835-2362)

### Global Partnership for Telehealth (GPT)

Additionally, CareSource has partnered with Global Partnership for Telehealth to provide our members with access to specialty doctors that can be seen at chosen locations near where they may work or live. Members who live in rural areas and a far distance from hospitals now have easier and more convenient access to the specialty care that they may need.

To schedule an appointment, CareSource members can access the scheduling platform from the GPT website https://gpth.org, call GPT at 912-285-0902 or through Member Services via scheduling@gatelehealth.org.

# Health Education

CareSource members receive health information from CareSource through a variety of communication vehicles including easy-to-read newsletters, brochures, phone calls and personal interaction. CareSource also sends preventive care reminder messages to members via mail and automated outreach messaging.

# Member Rewards

CareSource is committed to providing members with services that help them achieve their health and wellness goals. We believe taking steps to improve health and well-being deserves recognition.

CareSource rewards members for activities that lead to better health. Members can join our reward programs and earn rewards for preventive care activities.

Rewards can be used to purchase health and wellness items, redeemed for gift cards and can be used for online shopping (activities and redemptions option vary by age, gender and health conditions of the member). Details about each program are below.

## Babies First® Program

Babies First is a free program offered to pregnant members and parents or guardians of babies less than 15 months of age. Through this program, members can earn up to $265 on a MyCareSource Rewards® card.

The program focuses on encouraging pregnant members to visit their doctor for prenatal care early in their pregnancies, and then as often as their doctor recommends, including a postpartum visit. Additionally, the program encourages well-baby visits as recommended to help ensure mom and baby will be as healthy as possible. Through this program, members can earn rewards and incentives for completing specific activities related to prenatal, postpartum and well-baby care.

Upon completion and verification, the member will be able to purchase items (baby car seat, healthy items, baby toys, etc.) from a selection of merchants, such as Babies First Rewards Merchants. The rewards card blocks the purchase of items such as alcohol and/or tobacco, and cannot be converted to cash.

Members can enroll in Babies First by completing the form at **CareSource.com** > Benefits and Services > Additional Services > Rewards > Babies First or call Member Services at **1-855-202-0729**. Members must reenroll in the program with each pregnancy.

| Rewards Program | Activity | Reward Frequency | Reward Earned | Who is Eligible |
|---|---|---|---|---|
| Babies First | Program Registration | 1 reward per pregnancy | $15 per pregnancy | Pregnant members |
| Babies First | Attend 7+ prenatal visits | 1 reward per pregnancy | $85 per pregnancy | Pregnant members |
| Babies First | Attend a postpartum visit | 1 reward per pregnancy | $25 for the visit | New moms |
| Babies First | Attend 6 well-baby visits | 1 reward per visit | $15 per visit, up to $90 | Newborns up to 15 months |
| Babies First | Get a lead screening | 1 reward per screening | $10 per screening | Newborns up to 15 months |

## Kids First Program

Kids First is a free program offered to members ages 16 months to 18 years. Through this program, members can earn up to $50 per year on a MyCareSource Rewards™ card. Some reward activities vary by age and member health issues.

The program focuses on encouraging children and teenagers to get regular well-child visits, dental exams, and age-appropriate vaccinations.

Upon completion and verification, the member will be able to purchase items such as toys, books, food, health, and wellness items and more from a selection of merchants, such as Walmart, Dollar General and more. The rewards card blocks the purchase of items such as alcohol and/or tobacco, and cannot be converted to cash.

Members can enroll in Kids First by completing the form at **CareSource.com** > Benefits and Services > Additional Services > Rewards or call Member Services at **1-855-202-0729**.

| Rewards Program | Activity | Reward Frequency | Reward Earned | Who is Eligible |
|---|---|---|---|---|
| Kids First | Routine dental exam | 1 reward per visit, up to 2 visits per year (Once every 6 months) | $10 per visit, up to $20 per year | Children and teens ages 16 months-18 years |
| Kids First | Well-child visit | 1 reward per visit, up to 3 visits | $10 per visit, up to $30 | Children ages 18-30 months |
| Kids First | Well-child visit | 1 reward per visit, per year | $10 per year | Children ages 3-18 years |
| Kids First | Well-child vaccinations (Dtap, IPV, MMR and Varicella – given as a series) | 1 reward for completing the vaccination series (Available once) | $20 for the series | Children ages 4-6 years |

| Rewards Program | Activity | Reward Frequency | Reward Earned | Who is Eligible |
|---|---|---|---|---|
| Kids First | Well-child vaccination (Tdap) | 1 reward for the vaccination (Available once) | $10 for the vaccination | Children ages 11-18 years |
| Kids First | Well-child vaccination (HPV – given as a series) | 1 reward for completing the vaccination series (Available once) | $10 for the series | Children ages 11-18 years |
| Kids First | Well-child vaccination (Meningococcal) | 1 reward for the vaccination (Available once) | $10 for the vaccination | Children ages 11-18 years |
| Kids First | Annual flu shot | 1 reward per year | $10 per year | Children ages 18 months – 18 years |
| Kids First | ADHD follow-up visit within 30 days of filling the initial prescription | 1 reward per year | $10 per year | Children ages 18 months – 18 years (ADHD diagnosis required) |
| Kids First | ADHD follow-up visit within 10 months of filling the initial prescription | 1 reward per visit, up to 2 visits per year | $10 per visit, up to $20 per year | Children ages 18 months – 18 years (ADHD diagnosis required) |

## MyHealth Rewards

MyHealth Rewards is a free program offered to members 18 years and older. Through this program, members can earn up to $240 or more in rewards. Some reward activities vary by age, gender and member health issues.

The program encourages the member to complete healthy activities, such as taking their Health Needs Assessment (HNA); having routine physical and dental exams; and completing screenings for cholesterol, colorectal cancer and more. Members can also participate in a tobacco cessation program to earn rewards.

Members can redeem their rewards through the MyHealth website for a variety of gift cards to national retailers such as iTunes, Google Play, TJ Maxx, Sephora, Old Navy, Panera Bread and more. Members can access MyHealth by logging into MyCareSource at **My.CareSource.com**.

Members are automatically enrolled in MyHealth Rewards.

| Rewards Program | Activity | Reward Frequency | Reward Earned | Who is Eligible |
|---|---|---|---|---|
| MyHealth Rewards | Complete your preferences (Select PCP, confirm communications preferences) | 1 reward per year | $15 per year | Adults ages 18-64 years |
| MyHealth Rewards | Health Risk Assessment Completion | 1 reward per year | $10 | Adults ages 18-64 years |
| MyHealth Rewards | Routine dental exam | 1 reward per visit, up to 2 visits per year | $10 per visit, up to $20 per year | Adults ages 18-64 years |
| MyHealth Rewards | Annual Wellness Visit | 1 reward per visit | $20 per visit | Adults ages 18-64 years |
| MyHealth Rewards | Tetanus-Diphtheria booster | 1 reward per year | $10 per year | Adults ages 18-64 years |
| MyHealth Rewards | Chlamydia screening | 1 reward per year | $15 per year | Females ages 19-25 |
| MyHealth Rewards | Cervical Cancer Screening (Pap Smear) | 1 reward per year | $15 per calendar year | Females ages 18-64 |
| MyHealth Rewards | Breast Cancer Screening | 1 reward per year | $15 per screening | Females ages 50-64 |

| Rewards Program | Activity | Reward Frequency | Reward Earned | Who is Eligible |
|---|---|---|---|---|
| MyHealth Rewards | Annual flu shot | 1 reward per year | $10 per year | Adults |
| MyHealth Rewards | Diabetes A1c screening | 1 reward per year | $20 per year | Adults diagnosed with diabetes |
| MyHealth Rewards | Diabetes retinal eye exam | 1 reward per year | $20 per year | Adults diagnosed with diabetes |
| MyHealth Rewards | Complete a Journey in MyHealth | 1 reward per Journey, up to 2 Journeys per year | $10 per Journey, up to $200 per year | Adults |
| MyHealth Rewards | Antidepressant Medication Management | 4 rewards per year (quarterly) | $10 per quarter | Adults 18-64 years, must fill 3 prescriptions within the quarter to be eligible for quarterly reward |
| MyHealth Rewards | Tobacco Cessation | 1 reward per calendar year | $10 per reward | Adults 18-64 years |

# Care Management

## Care Management/Outreach

CareSource provides the services of care management medical and behavioral health nurses, social workers, community health workers, licensed professional counselors and outreach specialists to provide one-on-one, personal interaction with patients. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team.

Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging treatment adherence, reinforcing medical instructions, and assessing social and safety needs, as well as educating pregnant women on the importance of prenatal care, childbirth, postpartum, and infant care. We also offer individualized education and support for many conditions.

You can refer a member to Care Management by calling Provider Services at **1-855-202-1058**. Providers can also make referrals to care management on behalf of the member by submitting the request in the CareSource Provider Portal.

## MyResources

The MyResources search engine is a social service and community resource search tool. The MyResources Tool connects members with local low-cost and no cost community-based programs and social services.

The tool is easy to use and allows our staff and members to search for a wide category of resources like food, housing, transportation and job training programs by simply entering a zip code from anywhere in the United States.

The search information is provided in real time, including hours of operation, distance from the zip code entered, and other locations nearby. More than 100 languages are supported and resources can be updated and new resources suggested directly from the site. Other features include the ability to send a resource to a friend via email or text.

Members can log into their MyCareSource account to learn more or call CareSource Member Services at **1-855-202-0729** (TTY: 711).

## Health Needs Assessment & Screening

CareSource asks that all members complete the Health Needs Assessment (HNA). Through a few questions about their health and well-being CareSource can help identify health, housing, education and employment concerns where we may be able to help.

Members can complete the HNA in one of the following ways:

1. Call our Member Assessment Team at 833-230-2011 (TTY: 711) Monday – Friday, 7 a.m. to 6 p.m. ET
2. Visit **MyCareSource.com** and click on MyCareSource account
   a. Click on the Health tab at the top of the navigation bar
   b. Scroll and click on the 'Health Needs Assessment'
3. New members can complete the printed copy of the HNA included with their new member packet. It can be returned in the enclosed self-addressed, postage paid envelope

Members can earn a $15 reward* when they complete the HNA. The HNA should be completed annually and a reward can be earned once each year.

## Complex Members/High Risk Members

CareSource applies a particular community-based management model for our high-risk members. Utilizing nurses, social workers and community health workers, this multi-disciplinary approach integrates the Case Management Society of America (CMSA) Standards of Practice into key processes to help ensure implementation of a best-practice program. Community health workers help patients overcome health care access barriers and strengthen our provider and community resource partnerships through collaboration.

Our services include face-to-face meetings with our most at-risk members. Ideally, these are conducted at the point of care to ensure development of a treatment plan that is comprehensive and collaborative. Typical high-risk members served by this model may have multiple medical issues, socioeconomic challenges and behavioral health care needs.

Care coordination efforts may include:

- Care transition planning
- Identifying gaps in care and collaborating with the care team to close gaps
- Facilitating member access to appropriate care and services
- Providing referrals to appropriate medical, behavioral, social and community resources to address identified member needs
- Coordinating planned interventions, driven by a care coordination plan, consistent with evidence-based clinical guidelines

CareSource encourages you to take an active role in your patients' care management programs and participate in assessment activities and development of individualized care plans to help meet their needs. Together, we can make a difference.

### Perinatal Care Management

CareSource's perinatal and neonatal care management program utilizes a multi-disciplinary team with extensive obstetrics and neonatal intensive care unit (OB/NICU) clinical experience. Specialized nurses are available to help manage high-risk pregnancies and medically complex newborns by working in conjunction with providers and members. The expertise offered by the staff includes a focus on patient education and care coordination and involves direct telephone contact with members and providers.

All pregnant members receive educational packets throughout their pregnancy and in the immediate postpartum period. Members with high-risk pregnancy are offered additional detailed pregnancy information called BUMP – Better Understanding My Pregnancy. Pregnant members in care management will receive one-to-one perinatal education throughout her pregnancy.

## Care Management Services

CareSource's Care Management program is designed to support the care and treatment you provide and recommend to your patient.

We stress the importance of establishment of the medical home, identification of barriers and keeping appointments. We can assist in arranging transportation to the provider's office.

One-on-one personal interaction with community health workers and licensed, professional case managers helps provide a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional needed community resources, such as assistance with housing and food.

CareSource encourages you to take an active role in your patient's care management program through the Patient Profile feature on the Provider Portal. This profile provides member-specific information on pharmacy, inpatient and Emergency Department (ED) utilization, scheduled or planned services. This information provides you with critical information necessary to make informed decisions pertaining to your patient.

In addition, we invite and encourage you to direct and provide input into patient assessment activity and participate in the development and monitoring of a care plan individualized to the needs of your patient. We believe communication, coordination, and collaboration are integral to ensure the best care for your patients.

We offer individualized education and support for many conditions and needs, including:

- High risk pregnancy and complex newborns
- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Depression
- Special health care needs
- Serious and persistent mental illness (SPMI)

# Disease Management

Our free Disease Management Program helps our members find a path to better health through information, resources and support.

We help our members through:

- The MyHealth online program for members 18+ to participate in a journey to improve their health.
- Newsletters with helpful tips and information to manage their disease, promote self-management skills, and provide additional resources.
- Coordination with outreach teams such as wellness advocates and health coaches.
- One-to-one care management (if they qualify).

Members with specific disease conditions such as asthma, diabetes, and hypertension are identified by triggering events or criteria, such as emergency room visits, hospital admissions and health assessment. These members are automatically mailed quarterly condition-specific newsletters. The materials are available in English and Spanish. Any member may self-refer or be referred into the Disease Management Program to receive condition-specific information or outreach. If a member does not wish to be enrolled in this program, they can call **1-844-438-9498**.

## Disease Management Program Benefits

Members identified in the Disease Management Program receive help finding the appropriate level of care for their condition, and they are encouraged to actively participate in the patient-provider relationship. The program improves the percentage of CareSource members who receive their recommended screenings.

If you have a patient with a chronic condition who you believe would benefit from the Disease Management and/or Disease Health Coaching program and are not currently enrolled, please call **1-844-438-9498**.

# CareSource24, Nurse Advice Line

Members can call our nurse advice line 24-hours a day, seven days a week. With CareSource24, members have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions.

Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is the "gold standard" in telephone triage, offering evidence-based triage protocols and decision support.

CareSource24 nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the primary care provider (PCP) by explaining the importance of their role in coordinating the member's care. For improved care coordination with PCPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse gave.

Key features of this service include nurses who:

- Assess member symptoms
- Advise of the appropriate level of care
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP-member relationship

Members may access CareSource24 anytime night or day. The phone number is on the member's ID card.

## Emergency Department Diversion

CareSource is committed to making sure our members access the most appropriate health care services at the appropriate time for their needs. We instruct members to call their PCP or the CareSource24 Nurse Advice Line if they are unsure if they need to go to an emergency department (ED). CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access.

Members are informed to call 911 or go to the nearest ED if they feel they have an emergency. CareSource covers all emergency services for our members.

Member ED utilization is tracked closely. If there is frequent ED utilization, members are referred to our Care Management department for analysis or intervention. Members are contacted via phone or mail. Intervention includes education, as well as assistance with removing any identified health care access barriers. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

## Care Transitions

When care transitions occur, CareSource identifies members who require assistance as they transition from an inpatient stay. Our team works with members and their families to coordinate care needs and make the transition to home or a lower level of care as successful as possible.

Our Transitions of Care (TOC) program has focused outreach and discharge planning activities based on the Coleman Model, utilizing a team approach to coordinate post-discharge care needs for members at risk for readmission. Through these efforts, we strive to empower and educate members to help ensure all components of the member's discharge plan are in place.

When an at-risk member is discharged from an inpatient stay, our TOC team reaches out to ensure the member has a clear path to recovery, free from barriers to care. We can coordinate home care and medical equipment needs, assist with obtaining prescribed medications and coordinate other medical care and services as needed.

We believe in the importance of partnership. That is why we collaborate with primary care providers (PCPs) to provide our members with the services they need along the continuum of care.

A back transfer may occur in the following situations:

- When a member needs to transfer from a higher level of care back to a lower level of facility care, such as a rehabilitation center or skilled nursing facility
- When a child is sent to a facility that specializes in pediatric surgery and is then transferred back to a hospital closer to the parents' residence

A back transfer is subject to medical necessity review and the payment policies outlined in the provider's contract with CareSource. The facility receiving the back transfer is eligible for reimbursement if prior authorization is obtained from CareSource in accordance with the provider's contract.

When the member is transitioned, CareSource follows up with the facility and the member to confirm a smooth transition occurred and a care plan is in place that includes planning for discharge from the facility to the member's home.

## Medline Breast Pump Program

We want to help our members be successful, so we offer them the tools they need to breastfeed when their baby is born. With a physician's prescription, members can receive a high-quality electric breast pump through Aeroflow at no cost. This program also provides access to online/telephonic breastfeeding resources.

# PROVIDER RESOURCES

## Provider Services

| Provider Services | | |
|---|---|---|
| Phone: 1-855-202-1058 | Monday to Friday | 7 a.m. to 7 p.m. ET |

### Holiday Hours

Representatives are available by telephone Monday through Friday, except on observed holidays. Please visit **CareSource.com** > About Us > Contact Us for the holiday schedule or contact Provider Services for more information.

## Phone

Our interactive voice response (IVR) system will direct your call to the appropriate professional for assistance. We also provide telephone based self-service applications that allow you to verify member eligibility.

| | |
|---|---|
| Provider Services | 1-855-202-1058 |
| Prior Authorizations | 1-855-202-1058 |
| Pharmacy | 1-855-202-1058 |
| Georgia Medicaid Management Information System (GAMMIS) Centralized Prior Authorization | 1-800-766-4456 |
| Claims | 1-855-202-1058 |
| Member Services | 1-855-202-0729 |
| CareSource24 – Nurse Advice Line | 1-844-206-5944 |
| Fraud, Waste & Abuse Hotline | 1-855-202-1058 |
| TTY for the Hearing Impaired | 1-800-255-0056 or 711 |

## Fax

| | |
|---|---|
| Care Management Referral | 844-417-6255 |
| Fraud, Waste & Abuse | 800-418-0248 |
| Medical Prior Authorization* | 844-676-0370 |
| Provider Appeals | 937-531-2398 |
| Provider Maintenance | 937-396-3076 |

* For convenient centralized prior authorization submissions, visit the Georgia Medicaid Management Information System (GAMMIS) Web Portal at www.mmis.georgia.gov.

## State/Regulatory Contact Information

## Mail

### Medical Claim Submissions:

CareSource
Attn: Claims
P.O. Box 803
Dayton, OH 45401

### Pharmacy Claims Submissions:

Express Scripts/CareSource RxInnovations
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

### Delegated Credentialing:

CareSource
Attn: Vice President/Senior Medical Director
P.O. Box 8738
Dayton, OH 45401-8738

### Provider Complaints:

CareSource
Attn: Provider Complaints – Georgia
P.O. Box 2008
Dayton, OH 45401-2009

### Provider Appeals:

CareSource
Attn: Provider Appeals – Georgia
P.O. Box 2008
Dayton, OH 45401- 2008

### Member Appeals and Grievances:

CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401-1947

### Fraud, Waste and Abuse:

CareSource
Attn. Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.

## Website

Accessing our website, **CareSource.com**, is quick and easy. On the Provider section of the site you will find:

- Commonly used forms
- Newsletters, updates and announcements
- The provider manual and other plan resources
- Claim information
- Frequently asked questions
- Clinical and preventive guidelines
- Behavioral health information
- Rewards and incentives
- And much more

## Provider Portal

URL: **https://providerportal.CareSource.com**

Our secure online Provider Portal allows you instant access at any time to valuable information. You can access the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal. Simply enter your username and password (if already a registered user), or submit your information to become a registered user. Assisting you is one of our top priorities in order to deliver better health outcomes for our members.

### Benefits

- Free access to important resources
- Availability 24 hours a day, seven days a week
- Secure, convenient access to time-saving services and critical information
- Accessibility on any web browser without any additional software

## Tools

We encourage you to take advantage of the following time-saving tools:

- **Payment history** – Search for payments by check number or claim number.
- **Claim Features**
  - Submit Claims – Submit claims using online forms or upload a completed claim. Claim submission through the portal is available to traditional providers, community partners, delegates, and health homes.
  - Claim Status – Search for status of claims.
  - Claims Attachments – Submit documentation needed for claims processing.
  - Rejected Claims – Find claims that may have been rejected so that you can resubmit them.
- **Claim Dispute and Appeals** – Submit and search for claim appeals and disputes.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior authorization (PA)** – Request prior authorization for medical and behavioral inpatient/outpatient services, as well as pharmacy authorizations.

  Authorization for the following services should be submitted on the GAMMIS web portal:
  - Inpatient (POS21), outpatient (POS22) or ASC (POS24) setting services
  - Durable medical equipment
  - Children's intervention therapy services
  - Notification of pregnancy
  - Newborn notification
  - Outpatient behavioral health
- **Eligibility termination dates** – View the member's termination date (if applicable) under the eligibility tab.
- **Care management referrals** – Submit automated care management forms on our Provider Portal for efficiency in enrolling members.
- **Benefit limits** – Track benefit limits electronically in real-time before services are rendered for services like chiropractic visits.
- **Care treatment plans** – View care treatment plans for patients on our Provider Portal.
- **Clinical Practice Registry (CPR)** – Review member gaps in care. View and sort CareSource members into actionable groups for improved focus on preventive care (e.g., well-baby visits, diabetes, asthma and more). Look on the "Member Eligibility" page for alerts to notify you what tests a patient needs.
- **Monthly membership lists** – View and download current monthly panel lists.
- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **Information exchange** – Share relevant member information to facilitate better integration of behavioral health, dental and medical care.

### Registration

If you are not registered with CareSource's Provider Portal, please follow these easy steps:

1. Visit **CareSource.com** > Login > Provider and select Georgia. Click on the "Register for an account" button and complete the registration process. Note: you will need to have your tax ID number and CareSource Provider ID.
2. Click Continue. Note the username and password you create so that you can access the portal's many helpful tools.
3. If you do not remember your username/password, please call Provider Services at **1-855-202-1058**.

### GAMMIS Portal

The Georgia Medicaid Management Information System (GAMMIS) portal provides timely communications, data exchange and self-service tools for members and providers with both secure and public access areas. The GAMMIS system can process claims in real time, give claim status, verify eligibility, collect prior authorization requests and more.

The GAMMIS portal serves as the centralized portal for the submission of fee-for-service (FFS) authorization requests and authorization requests for certain services provided to Medicaid members enrolled in a CMO. Access the portal at www.mmis.georgia.gov.

DXC Technology is the fiscal agent for the Georgia Department of Community Health, which includes updating and maintaining the GAMMIS portal. DXC Customer Service Representatives may be reached at 1-800-766-4456 or by inquiring on the GAMMIS portal at www.mmis.georgia.gov.

## Office of the Ombudsman

The CareSource Office of the Ombudsman is an independent, neutral department within CareSource that serves the needs of CareSource members, providers and other stakeholders.

The CareSource Office of the Ombudsman is committed to ensuring stakeholders obtain impartial resolution to their concerns. In addition, this department identifies and mitigates potential systemic issues within the health plan.

The Office of the Ombudsman:

- Is free of charge
- Is a neutral, independent advocate for CareSource members
- Helps coordinate services with local community/advocacy organizations (This includes both covered and non-covered services.)
- Provides health plan navigation and advocacy assistance to research and resolve outstanding issues
- Assists with complaint and grievance resolution

Contact the CareSource Office of the Ombudsman: **1-678-214-7580**
Toll Free: **1-877-683-8993**

## Policies

Policies offer guidance on determination of medical necessity and appropriateness of care for approved benefits. CareSource's medical, reimbursement, administrative and pharmacy policies may be found at **CareSource.com** > Providers > Tools & Resources > Provider Policies.

## Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway at CareSource. Our newsletter is both mailed and posted online at **CareSource.com** > Education > Newsletters & Communications.

## Network Notifications

We regularly communicate policy and procedure updates to CareSource providers via network notifications. Network notifications are found on our website at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements.

## Clinical Practice Guidelines & Preventive Guidelines

CareSource approves and adopts evidence-based nationally recognized standards and guidelines and promotes them to practitioners to help inform and guide clinical care provided to members. Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management tools.

Guidelines are reviewed at least every two years or more often as needed and updated as necessary. They may be found at **CareSource.com** > Providers > Education > Patient Care > Health Care Links.

The use of these guidelines allows CareSource to measure their impact on member health outcomes. Review and approval of the guidelines are completed by the Market CareSource Provider Advisory Committee (PAC). The CareSource Enterprise PAC and Quality Enterprise Committee (QEC) are notified of guideline approval. Topics for guidelines are identified through analysis of member population demographics and national or state priorities. Guidelines may include, but are not limited to:

- Behavioral health (e.g., depression)
- Adult health (hypertension, diabetes, cardiovascular disease, cerebrovascular disease and chronic obstructive pulmonary disease)
- Population health (e.g., obesity and tobacco cessation)

Guidelines may be promoted to providers through one or more of the following: newsletters, our website, direct mailings, provider manual, and through focused meetings with CareSource Provider Engagement Specialists. Information regarding clinical practice guidelines and other health information are made available to members via member newsletters, the CareSource member website, or upon request.

If you would like more information on our Quality Management and Improvement Program, please visit **CareSource.com** > Providers > Education > Quality Improvement or call Provider Services at **1-855-202-1058**.

To ensure consistent application with selected guidelines, we measure compliance with these guidelines until 90 percent or more of providers are consistently in compliance.

Each quarter CareSource conducts a review of a minimum random sample of 50-member medical records using the DCH-selected, evidence-based CPGs. We appreciate your participation in this review process to ensure the highest level of quality care is provided to our members.

## Benefit Managers

### Dental

Dental benefits are administered by SkyGen.

Member Services: 1-855-202-0729

### Vision

Vision benefits are administered by Superior Vision.

# PROVIDER RESPONSIBILITIES

## Access Standards

CareSource has a comprehensive quality 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 providers.

CareSource expects participating providers to have procedures in place to see patients within these time frames and to offer hours of operation to their CareSource patients that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. Please keep in mind the following access standards for differing levels of care.

### Primary Care Providers

| Type of Visit | Should be seen… |
|---|---|
| Emergency needs | Immediately upon presentation |
| Sick visits (adult and pediatric)* | Within 24 hours of initial contact with the PCP site |
| Regular and routine care | Not to exceed 14 calendar days |

### Non-Primary Care Providers (Specialists)

| Type of Visit | Should be seen… |
|---|---|
| Emergency needs | Immediately upon presentation |
| Persistent symptoms* | No later than 30 calendar days after their initial contact with the specialist site |
| Regular and routine care (stable condition) | Not to exceed 30 calendar days |

## Behavioral Health Providers

| Type of Visit | Should be seen… |
|---|---|
| Emergency needs | Immediately upon presentation |
| Non-life-threatening emergency | Within 6 hours of initial contact with behavioral provider |
| Urgent care* | Not to exceed 48 hours |
| Initial visit for routine care | Not to exceed 10 business days |
| Follow-up routine care | Not to exceed 30 calendar days based off the condition |

## Maternity Care Providers

| Patients with… | Should be seen… |
|---|---|
| Routine maternity care | First Trimester – within 14 calendar days of initial contact with maternity care provider<br><br>Second Trimester – within 7 calendar days initial contact with maternity care provider<br><br>Third Trimester – within 3 business days initial contact with maternity care provider |

## Urgent Care Providers

| Patients with… | Should be seen… |
|---|---|
| Emergency needs | Immediately upon presentation |
| Urgent care needs (non-dental) | Within 24 hours of initial contact with urgent care provider |
| Urgent dental care needs | Within 48 hours of contact with urgent care provider |

## Emergency Care Providers

| Patients with… | Should be seen… |
|---|---|
| Emergency care needs | Immediately upon presentation (24 hours a day, 7 days a week and without prior authorization) |
| Elective Hospitalizations | Within 30 calendar days of initial presentation |

## Dental Providers

| Patients with… | Should be seen… |
|---|---|
| Routine care needs | Within 21 calendar days of initial contact with dental provider |

## Vision Providers

| Patients with… | Should be seen… |
|---|---|
| Routine care needs | Within 30 calendar days of initial contact with vision provider |

## Therapy Providers (Physical, Occupational, Speech and Aquatic)

| Patients with… | Should be seen… |
|---|---|
| Routine care needs | Within 30 calendar days of initial contact with therapy provider |

**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 time frame, CareSource will facilitate an appointment with a participating provider or a nonparticipating provider, if necessary.*

For the best interest of our members and to promote their positive health care outcomes, CareSource supports and encourages continuity of care and coordination of care between medical care providers, as well as between medical care providers and behavioral health providers.

CareSource continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

### Telephone Arrangements/24-Hour Access

Providers are required to meet response time standards for patient calls after normal business hours. This may be reviewed by DCH.

| After-Hours Call Type | Response Time |
|---|---|
| Urgent Care Calls | Shall not exceed twenty (20) minutes |
| Other Calls | Shall not exceed one (1) hour |

PCPs must provide 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be provided the means to contact their PCP or a back-up physician to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up physician and only recommends emergency room use for after hours.

## Appointment Wait Times

Providers are required to track wait times, which may be reviewed by DCH upon request.

| Appointment Time | Waiting Time |
|---|---|
| Scheduled Appointments | Waiting times shall not exceed 60 minutes. After 30 minutes, your patient must be given an update on waiting time with an option of waiting or rescheduling the appointment. |
| Work-In or Walk-In Appointments | Waiting times shall not exceed 90 minutes. After 45 minutes, your patient must be given an update on waiting time with an option of waiting or rescheduling the appointment. |

## Americans With Disabilities Act (ADA)

Providers are required to comply with ADA standards, including but not limited to:

- Providing waiting room and exam room furniture that meet the needs of all enrollees, including those with physical and non-physical disabilities
- Accessibility along public transportation routes and/or providing enough parking
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities
- Providing secure access for staff-only areas

The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, providers may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities, and follow ADA accessibility standards for new construction and alteration projects. Furthermore, providers' diagnostic equipment must accommodate individuals with disabilities.

The CareSource provider network will reasonably accommodate persons and ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. CareSource and its provider network will comply with the ADA (28 C.F.R. 35.130) and the Rehabilitation Act of 1973 (29 U.S.C. 794) and will maintain capacity to deliver services in a manner that accommodates the needs of its members.

For more information about the ADA, go to www.ada.gov/.

### Policies and Procedures

Providers are required to modify policies and procedures when necessary to serve a person with a disability. The ADA, however, does not require providers to make changes that would fundamentally alter the nature of their service.

## Cultural Competency

Cultural competency within CareSource is defined as "the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population." It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization.

Cultural competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Participating providers are expected to deliver services in a culturally competent manner, which includes removing all language barriers to service and accommodating the unique ethnic, cultural and social needs of the member. Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

Providers can address racial and ethnic gaps in health care with an awareness of cultural needs and improving communication with their growing numbers of diverse patients. CareSource recognizes cultural differences, including religious beliefs and ethical principles. In accordance with this, providers are not required to perform any treatment or procedure that is contrary to their religious or ethical principles.

Network providers must ensure that:

- Members understand that they have access to medical interpreters, signers and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the members' race/ethnicity and language and its impact/influence on the members' health or illness.
- The office staff that is responsible for data collection make reasonable attempts to collect race-and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify his/her own race/ethnicity and that of his/her children.
- Treatment plans are developed, and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physician abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

CareSource encourages its participating providers to complete the U.S. Department of Health and Human Services Physician's Practical Guide to Culturally Competent Care, which is a free on-line accredited educational program. We provide links to cultural competency training, as well as to our full Cultural Competency Plan for Georgia, online at **CareSource.com** > Providers > Education > Patient Care > Primary Care Provider Roles and Responsibilities, selecting Georgia Medicaid from the dropdown menu.

# FRAUD, WASTE & ABUSE REPORTING

## Overview

Health care fraud, waste and abuse hurts everyone, including members, providers, taxpayers and CareSource. As a result, CareSource has a comprehensive Fraud, Waste and Abuse program in our Program Integrity department. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

## Definition of Terms

### Fraud

Fraud is defined as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law” (42 CFR, Part 455.2).

### Waste

Waste involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight (Inspector General).

## Abuse

Abuse is defined as "provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program" (42 CFR Part 455.2).

## Improper Payment

Improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts (Improper Payments Elimination and Recovery Act, IPERA). Any improper payment may constitute fraud, waste and/or abuse. CareSource has the right to recoup improper payments.

## Examples of Member Fraud, Waste and/or Abuse

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions – i.e. changing prescription form to get more than the amount of medication prescribed by their physician
- Sharing a member ID card
- Non-disclosure of other health insurance coverage
- Changing prescription forms to get more than the amount of medication prescribed by a physician
- Obtaining unnecessary equipment and supplies
- Member receiving services or picking up prescriptions under another person's name or ID (identity theft)
- Providing inaccurate symptoms and other information in order get treatment, drugs, etc.
- Any other action by a member that CareSource considers to be fraud, waste and/or abuse

  Note: This is not an all-inclusive list.

## Examples of Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower Medicaid/Medicare reimbursement rates
- Billing for services not provided
- Requiring members to pay for CareSource covered services
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Prescribing high quantities of controlled substances without medical necessity

- Unbundling services to obtain higher reimbursement
- Not checking member IDs (RID), resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using member/enrollee lists for the purpose of submitting fraudulent claims
- Billing drugs billed for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark violations
- Retaining overpayments made in error by CareSource
- Preventing members from accessing eligible or covered services resulting in underutilization of services offered
- Failing to comply with federal and/or state laws

  Note: This is not an all-inclusive list.

### Examples of Pharmacy Fraud, Waste and/or Abuse:

- Dispensing prescription drugs not dispensed as written
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed
- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted, tainted or illegal drugs
- Billing prescriptions not filled or picked up

### Examples of Employee Fraud, Waste and/or Abuse:

- Receiving gifts or kickbacks from vendors for goods or services
- Inappropriately marketing our company to potential members
- Behaving in an unethical or dishonest manner while performing company business

It is also important for you to tell us if a CareSource employee acts inappropriately.

### Examples of Vendor Fraud, Waste and/or Abuse:

- Falsifying business data or reports
- Not reporting or taking action on employees that are debarred
- Billing for services not rendered
- Billing for a more expensive service, but providing a less expensive service

## Corrective Actions

The CareSource Program Integrity department routinely monitors for potential fraud, waste and abuse. We review claims data and medical records to look for billing discrepancies. When found, an investigation is initiated and, if warranted, a corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Reporting to one or more applicable state and federal agencies
- Contract termination
- Employee disciplinary actions
- Legal action

Refer to your Provider Agreement for specific information on each type of provider termination/suspension. Also, refer to the Fair Hearing Plan, for the information on the appeal process. The CareSource Fair Hearing Plan is available at **CareSource.com** > Provider Overview > Education > Fraud, Waste & Abuse. The "Fair Hearing Plan" provides information on an appeal process for specific corrective actions.

## The False Claims Act

Using the False Claims Act (the Act), you can help reduce fraud against the federal government. The Act allows everyone to bring "whistleblower" lawsuits on behalf of the government – known as "qui tam" suits – against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

As amended in 2009, the False Claims Act addresses those who:

- Knowingly* present, or cause to be presented, a false or fraudulent claim for payment or approval
- Knowingly* make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim
- Conspire to commit a violation of any other section of the False Claims Act
- Have possession, custody or control of property or money used, or to be used, by the government and knowingly deliver, or cause to be delivered, less than all of that money or property
- Are authorized to make or deliver a document certifying receipt of property used, or to be used by the government, and intending to defraud the government, makes or deliver the receipt without completely knowing that the information on the receipt is true
- Knowingly* buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the armed forces, who lawfully may not sell or pledge property

- Knowingly* make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the government.

*"Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.

An example would be if a provider, such as a hospital or a physician knowingly "upcodes" or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.

The time period for a claim to be brought under the False Claims Act is the latter of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity

## Protection for Whistleblowers

Federal and state law and CareSource's policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our Program Integrity department using one of the reporting methods outlined at the end of this section.

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement. Additional information on the False Claims Act and our fraud, waste and abuse policies can be found at **CareSource.com** > Providers > Education > Fraud, Waste & Abuse.

## Anti-Kickback Statute

Under the Federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program (42 U.S.C. §1320a-7b).

## Stark Law

Under the Federal Stark Law, and subject to certain exceptions, providers are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs (42 U.S.C. §1395nn).

## Health Insurance Portability and Accountability Act (HIPAA)

As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. (18 U.S.C. §1347).

## The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, CareSource is required to comply with certain provisions of the DRA.

One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Acts, and other state laws regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste and abuse when handling CareSource business.

## Georgia Law

Georgia has enacted a false claims statute that meets the requirements of Section 1909 of the Social Security Act. Section 1909 provides a financial incentive for a state to enact a false claims statute that is at least as effective in rewarding and facilitating qui tam actions for false claims as those described in the federal False Claims Act.

Georgia's State False Medicaid Claims Act statute applies to any individual or entity that:

- Knowingly presents or causes to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval;
- Knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;
- Conspires to commit a violation of any other section of the statute;
- Has possession, custody or control of property or money used, or to be used, by the Georgia Medicaid program and knowingly delivers, or causes to be delivered, less than all of that money or property;
- Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Georgia Medicaid program and, intending to defraud the state or local government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Georgia Medicaid program who lawfully may not sell or pledge the property; or
- Knowingly makes, use, or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the Georgia Medicaid program, or knowingly conceals, knowingly and improperly avoids, or decreases an obligation to pay or transmit money or property to the Georgia Medicaid program.

Georgia's State False Medicaid Claim Act may be found at Georgia Code 23-3-120, et seq.

## Prohibited Affiliations

CareSource is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended or otherwise excluded from participating in federal procurement and non-procurement activities (42 C.F.R. § 438.610).

Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that your corporate entity, those with more than five percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us immediately utilizing the contact information in the "How to Report Fraud, Waste or Abuse" reporting section.

## Disclosure of Ownership, Debarment and Criminal Convictions

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

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.

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. Please contact us by emailing ProviderMaintenance@CareSource.com.

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.

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

## How to Report Fraud, Waste or Abuse

It is CareSource's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act or any state Medicaid fraud laws.

If you have knowledge or information that any such activity may be or has taken place, please contact our Program Integrity department. Reporting fraud, waste or abuse can be anonymous or not anonymous.

**Options for reporting anonymously:**

- **Call: 1-844-607-2831** and ask to report fraud.
- **Write:**

  CareSource
  Attn: Program Integrity
  P.O. Box 1940
  Dayton, OH 45401-1940

**Options for reporting that are not anonymous:**

- **Fax:** 800-418-0248
- **Email***: Fraud@CareSource.com

  *Most email systems are not protected from third parties. Please do not use email to send confidential information. If you will be sending confidential or health information, please use the form or phone number to report your concerns to help protect your privacy.

Or you may choose to use the **Fraud, Waste and Abuse Reporting Form** located on **CareSource.com** > Providers > Tools & Resources > Forms.

When you report fraud, waste or abuse, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law. Thank you for helping CareSource keep fraud, waste and abuse out of health care.

### Physician Education Materials

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse. This brochure can be found on the Office of Inspector General's website at https://oig.hhs.gov/compliance/physician-education/index.asp.

## Key Contract Provisions

To make it easier for you, we have outlined key components of your contract. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

### Provider Responsibilities

- Participating providers are expected to treat members with respect. CareSource members should not be treated any differently than patients with any other health care insurance. Please reference our Member Rights & Responsibilities.
- **Participating providers are responsible for providing CareSource with advance written notice of any intent to terminate an agreement with us.**
  - This must be done 60 days prior to the date of the intended termination and submitted on your organization's letterhead
- Submitting clean claims within 180 days of the date of service or discharge.
- Appeals must be filed within the required time frame from the date of service or discharge.
- Providers should keep demographic and practice information up to date.
- Participating providers, or their designee, are expected to make daily visits to their patients who have been admitted as inpatients to an acute care facility or to arrange for a colleague to visit.
- Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.

CareSource expects participating providers to verify member eligibility and ask for all of their health care insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other health care insurance coverage that we have on file by logging onto the Provider Portal from the menu options.

### CareSource Responsibilities

**Our agreement also indicates that CareSource is responsible for:**

- Paying clean claims within 15 business days of receipt.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the "Provider Appeals" section of this manual.
- Offering a 24-hour nurse advice line for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance, which involves subtracting the primary payment from the lesser of the primary carrier allowable or the Medicaid allowable. If the member's primary insurer pays a provider equal to or more than CareSource's fee schedule for a covered service, CareSource will not pay the additional amount.
    - Making available member details on coverage and benefits.

These are just a few of the specific terms of our agreement. In addition, we expect participating providers to follow standard practice procedures even though they may not be spelled out in our provider agreement.

## Member/Caregiver Rights & Responsibilities

As a CareSource provider, you are required to respect the rights of our members. CareSource members are informed of their rights and responsibilities via their Member Handbook. The list of our members' rights and responsibilities are listed below. All members are encouraged to take an active and participatory role in their own health and the health of their family.

### Member rights, as stated in the Member Handbook, are as follows:

- To receive information about CareSource, its services, its practitioners and providers, and member rights and responsibilities.
- To receive all services that CareSource must provide.
- To be treated with respect and with regard for their dignity and privacy.
- To ensure medical records and personal information will be kept private.
- To be given information about their health. This information may also be available to someone who the member has legally authorized to have the information or whom the member has said should be reached in an emergency when it is not in the best interest of the member's health to give it to him/her.
- To discuss any appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- To participate in decisions regarding his or her health care, including the right to refuse treatment.

- To voice complaints or appeals about the plan or the care it provides.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- To be sure that others cannot hear or see the member when he/she is getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease or revenge as specified in federal regulations.
- To request and receive a copy of his or her medical records and request to amend or correct the record.
- To be able to say yes or no to having any information about himself/herself given out unless CareSource has to by law.
- To be able to say no to treatment or therapy. If the member says no, the doctor or CareSource must talk to him/her about what could happen and a note must be placed in the member's medical record about the treatment refusal.
- To be able to file an appeal, a grievance (complaint) or state hearing about CareSource or the care it provides, and that the exercise of those rights will not adversely affect the way the member is treated.
- To be able to get all CareSource written member information from CareSource:
  - At no cost to the member.
  - In the prevalent non-English languages of members in CareSource's service area;
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from CareSource and its providers if the member does not speak English or needs help in understanding information.
- To be able to get help with sign language if the member is hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will).
- To freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated.
- Know that CareSource must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives the member care whenever possible and appropriate.
- To be able to get a second opinion from a qualified provider on CareSource's panel. If a qualified provider is not able to see the member, CareSource must set up a visit with a provider not on its panel.
- To not be held liable for the supplier's debts in the event of insolvency.
- To not be held liable for covered services provided to the member for which OMPP or CareSource does not pay the health care provider that furnishes the services.
- To not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the supplier provided the services directly.

- To be responsible for cost sharing only in accordance with 42 CRF 447.50 through 42 CRF 447.60.
- To not be billed for any service covered by Medicaid.
- To make recommendations regarding CareSource's member rights and responsibility policy.
- To contact the United States Department of Health and Human Services Office of Civil Rights at the address below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services:

  Office for Civil Rights
  U.S. Department of Health and Human Services
  Sam Nunn Atlanta Federal Center, Suite 16T70
  61 Forsyth Street, S.W.
  Atlanta, GA 30303-8909

  Customer Response Center: (800) 368-1019
  Fax: (202) 619-3818
  TDD: (800) 537-7697

**Members of CareSource are also informed of the following responsibilities:**

- Use only approved providers, except in emergency or other situations approved by CareSource.
- Keep scheduled doctor appointments, be on time and call 24 hours in advance of a cancellation.
- Follow the advice and instructions for care he/she have agreed upon with his/her doctors and other health care providers.
- Always carry his/her ID card and present it when receiving services.
- Never let anyone else use his/her ID card.
- Contact his/her PCP (primary care provider) after going to an urgent care center or after getting medical care outside of CareSource's covered counties or service area.
- Let CareSource and the county DFCS DFR know if he/she has other health insurance coverage.
- Provide the information that CareSource and his/her providers need in order to provide care.
- Understand as much as possible about his/her health issues and take part in reaching goals that the member and his/her providers agree upon.
- Let us know if he/she suspects fraud, waste or abuse.

# Notification of Practice Changes

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and are critical for claims processing. Additionally, it ensures our directories are up to date, and reduces unnecessary calls to your practice.

## How to Submit Changes

All demographic changes for Georgia Medicaid providers must be made through GAMMIS.

Providers with a delegated credentialing arrangement with DCH will continue to submit demographic changes to CareSource. Please submit changes promptly via the following methods:

**Email**
ProviderMaintenance@CareSource.com

**Mail**
CareSource
Attn: Provider Maintenance
P.O. Box 8738
Dayton, OH 45401-8738

## Timeline of Provider Changes

Providers should notify CareSource of intent to terminate 60 calendar days prior to the intended date of termination.

# Provider Directory Information Attestation

State and Federal regulations require Health Plans to validate and update published information regarding their contracted provider network every 90 days. This validation ensures we have the most accurate information for claims payment and provider directories. This information is critical to process your claims. In addition, it ensures our Provider Directories are up to date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare. **Providers are required to attest to directory information every 90 days.**

Accurate provider directory information ensures we can connect the **right patients** to the **right provider.**

## What happens if I do not attest to my information?

CMS require health plans to verify the accuracy of provider directory information every 90 days. Not attesting to your information and/or providing updated information when applicable can result in claims payment issues and inaccurate provider data in our online and printed directories. With the No Surprises Act in effect as of Jan. 1, 2022, providers who do not attest quarterly, risk being suppressed in impacted provider directories.

## Personally Identifiable Information

In the day-to-day business of patient treatment, payment and health care operations, CareSource and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide that PII be appropriately protected wherever it is stored, processed and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your sensitive provider data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure protected health information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace and shred this content when no longer needed.
- Ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

There may be times when we share patient information with you or ask you to share with us. CareSource, like you, is a covered entity under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment or health care operations.

## HIPAA Notice of Privacy Practices

Members are notified of CareSource's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CareSource's privacy practices, available at **CareSource.com** > About Us > Legal > HIPAA Privacy Practices, selecting the applicable state and plan, includes a description of how and when member information is used and disclosed within and outside of the CareSource organization. The notice also informs members how they may obtain a statement of disclosures or request their medical claim information.

CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members. Please remember that as a provider/covered entity, you are obligated to follow the same HIPAA regulations as CareSource and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Please remember that disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the HIPAA regulation 45 CFR 164. For example, providers may disclose patient information to CareSource for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others. Thank you for your assistance in providing requested information to CareSource in a timely manner.

# Sensitive Health Diagnoses

Consent is the member's written permission to share their information. Not all disclosures require the member's permission. Consent requirements pertain to Sensitive Health Information (SHI) and Substance Use Disorder (SUD) treatment.

- SHI is defined by the state (e.g., HIV/AIDS, mental health, sexually transmitted diseases).
- SUD 42 CFR Part 2 (Part 2), at https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl, pertains to federal requirements that apply to all states.

While all member data is protected under the HIPAA Privacy Rules, Part 2 provides more stringent federal protections in an attempt to protect individuals with substance use disorders who could be subjected to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protections for the sharing of certain information determined to be SHI.

In an effort to help you efficiently coordinate care for our members, CareSource has automated the Member Consent/HIPAA Authorization Form available on our member Forms page at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Georgia Medicaid from the dropdown menu.

When consent is on record, CareSource will display all member information on the Provider Portal at **CareSource.com** > Login > Provider, selecting Georgia, and any health information exchanges. Please explain to your patients that if they do not consent to let CareSource share this information, the providers involved in their care may not be able to effectively coordinate their care. When a member does not consent to share this information, a message displays on the Provider Portal to indicate that all of the member's health information may not be available to all providers.

The Member Consent/HIPAA Authorization Form can also be used to designate a person to speak on the member's behalf. This designated representative can be a physician, an attorney, a relative or some other person that the member specifies.

# Primary Care Providers

## Primary Care Provider Concept

All CareSource members choose or are assigned to a PCP upon enrollment in the plan. PCPs should 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 during the first 90 days of enrollment and then annually after that. Members may initiate the change by calling our Member Services department.

## Roles & Responsibilities

PCP care coordination responsibilities include at a minimum, the following:

- Assisting with coordination of the member's overall care, as appropriate for the member.
- Serving as the ongoing source of primary and preventive care.

- Recommending referrals to specialists, as required.
- Triaging members.
- Participating in the development of case management care treatment plans and notifying CareSource of members who may benefit from care management.

In addition, CareSource PCPs play an integral part in coordinating health care for our members by providing:

- Availability of a personal health care practitioner 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 Responsible For:

- Treating CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Providing preventive care and teaching healthy lifestyle choices.
- Assessing the urgency of member's medical needs and directing members to the best place for that care.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plan and DCH.
- Providing 30 days of emergency coverage to any CareSource patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by CareSource patients for emergency or urgent care if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use.
- Reporting suspected fraud and/or abuse.

In addition, CareSource PCPs play an integral part in coordinating health care for our members by providing:

- Availability of a personal health care practitioner 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

## Provider Selection

CareSource allows for PCPs to include not only traditional provider types that have historically served as PCPs but also alternative provider types such as specialists and patient-centered medical homes (PCMH) with documented physician oversight and meaningful physician engagement. A member who has a primary diagnosis of a severe persistent mental illness may be permitted to have any physician, including a psychiatrist, as his or her PCP.

A member may select a PCP as a medical home from the following types of providers:

- Family practice physicians
- General practice physicians
- Pediatricians – for members up to age 19
- Internal medicine
- Obstetricians and gynecologists – optional
- Nurse practitioners certified (NP-C) specializing in:
  - Family practice
  - Pediatrics

  **Note:** NP-Cs in independent practice must also have a current collaborative agreement with a licensed physician who is a network provider, who has hospital admitting privileges and who oversees the provision of services furnished by NP-Cs.
- Psychiatrists who agree to serve as PCPs for members who have a primary diagnosis of Severe Persistent Mental Illness
- Physicians who provide medical services at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Providers who practice at Public Health Department clinics and hospital outpatient clinics when the majority of their practice is devoted to providing continuing comprehensive and coordinated medical care
- Physician assistants (physician will be listed as member's PCP)
- Retail Health Clinics, such as Walmart, Little Clinics, CVS and Walgreens
- Specialists treating a member's chronic condition(s) who agrees to act as his or her PCP

If a member does not select a PCP, CareSource will assign them one.

## Medical Home

To facilitate total care integration for our members, CareSource encourages a medical home care model. A medical home is a long-term partnership between the PCP/provider team, the patient and the patient's family. The care model focuses on the whole patient, with support and advice for prevention, behavioral health and dental health.

The model provides many benefits to the member and provider, including fewer hospital/ER visits, higher patient satisfaction, improved access for members in rural environments and higher quality at a lower cost to the health care system.

CareSource encourages providers to attain National Committee on Quality Assurance (NCQA) patient-centered medical home (PCMH) recognition. We offer financial incentives to providers who have NCQA PCMH recognition. To support providers working to attain NCQA PCMH accreditation, CareSource offers free consultative assistance to navigate the recognition process with NCQA. Contact your Provider Engagement Representative for more information.

### Dental Providers

CareSource supports the ongoing relationship between our network dentists and our members. We want to ensure our members have access to a full array of dental services that deliver appropriate and timely dental care. We offer eligible members access to a comprehensive dental network across the State of Georgia that leverages the model of a "health home" to organize and coordinate access to dental care for all of our qualified populations.

### Dental Home

The dental home model includes all aspects of meeting adult or pediatric oral health needs and is a partnership between parents/caregivers, the patient, dentists, dental and non-dental professionals. The dental care provider arranges for the provision of all covered or EPSDT dental care services for Georgia Families® and PeachCare for Kids® members under the age of 21. A dental home can be either a general dentist, or in the case of children, a pediatric dentist. For a list of covered services, please see the Covered Services section of this manual.

CareSource communicates with its members to provide information about the importance of preventive dental care and selecting a dental home as early as possible. We encourage our members to select a primary dentist at the time of enrollment along with a PCP. If a member does not select a dentist to coordinate care at the time of enrollment, we will assign a dentist using the following criteria:

- Claim history, if the member has a historical dental relationship
- Geographic proximity, if the member does not make a selection

We notify members within ten calendar days of their dental PCP assignments and provide the option to change their dental homes anytime during the first 30 days. A member can change their dental home at any time and can still go to any participating network dentist to receive treatment.

CareSource continually assesses the quality of our network and health homes to ensure members have access to the dental care they need. We perform periodic quality checks of our network to guarantee the timely and high-quality treatment of our members.

## Advance Directives

An advance directive is a written instruction, such as living will or durable power of attorney for health care including mental health, recognized under Georgia law, relating to the provision of health care when a member is incapacitated.

An advance directive is a written instruction, recognized under Georgia law, relating to the provision of health care when a member is incapacitated.

Under Georgia law, CareSource members have the right to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

Providers delivering medical care to CareSource members must ensure all adult CareSource members 18 years of age and older receive information on advance directives and are informed of their rights to execute advance directives. Information regarding advance directives should be made available in provider's offices and discussed with CareSource members or provider's staff when questions arise.

Providers should discuss advance directives with adult CareSource members during the member's initial office visit and document in the member's medical record whether or not the member has executed an advance directive.

Providers delivering medical care to CareSource members shall not, as a condition of treatment, require a member to execute or waive an advance directive. In addition, providers shall not discriminate against CareSource members based on whether or not the member has executed an advance directive.

## Medical Records

Physicians shall prepare, maintain and retain as confidential the health records of all members receiving health care services and members' other personally identifiable health information received from CareSource, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Providers are required to maintain member records on paper or in an electronic format. Member medical records shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review.

Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records and other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the contract. Medical records shall be signed by the provider of service.

The PCP also must maintain a primary medical record for each member that contains sufficient medical information from all providers involved in order to ensure quality of care.

The medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information, on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school name and telephone numbers (if no phone, contact name and number) of emergency contacts, consent forms, identification of language spoken and guardianship information
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions and known allergies noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses [for children, past medical history includes prenatal care and birth information, operations and childhood illnesses [e.g., documentation of chickenpox)]
- Identification of current problems

- The consultation, laboratory and radiology reports in the medical record shall contain the ordering provider's initials or other documentation indicating review
- Documentation of immunizations
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or the Department for Public Health
- Follow-up visits provided and (secondary) reports of emergency room care
- Hospital discharge summaries
- Advance medical directives, for adults
- All written denials of service and the reason for the denial
- Record legibility to at least a peer of the writer (records judged illegible by one reviewer shall be evaluated by another reviewer)

A member's medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's physical/behavioral health, including mental health and substance abuse status
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (e.g., EPSDT) addressed from previous visits
- Plan of treatment including:
  - Medication history, medications prescribed, including the strength, amount, directions for use and refills
  - Therapies and other prescribed regimen
  - Follow-up plans including consultation and referrals and directions, including time to return

A member's medical record shall include the following minimal detail for hospitals and mental hospitals:

- Identification of the beneficiary
- Physician name
- Date of admission and dates of application for and authorization of Medicaid benefits, if application is made after admission; the plan of care (as required under 42 CFR 456.172 (mental hospitals) or 42 CFR 456.70 (hospitals)
- Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)
- Reasons and plan for continued stay if applicable
- Other supporting material the committee believes appropriate to include
- For non-mental hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable

# Georgia Health Information Network

Providers are encouraged to participate in the Georgia Heath Information Network (GaHIN). GaHIN provides access to a more complete view of patient health information directly from electronic health record (EHR) systems. This exchange of information can save time, improve care, reduce costs and enhance privacy for your patients. This improves care coordination for our members.

The GaHIN supports the following types of providers:

- Physicians
- Mid-level practitioners (physician assistants, nurse practitioners, certified nurse midwives)
- Doctors of dentistry, optometry and podiatry
- Hospitals
- Safety net clinics
- Behavioral and mental providers
- County/state departments of public health
- Long-term care
- Home health
- Hospice
- Labs
- Imaging centers
- Urgent care clinics

Participation in the GaHIN gives immediate access to send or receive data from any other participating provider, working to connect the state, vendors and other key stakeholders.

At any time, a patient may choose to opt-out of having his or her electronic records shared through the network. He or she can simply complete an opt-out form from the provider. If a patient does opt-out, no provider can share his or her health records through the network. If an opt-out patient changes his or her mind, he or she can easily opt back into the system.

For more information, visit https://www.gahin.org/products-services/georgia-connectedcare.

# QUALITY IMPROVEMENT

## Program Purpose

The purpose of the QMIP is to ensure that CareSource has the necessary infrastructure, systems, processes and people to:

- Coordinate member care and services to improve health outcomes
- Promote the use of evidence-based best practices for the treatment of member health conditions
- Ensure high performing and efficient systems for delivery of care
- Address the health, safety and welfare concerns of CareSource members and implement appropriate interventions

There are two guiding tenets for the program:

- Our mission, which is our heartbeat, is to make a lasting difference in our members' lives by improving their health and well-being. Our vision is to transform lives through innovative health and life services.
- The Institutes for Healthcare Improvement's Quintuple Aim: simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, reducing the per capita cost of care for the benefit of communities; promoting staff well-being, and promoting health equity.

The Quality Improvement program includes both clinical and nonclinical services and is revised at least annually, or more often as needed to remain responsive to member needs, provider feedback, standards of care and business needs.

## Program Goals & Objectives

CareSource strives to be a top performing health plan nationally. Performance goals are determined and aligned with national benchmarks where available.

The goals and objectives of the program are to maintain NCQA accreditation:

- Maintain NCQA accreditation for Georgia Medicaid in alignment with contract requirements
- Attain a four or five STAR performance status based on NCQA Accreditation STARS Quality Ratings System
- Compliance with NCQA accreditation standards
- High level of HEDIS performance
- High level of **Consumer Assessment of Healthcare Providers and Systems** (CAHPS®) performance
- Comprehensive population health management program
- Comprehensive provider engagement program

## Program Scope

The CareSource Quality Management and Improvement Program oversees quality improvement and assessment activities for CareSource. The scope includes:

- Establish safe clinical practices throughout our network of providers
- Provide quality oversight of all clinical services, including addressing all quality-of-care concerns
- Advocate for members across settings, including review and resolution of quality-of-care concerns
- Meet member access and availability needs for physical and behavioral health care
- Determine interventions for HEDIS® overall rate improvement that increase preventive care rates and facilitate support of member acute and chronic health conditions and other complex health, safety or welfare needs
- CareSource uses the annual member CAHPS® survey to capture member perspectives on health care quality and establishes interventions based on results to enrich member and provider experience and satisfaction. Use the Institute for Healthcare Improvement (IHI) model for improvement methodologies to evaluate initiatives and effect change
- Ensure CareSource is effectively serving our members with cultural and linguistic needs, as well as identified disparities that may impact member receipt of health care services and achieving positive member outcomes
- Monitor important aspects of care to ensure the health, safety and welfare of members across healthcare settings
- Ensure that CareSource is effectively serving members with complex health needs
- Ongoing assessment of member population health characteristics
- Regularly assess the geographic availability and accessibility of primary and specialty care providers
- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies

Our commitment to the Quality Management and Improvement Program is aligned with the Georgia Department of Community Health (DCH).

## Quality Strategy

CareSource seeks to advance a culture of quality and safety that begins with our senior leadership and is cultivated throughout the organization. CareSource utilizes the Institute of Healthcare Improvement (IHI) framework developed to optimize health system performance.

*Institute for Healthcare Improvement Quintuple Aim for Populations*

CareSource aligns with the Institute for Healthcare Improvement Quintuple Aim (IHI) framework to:

- Improve the member experience of care (including quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care
- Promote staff care and satisfaction
- Promote health equity

In addition, CareSource utilizes Six Sigma tools, when indicated, to focus on improving member experience, member safety and ensuring our processes consistently deliver the desired results.

## Quality Measures

CareSource continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve member outcomes.

CareSource uses HEDIS to measure the quality of care delivered to members. Potential quality measures include:

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer and chlamydia)
  - Well-childcare
  - Metabolic screening for members with behavioral health (BH) conditions taking antipsychotic medications
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure
- Behavioral health
  - Follow-up after hospitalization for mental illness
  - Antidepressant medication management
  - Follow-up for children prescribed ADHD medication

- Safety
  - Use of imaging studies for low back pain
  - Opioid safety measures

CareSource uses the annual member CAHPS surveys to capture member perspectives on health care quality. Potential CAHPS measures include:

- Customer service
- Getting care quickly
- Getting needed care
- How well doctors communicate
- Ratings of all health care, health plan, personal doctor and specialists

Providers can log in to our Provider Portal at **CareSource.com** > Login > Provider, selecting Georgia, to access our Clinical Practice Registry and historical medical and pharmacy data.

## External Quality Reviews

Through our contract with DCH, we are required to participate in periodic record reviews. DCH retains an External Quality Review Organization (EQRO) to conduct medical record review for CareSource Georgia members.

You may periodically receive requests for medical record copies from CareSource or from the DCH-contracted EQRO. Your contract with CareSource requires that you furnish copies of patient medical records for this purpose.

EQRO and CareSource reviews are a permitted disclosure of a member's personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

CareSource realizes that supplying medical records for review requires your staff's valuable time, and we appreciate your cooperation with our requests and associated timelines.

If you would like more information about the CareSource Quality Improvement program, please call Provider Services at **1-855-202-1058**.

## Value-Based Reimbursement (VBR)

Your success is important to us. We offer a series of value-based reimbursement (VBR) programs for our providers. These programs provide a progressive approach along a continuum of payment programs that will reward you as you attain higher levels of quality.

Our flexible approach will enable you to participate in VBR programs at an initial level and grow to successively higher levels of reimbursement. You are rewarded for providing higher value services and for achieving better health outcomes for our members.

Contact your Provider Contracting Manager for more information about our VBR programs.

# UTILIZATION MANAGEMENT

## Specialist Referrals

### Referral Information

If you have questions about referrals and prior authorizations, please call our Utilization Management department at **1-855-202-1058**.

### Referral Procedures

Any treating provider can refer CareSource members to specialists. Simply put a note about the referral in the patient's chart. Please remember, in most cases, non-participating specialists must request prior authorization for any services rendered to CareSource patients. Members may schedule self-referred services with participating providers as long as applicable benefit limits have not been exhausted.

If you have difficulty finding a specialist for your CareSource member, please use our online Find a Doctor/ Provider tool at **CareSource.com** > Members > Tools & Resources > Find a Doctor or call Provider Services at **1-855-202-1058**.

**Referring Doctor** – Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

**Specialist** – Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure. CareSource expects specialists to collaborate on the member's care and inform the member of treatment plan updates.

**Standing Referrals** – A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral.

**Referrals to Nonparticipating Providers** – A member may be referred to an out-of-plan provider if the member needs medical care that can only be received from a doctor or other provider who is not participating with our health plan. Treating providers must get prior authorization from CareSource before sending a member to an out-of-plan provider.

**Referrals for Second Opinions** – A second opinion is not required for surgery or other medical services. In accordance with 42 CFR 438.206(b)(3), CareSource complies with all member requests for a second opinion from a qualified professional. If our network does not include a provider who is qualified to give a second opinion, CareSource shall arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a nonparticipating provider.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

## Services Not Requiring Referral

Services that do not require a referral include the following:

- Certified Nurse Practitioner (CNP) services
- Dental care (excluding oral surgery, orthodontic, endodontic, periodontics, prosthodontics and some adjunctive services)
- Services to treat an emergency
- Family planning services
- Laboratory services (must be ordered by a participating provider)
- Podiatric care
- Psychiatric care at community mental health centers only
- Psychological care (from private practitioners or at Community Mental Health Centers)
- Care at public health clinics
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Most radiology services (must be ordered by a participating provider)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours
- Services for children with medical handicaps

Note that although CareSource does not require members obtain referrals for the providers below, the specific services rendered may still require prior authorization from CareSource. In addition, all services rendered are still subject to benefit limits. PCPs or dental providers do not need to arrange or approve these services for members as long as any applicable benefit limits have not been exhausted.

## Non-Participating Providers

Members may go to nonparticipating providers for:

- Emergency care
- Care at Community Mental Health Centers
- Family planning services provided at qualified family planning providers
- Care at FQHCs and RHCs

Any provider who is not a participating provider with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource member, with the exception of Family Planning services provided to CareSource members and P4HB participants.

## Radiology Services

Ordering physicians must obtain a prior authorization for the following outpatient, non-emergent diagnostic imaging procedures:

- MRI/MRAs
- CT/CTA scans
- PET scans

Providers can obtain prior authorization from NIA Magellan for an imaging procedure in the following ways:

- Online – https://www1.radmd.com
- By phone – 1-866-392-5173 (follow the options to obtain a prior authorization and select the option for advanced radiology prior authorization), Monday through Friday, from 8 a.m. to 8 p.m. ET.

Authorization requests are approved at intake in most cases. If an approval cannot be issued during the initial intake, more information may be required.

**Please Note:** Imaging procedures performed during an inpatient admission, hospital observation stay, or emergency room visit are not included in this program.

Prior authorization is required from TurningPoint for certain cardiac and orthopedic services. Services are provided within the benefit limits of the member's enrollment. Please visit **CareSource.com** > Providers > Provider Portal > Prior Authorization for the most up-to-date information of services that require PA.

You can obtain PA from TurningPoint through the following methods:

- Online – www.myturningpoint-healthcare.com
- By phone – 1-678-528-2056 (Local) | 1-855-941-5310 (Toll Free)
- By fax - 1-404-201-6624 (Local) | 1-844-472-0483 (Toll Free)

# Utilization Management Information

Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The Utilization Management department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources.

We also monitor the coordination of medical care to ensure its continuity. Referrals to the CareSource care management team are made, if needed. CareSource makes its UM criteria available in writing by mail, fax and online. On an annual basis, CareSource completes an assessment of satisfaction with the UM process and identifies any areas for improvement opportunities.

UM criteria is available via the following request methods:

## Mail

CareSource
Attn: Medical Management Dept.
PO Box 1598
Dayton, OH 45401

## Fax

844-676-0370

## Email

gamedmgmt@CareSource.com

## Criteria

The CareSource UM model supports appropriate access to quality care for members. We utilize member-specific information and nationally-recognized, evidence-based clinical criteria to evaluate medical necessity and support the appropriateness of requested health care services such as outpatient care, DME, inpatient hospital admissions, rehabilitation services, skilled nursing facility admissions, and behavioral health services.

CareSource follows all applicable state and federal requirements regarding the implementation and application of criteria used to manage the authorization of covered services. CareSource also has medical policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource Clinical Peer Reviewer for further review and determination. Clinical Peer Reviewers from CareSource are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health care providers or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

Our members' health is always our number one priority. Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations. You can also discuss an adverse decision with CareSource's physician reviewer or request a peer-to-peer conversation.

Please call the Utilization Management department at **1-855-202-1058** within five business days of the determination.

If you are dissatisfied with a determination made by our Utilization Management department regarding a member's health care services or benefits, you may request a peer-to-peer conversation or appeal the decision. Please see the Grievances & Appeals section of this manual for information on the peer-to-peer consultation and how to file a clinical appeal.

## Access to Staff

Providers may call our toll-free number, **1-855-202-1058**, to contact UM or Provider Services staff with any UM questions.

- Staff members are available from 7 a.m. to 7 p.m. ET, Monday through Friday for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

# Prior Authorization Overview

Some services require prior authorization. If a request for authorization is submitted, CareSource will notify the provider and member in writing of the determination. Authorizations can also be requested retroactively in emergencies requested within 30 days after the date of service when one of the following circumstances applies:

- The member is unable to advise the provider what plan they are enrolled in due to a condition that renders them unresponsive or incapacitated
- Retrospective enrollment
- When urgent service(s) was/were performed, and it would have been to the member's detriment to take the time to request authorization
- The new service was not known to be needed at the time the original prior authorized service was performed
- The service is directly related to another service for which prior approval has already been obtained and that has already been performed
- For services provided to a dual-eligible member and the provider is notified that Medicare benefits have been exhausted after the delivery of service.

If a service cannot be covered, providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Grievances and Appeals" section for information on how to file an appeal.

# Prior Authorization for Emergency Services

CareSource provides reimbursement for medically necessary emergency services when rendered by a qualified provider, in accordance with the provider's contract with CareSource or in accordance with the Department of Community Health's fee-for-service reimbursement rates for providers that do not have a contract with CareSource, less any applicable percentage.

CareSource reimburses for all medically necessary emergency services that are provided to stabilize the member. After a member's condition is stabilized, providers must notify CareSource as soon as reasonably possible in order for CareSource to issue any needed authorization.

CareSource will not:

- Deny or inappropriately reduce reimbursement for a provider's provision of emergency care services for any evaluation, diagnostics or treatment provided to a member who needs emergency medical assistance, or
- Reimburse emergency care services contingent upon on the member or provider providing any notification, either before or after receiving emergency services.

# Prior Authorization

Prior authorization is not based solely on medical necessity, but on a combination of factors including, but not limited to: member eligibility, medical necessity, medical appropriateness and benefit limitations. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Services are provided within the benefit limits of the member's enrollment. To review applicable prior authorization requirements, please review the CareSource Prior Authorization List and the Procedure Code Lookup Tool located at **CareSource.com**.

# Requesting Prior Authorization

Any provider who is not a participating provider with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource member, with the exception of Family Planning services provided to CareSource members and P4HB participants.

## Medical

The Georgia Medicaid Management Information System (GAMMIS) serves as the centralized portal for the submission of fee-for-service (FFS) authorization requests and authorization requests for certain services provided to Medicaid members enrolled in a Care Management Organization (CMO). Access the portal at www.mmis.georgia.gov.

The following prior authorization types should be submitted via GAMMIS:

- Inpatient (POS21), outpatient (POS22) or ASC (POS24) setting services
- Laboratory services
- Durable medical equipment
- Children's intervention therapy services
- Notification of pregnancy
- Outpatient behavioral health
- Orthotics and prosthetics
- Autism spectrum disorders

Prior authorization for other health care services can be obtained by contacting the CareSource Utilization Management department online or by email, phone or fax. If submitted by mail or fax, you can use the Medical Prior Authorization Form available at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Georgia Medicaid from the menu.

## Online

Access the Provider Portal at **CareSource.com** > Login > Provider, select Georgia

## Phone

Please call **1-855-202-1058**, then tell our IVR that you need to submit an authorization request.

### Fax

937-487-1664

### Email

gamedmgmt@CareSource.com

### Mail

Send prior authorization requests to:

CareSource
P.O. Box 1307
Dayton, OH 45401-1307

### Information Needed for Review of Prior Authorization Submissions

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource member ID number
- Provider name, TIN and NPI
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-network provider, if applicable
- Clinical information to support the medical necessity for the service

## Authorization Determination Time Frames

For standard prior authorization decisions, CareSource provides notice to the provider and member as expeditiously as the member's health condition requires, but no later than three business days after receipt of the request for service.

Urgent prior authorization decisions are made within 24 hours of receipt of the request for service. Please specify if you believe a request is urgent.

| Authorization Type | Decision Time Frame | Extension Period |
|---|---|---|
| Concurrent (Continued Stay Reviews) | 72 Hours | |
| Standard pre-service (routine) | Three business days | 14 calendar days |
| Expedited pre-service | 24 hours | Five business days |
| Post service (retrospective review) | 30 calendar days | |
| Pharmaceuticals | 24 hours | |

**Note:** Extensions may be granted if the member or provider requests it or if CareSource justifies to

the Department of Community Health that additional information is needed and the extension is in the member's best interest.

## Medical Necessity Standards and Practice Guidelines

"Medical necessity" or "medically necessary" means services that are:

- Required to correct or ameliorate a defect, physical or mental illness, or a condition;
- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the member or the convenience of the provider or hospital;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage; and
- Provided when there is no other effective, more conservative or substantially less costly treatment, service or setting is available

## Retrospective Review

Providers must submit a retro authorization within 30 calendar days of the service date, or discharge date for inpatient services where prior authorization was required but not obtained. CareSource will provide a determination on the provider's request within 30 calendar days of the receipt of the request. Claims not meeting the requirement as described above will be administratively denied.

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.

A retrospective review is a request for an initial review for authorization of care, service or benefit for which an authorization is required but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately.

CareSource shall provide retrospective review of requests for authorization of services submitted within 30 calendar days of the date of service or the date of discharge where a prior authorization was required but not obtained. Claims not meeting the requirement will be administratively denied.

If the request is received within these time frames and a medical necessity denial is issued, you may submit a request for an appeal within 30 days from the date of denial.

A request for retrospective review can be made by contacting the Utilization Management department at **1-855-202-1058** and following the appropriate menu prompts or by faxing the request to 1-844-676-0370. You must include clinical information supporting the request for services.


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