CareSource® MyCare Ohio (Medicare-Medicaid Plan)
Behavioral Health Providers
Frequently Asked Questions (FAQs)

NOTE: CareSource has extended the MyCare Transition of Care (TOC) through December 31, 2015 for behavioral health services. This will ensure continuity of care for our members and allow more time for non-par behavioral health providers to contract with CareSource. Providers will not see any interruptions or changes in reimbursement fees. Effective January 1, 2016, the State's new fee schedule will be implemented.

DOING BUSINESS WITH CARESOURCE

Q1. How do I become a CareSource MyCare Ohio provider?
A. CareSource credentials all licensed independent practitioners. Some groups, such as Community Behavioral Health Centers (inclusive of Community Mental Health Centers and all MHAS certified behavioral health providers) and Federally Qualified Health Centers, can be credentialed at the group level. The credentialing process for the community behavioral health centers begins by submitting the following materials to CareSource on behalf of the group. You may submit them via email, fax or mail. CareSource does not credential providers that are not independently licensed.

- a Standardized Credentialing Form Part B Agency/Program/Organization Providers or CAQH number
- National Provider Identifier (NPI) number
- Malpractice Insurance Face Sheet
- Drug Enforcement Administration (DEA) Certificate (current)
- Clinical Laboratory Improvement Amendment (CLIA) Certificate (if applicable)

Email: contract.implement@caresource.com
Fax: 937-396-3632
Mail: Send by certified mail with return receipt to:
CareSource
Attn: Contract Implement
P.O. Box 8738
Dayton, OH 45401

For more Credentialing information, please go to our CareSource website for the most current Provider Manual.

Q2. I am an existing CareSource provider. Do I need to take action to become a MyCare provider as well?

A. Please complete the CareSource Provider Group Change request form and email it to Providermaintenance@caresource.com. The form can be found on our website under Provider Materials/Forms.

Q3. What is the difference between credentialing and contracting?

A. Credentialing is the process by which CareSource verifies the qualifications and performance of physicians and other health care practitioners as well as groups, organizations and facilities, who are contracting with CareSource. Contracting is the legal process that outlines the terms, conditions and responsibilities under which we work together to best serve our members.

Q4. Are there specific licenses, credentials or certifications required for Behavioral Health providers?

A. All providers, including behavioral health providers, must meet the credentialing requirements outlined in the current Provider Manual, either at the individual or group level. This includes but is not limited to the following:

- Active license to practice independently in the state of practice
- Hold a valid, current certification from a recognized certifying board. This includes the BACB
- Hold a valid, current certificate from the Ohio State Board of Psychology

CareSource will credential all community behavioral health centers at the group level.

MEMBER ELIGIBILITY

CareSource has several different health plans. Members have different eligibility for services depending upon the plan in which they are enrolled. Providers bill for services differently depending upon the plan for which the member is eligible. This is because there are different payers for services depending upon the member's eligibility and plan in which they are enrolled.

Even within the CareSource MyCare Ohio plan, members may have different eligibility. This is because a member may have dual benefits (Medicare-Medicaid) or Medicaid-only (aka opt-out) benefits with CareSource.

Thus, accurate member eligibility is critical to submit claims properly.

Q5. How do I check the exact member eligibility status?

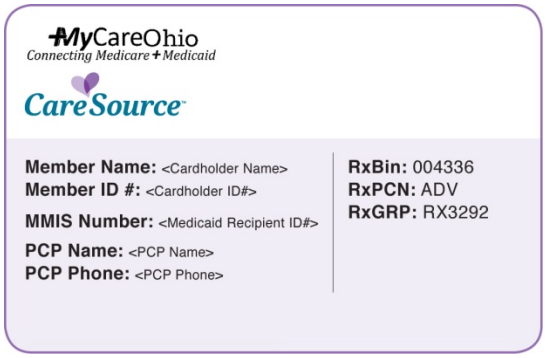
A. Providers can check the MITS provider portal to determine the level of MyCare plan for the enrollee. Providers can also check with CareSource via the portal or by calling 1-800-488-0134. When obtaining services, the member is expected to provide a valid/current Medicare card, as well as the CareSource MyCare Medicaid ID Card, OR the CareSource dual card showing both Medicare and Medicaid coverage. See card images in **Q7** below. **Note:** Seeing a membership card does not substitute for checking current eligibility. Additionally, retroactive terminations and retroactive membership adds are ongoing so "exact" member eligibility is not really possible.

Q6. Can I get a member eligibility report? What about the 270/271 report?
A. You can check member eligibility via the CareSource portal. CareSource does not provide 271 reports (response to a provider eligibility inquiry 270). These may be available through your clearinghouse.

Q7. What do the membership ID cards look like for CareSource MyCare Ohio members?

A. MyCare Dual Member: Medicare – Medicaid

B. MyCare Medicaid only Member



Q8. Can I tell by looking at the member ID card if the member has both Medicare and Medicaid benefits with CareSource?
A. Yes, if a member has both Medicare and Medicaid with CareSource they will have a new card that replaces the separate Medicaid and Medicare cards. The CareSource membership ID card for both Medicare and Medicaid will have Medicare on the front side; however, seeing the membership card is not a replacement for checking current eligibility each time. This can be done by using the portal or by calling 1-800-488-0134.

Q9. If a MyCare member has only Medicaid benefits with CareSource, how do they enroll for MyCare Medicare as well? Note: By definition, a MyCare member is eligible for both Medicare and Medicaid. MyCare members with only Medicaid benefits aka "opt outs" have elected to obtain their Medicare benefits through another carrier.
A. To switch to a new Medicare plan, or to choose CareSource for both Medicare and Medicaid, members should call the Ohio Medicaid Consumer hotline at 1-800-324-8680.

Q10. Is Prior Authorization required? What is the process to obtain a Prior Authorization and how long does it take?

- Prior authorization is required for select services. See the MyCare Ohio section of the provider manual for the most current information. Prior authorizations can be obtained by contacting Medical Management online, by email, phone, fax or mail. In all cases the Prior Authorization form should be used from our website.
    a. Online: Caresource.com and select the Provider Portal option from the menu.
    b. Email: mmauth@caresource.com
    c. Fax: 1-888-752-0012
    d. Mail: CareSource
        P.O.Box 1307
        Dayton, OH 45401-1307
    e. Phone: 1-800-488-0134
- While prior authorizations can take up to fourteen (14) days, CareSource's track record is significantly better, taking on average 3-4 days.

CLAIMS & PAYMENT

Q11. What provider information/identifiers are needed for claims submissions?

A. **For MyCare**, the group tax ID and NPI should be used for claims because the CMHCs are required to bill at the group level for MyCare. If a CMHC is participating in other CareSource plans, it should continue billing as in the past for those plans only.

Q12. How do I submit a claim for CareSource MyCare?

A. You can submit a claim in one of four (4) ways:

1. Electronic submission (837P) using your current clearinghouse (CareSource payer ID # 31114)
2. Electronic submission (837P) using Practice Insight (no fee)
    a. Enroll with Practice Insight by completing the form found on our website
    b. Email form to enrollment @practiceinsight.net or Fax (713) 333-0138
    c. To learn more about Practice Insight visit www.practiceinsight.com
3. Electronic submission via the portal - see recent network notifications regarding electronic submission of coordination of benefit claims and corrected claims.
4. Paper submission by using the industry standard CMS1500 claims form:

CareSource
ATTN: Claims Department
P.O. Box 8730
Dayton, OH 45401-8730

Q13. What is the purpose of a clearinghouse? Do you have a clearinghouse recommendation?
A clearinghouse is required for the electronic submission of claims via EDI. Electronic claims submission is preferred over paper submission because it will save time and money, and expedite payment to you; thus, it is highly recommended that you establish a relationship with a clearinghouse unless you submit claims via our portal. A clearinghouse is an entity that that processes or facilitates the processing of nonstandard data elements of health information into standard data elements. In the case of claims, the clearinghouse translates the data from a given format into one acceptable to CareSource as the payer. For a complete list of clearinghouses that CareSource works with visit the Claims chapter in the Ohio Provider Manual located on our website.

Q14. How can I get an electronic 835 file sent automatically to the clearing house we submit our claims through?
A. First you must be set up to receive your payment through EFT (See **Q16** below). After you are set up for EFT you will need to complete the Electronic Remittance Advice (ERA) Routing Form to update remittance delivery of your electronic 835 to your clearinghouse. This form is available on-line at our website.

Q15. Can I have electronic funds transfer (EFT)?
A. Absolutely. EFT is the preferred payment option of CareSource. While printed checks are also available, you'll find EFT simple, reliable, and more convenient. To enroll in EFT with InstaMed see **Q16**.

Q16. How do I get set up with EFT? How do I contact InstaMed?
A. BH providers can receive payment by a printed check or the preferred payment option, Electronic Funds Transfer (EFT). To enroll in EFT with InstaMed:

a. Complete the InstaMed enrollment form on the "Claims Payment" page of CareSource.com
b. Fax it to InstaMed at 1-877-755-3392
c. Call InstaMed for EFT or enrollment questions. 1-215-789-3682

Free training available through InstaMed www.instamed.com/aha-eraeft

Q17. What steps can I take to ensure I submit an accurate claim?
A. Reference the top twelve (12) reasons that claims are being denied and the top five (5) reasons for rejection of an EDI claim and note the recommendations. You will find this information on our website.

Q18. How do I correct a claim that has already been submitted to CareSource?
A. You can submit a corrected claim electronically or via paper. The claim must be resubmitted in its entirety. For details on submitting a corrected claim electronically please see the recent

network notification. If resubmitting/correcting a paper claim, please have the claim stamped or marked "corrected" and add the previous claim number. This information is critical for timely processing.

Please send corrected paper claim to:

CareSource
ATTN: Claims Department
P.O. Box 8730
Dayton, Ohio 45401-8730

Q19. How do I check the status of a claim?

A. You can check the status of a claim in two ways:

1. View claim status online via the CareSource secure portal 24/7
   To register with the portal, visit https://providerportal.caresource.com/OH and click on "Register Here" **Note: You must be set up in the CareSource system in order to be able to register for portal use. You must have a provider ID. Contact Provider Services if you have questions.**
2. Call Provider Services 1-800-488-0134, 8am – 6pm, Monday – Friday.

Q20. How does cross-over billing work?

Cross-over billing only applies to "dual" members, those having both Medicare and Medicaid benefits from CareSource MyCare Ohio. If the individual is enrolled as a dual benefit member, the provider will only need to submit one claim and the MyCare Ohio plan will process the "crossover" internally. Claims cannot contain both Medicare/Medicaid codes and OMHAS codes. OMHAS codes pay under the Medicaid benefit only. Additionally, the same service cannot be billed under two separate codes.

Q21. Do I submit claims differently if the MyCare member has both Medicare and Medicaid benefits with CareSource vs. only Medicaid benefits?

A. Yes, if the MyCare member has both Medicare and Medicaid only one claim to CareSource is required (see Q20 above). If an individual maintains their existing Medicare coverage (FFS or Medicare Advantage), then the provider will need to bill the appropriate Medicare plan for the service, wait for an EOP with Medicare payment, then submit the Medicaid portion with the COB information included on the 837P to CareSource MyCare Ohio. The automated "Medicare-Medicaid crossover" process used with MITS will no longer work for Medicaid only enrollees.

Q22. How long does it take to process a claim with CareSource?

A. Most claims are processed within 30 days.

Q23. What if my claim was not processed correctly?

A. It's always a good idea to review the claim for accuracy and completeness and reference the top reasons claims reject, found on our website. If, after reviewing the common errors, you still feel the claim was not processed correctly, contact Provider Services at 1-800-488-0134.

Q24. Who do I call if my claims are not being processed in a timely fashion?
A. Contact Provider Services 1-800-488-0134 or your provider relations representative.

Q25. How do you handle take-backs or recoupment?
A. Adjustments for overpayments are made on future reimbursements. It is also acceptable for providers to issue refund checks to CareSource for any overpayments. Providers should not refund any money received from a third party to a member.

Q26. What is your COB policy?
A. CareSource's MyCare COB claims processing methodology is consistent with the Ohio Department of Medicaid's policy. CareSource pays up to 100% of the Medicare allowable, less what Medicare pays, regardless of the Medicaid allowable, *for specific provider types*. The COB methodology does **not** apply to all MyCare providers. The affected provider types, which include Community Mental Health Centers, are outlined in the Network Notification.

Q27. My EOP is incorrect. What is going on?
A. Some MyCare Explanation of Payment (EOP) documents were incorrectly reflecting a patient responsibility amount due. However, CareSource has resolved this problem. Any coinsurance, deductible and/or copays should show on an EOP as a disallowed amount in the disallowed/non-covered field.

Q28. I thought I could get a claims status report but I am having difficulty getting this from the clearinghouse. Can you help?
A. You can check claims status on the CareSource portal. Or, you can ask your clearinghouse for a report that identifies all rejected claims.

Q29. What is the difference between a claims reject and a claims denial?
Rejected claims are defined as claims with invalid or missing data elements, such as the provider tax identification number or member ID number, that are returned to the provider or EDI clearinghouse before entering the claim processing system. Rejected claims need to be reworked and resubmitted as a new claim. Denied claims have entered the claim processing system but do not meet requirements for payment under Plan guidelines. Denied claims need to be resubmitted as a corrected claim.

Q30. What are the required EDI specifications? Who can help me?
A. Contact your clearinghouse.

Q31. Where can I get additional information on claims submission and processing with CareSource MyCare Ohio?
A. There is a complete provider manual online. Go to CareSource.com, click "Providers" tab at top of the page, select Ohio; select Ohio Providers, then "Provider Manual". See the chapter on Claims, page 9.

SERVICES COVERED / NOT COVERED

Q32. What Behavioral Health services does CareSource pay for in its MyCare plan?

A. CareSource covers the following services:
   a. Alcohol/Drug screening analysis/lab urinalysis
   b. Ambulatory Detoxification
   c. Assessment
   d. Case Management
   e. Community Psychiatric Support Treatment (CPST)
   f. Counseling and therapy, individual and group
   g. Crisis intervention
   h. Intensive Outpatient program services
   i. Medical/Somatic
   j. Mental Health assessment
   k. Methadone administration
   l. Partial Hospitalization
   m. Pharmacological management
   n. Psychiatric diagnostic interview

Q33. Is Methadone a covered drug?

A. Methadone is covered under MyCare by both Medicare and Medicaid when billed with modifier HA or HF.

Q34. What behavioral health coding will be used by the CMHCs?

A. BH coding structures will remain consistent with current practices during the transition period.

Q35. Are there same day service limits under MyCare Ohio?

A. Same day service limits that apply to Medicaid BH services in traditional Medicaid will also apply in MyCare Ohio, unless otherwise authorized by the Plan. CareSource will not apply service limits or prior authorization for any Medicaid out-patient CBHC services through December 31, 2015.

Q36. Where do I find the billing codes?

A. The billing codes and modifiers are published on MITS and on the Ohio MHAS website.

Q37. What rates are paid for which services? Are there published fee schedules? Do rates vary for participating and non-participating providers?

A. The OMHAS rates are published and can be viewed here at the OMHAS web site. The rates are the same for all providers.

Q38. We currently bill in fractions of a unit or minute increments (aka "split billing") based on an hourly rate. Will this practice continue with CareSource MyCare Ohio?
A**.** Yes, CareSource will continue to accept split billing per the following:

Code(s)
XXXX
Services provided to member in Time/Minutes
0 - 7 minutes
8 minutes
9 - 14 minutes
15 - 20 minutes
21 - 26 minutes
27 - 32 minutes
33 - 38 minutes
39 - 44 minutes
45 - 50 minutes
51 - 56 minutes
57 - 62 minutes
63 - 68 minutes
69 - 74 minutes

Q39. Some providers are receiving higher amounts of reimbursement for their Pharmacological Management billing. Why is this and will providers face paybacks or adverse audit findings?
A. Because of the complexities in configuring our system to accommodate the CMHC services which are billed in tenth of units, and specific to pharmacological management services, CareSource configured our system in minutes, which, in some instances may result in a somewhat higher payment for pharmacological management services. For example, instead of a 23 minute pharmacological management service converting to .2 unit, under the current logic configuration CareSource will pay 23 minutes or .23 of a unit. This payment logic and configuration will not create a payback request or any adverse finding relative to payment from CareSource, since it's different than what is currently in place.

Q40. What do I do if a CPT code is not covered? Who can help me?
A. In some cases, when a provider is not paid for a service, it's because the code is not yet configured in the benefits system. If you have a question about a CPT code, payment amounts or coverage, call provider services or your provider relations representative.

PROVIDER PORTAL

Q41. What is your provider portal all about?
A. CareSource's secure online Provider Portal makes it easier for you to work with us 24/7. You can check eligibility, claim status, obtain prior authorization and view care treatment plans.

Q42. Do I need to register? How can I get access?
A. Yes, you must register for portal access. In order to register, your information must be loaded into the CareSource system. You must have a CareSource assigned provider ID which is auto-generated at the time a provider is loaded to our system. Participating providers will receive their provider ID automatically once they are loaded to the system. Non-participating providers will need to contact Provider Services to obtain their ID for portal registration. To register for the portal, visit https://providerportal.caresource.com/OH and click on "Register Here". You will need your group name, tax name, provider ID and zip code.

Q43. What is the CareSource ID that is being requested for portal registration?
A. This is NOT your Medicaid ID number. It is the provider ID generated at the time the provider is loaded to the CareSource system.

Q44. Can I submit claims on the portal?
A. Yes. See previous Claims section.

Q45. Is there other information I can access on the portal that will help me?
A. Yes, Q41.

TRANSITION PERIOD

The Ohio Department of Medicaid (ODM) and the Ohio Department of Mental Health and Addiction Services (OhioMHAS) have committed to continued coverage of current professionals during the first year of the Demonstration period and through December 31, 2015.

Q46. If a Medicare eligible service is provided by a non-Medicare eligible professional, will the service be reimbursed by Medicaid as the primary payer?
A. Yes, during the transition period.

Q47. Are MyCare plans permitted to contract with behavioral health organizations that are not enrolled with Medicare?
A. Yes, MyCare Ohio plans may contract with BH organizations that are not currently enrolled as eligible Medicare providers to meet the needs of dual eligible enrollees. Plans can contract for services that are not Medicare eligible without consideration of a provider's Medicare certification/enrollment. Effective January 1, 2016 Medicare primary billing for eligible services will be required.

Q48. If a BH provider is still in the process of completing an agreement with CareSource to be a participating provider, but the final agreement hasn't been signed, what's the process for service delivery and claims submission? Will you require single case agreements or will there be an interim process for the transition?
A. CareSource will not require single case agreements or prior authorizations during the transition period. See provider manual for additional detail.

ESCALATION POINTS

Q49. Who can I call for help? What hours is someone available to help me?
A. Provider Services can be reached at 1-800-488-0134, Monday through Friday, 8am – 6pm.