November 2011

Dear CareSource Provider:

As we end 2011 and look forward to 2012, I wanted to take a moment to mention a few programs that demonstrate our commitment to our members' health and to highlight operational efficiencies for you, our providers.

Pharmacy Benefit Transition – As you know, effective October 1, 2011, the Ohio Department of Job & Family Services (ODJFS) changed the administration of prescription drug coverage to the Managed Care Plans in the state. CareSource members now receive their prescription drug coverage through CareSource. With this change in benefits, the state has instituted a transition period for prior authorization of select medications. We encourage you to visit www.caresource.com to verify if prior authorization is needed for your members' medications prior to the transition period ending. Being proactive in this area can make a big difference for you and your patients.

New Case Management Model for 2012 – CareSource is busy preparing for the new case management model, which includes face-to-face meetings with our most at-risk members. Other members may be transitioned to a more appropriate level of care. Stay tuned for more details on this new model and how it impacts our provider network.

Updates to our Secure Provider Portal – We continue to make improvements to our Provider Portal, thanks to your feedback. The newest Portal features include: member termination dates, separate prior authorization for Synagis and online case management referrals.

Electronic Funds Transfer – As a reminder, we launched Electronic Funds Transfer (EFT) earlier this year. Benefits to providers include: claim payments electronically deposited to your bank account, and eliminating paper checks and EOPs. Visit our Provider Portal or the claims section of www.caresource.com to enroll in EFT.

These improvements are highlighted more in-depth in the latest edition of our *ProviderSource* newsletter enclosed. Thank you for all that you do to improve the health of the underserved.

Respectfully,

Craig Thiele, M.D.
Chief Medical Officer

P.O. Box 8738
Dayton, OH 45401-8738
800-488-0134
caresource.com

CareSource®

ProviderSource

FALL 2011

A newsletter for CareSource providers

HEDIS measures focus on quality of care

Quality care to our members has always been at the cornerstone of CareSource's foundation. CareSource uses the Healthcare Effectiveness Data and Information Set (HEDIS) as one measure of quality of care delivered to our members. HEDIS scores are compiled using claims and medical records data.

How you can help:
In 2012, CareSource will focus on the following HEDIS measures below. These specific measures can be found on www.ncqa.org.

- **Women's health**
  - Timeliness of prenatal and postpartum care
  - Breast cancer screening
  - Cervical cancer screening
  - Chlamydia screening
- **Children's health**
  - Well-child visits for ages 0-15 months, 3-6 years and 12-21 years
  - Lead screening
  - Avoidance of antibiotics for children with viral upper respiratory infection
- **Comprehensive diabetes care**
  - Retinal eye exam
  - HbA1c testing and control
  - LDL-C screening
  - Medical attention for nephropathy
- **Asthma care** – Use of appropriate asthma medications
- **Behavioral health** – Follow up within seven days after a mental health admission
- **Cardiovascular disease** – Controlling hypertension

Providers can use tools such as the CareSource Clinical Practice Registry on the Provider Portal to look up services and tests needed for members, such as a mammogram or Hemoglobin A1C. Also on our portal, providers have access to the Member Profile showing historical medical and pharmacy data.

In this issue:

How to reach us

Provider Services: **1-800-488-0134** (TTY: 1-800-750-0750 or 711)
CareSource 24, 24-Hour Nurse Advice Line: **1-866-206-0554**

Provider Portal SOLUTIONS

CareSource is excited to announce new time-saving features on our Provider Portal. Register for the portal at: **https://providerportal.caresource.com/OH/**

Member eligibility termination dates – Providers can now view the member's termination date (if applicable) under the member eligibility tab.

Case management referrals – The case management form is now automated on our Portal, offering efficiency in enrolling patients in this important program.

Synagis prior authorization – Providers offering Synagis during RSV season can request prior authorization (PA) through the portal for faster processing.

Prior authorization warning message – A warning message will now appear on the inpatient/outpatient section of prior authorization upon checking eligibility asking providers to verify the information entered is accurate. If the prior authorization is an inpatient delivery and the member is 12 years old or younger, the prompt will ask providers to confirm accuracy.

Members missing appointments? We can help

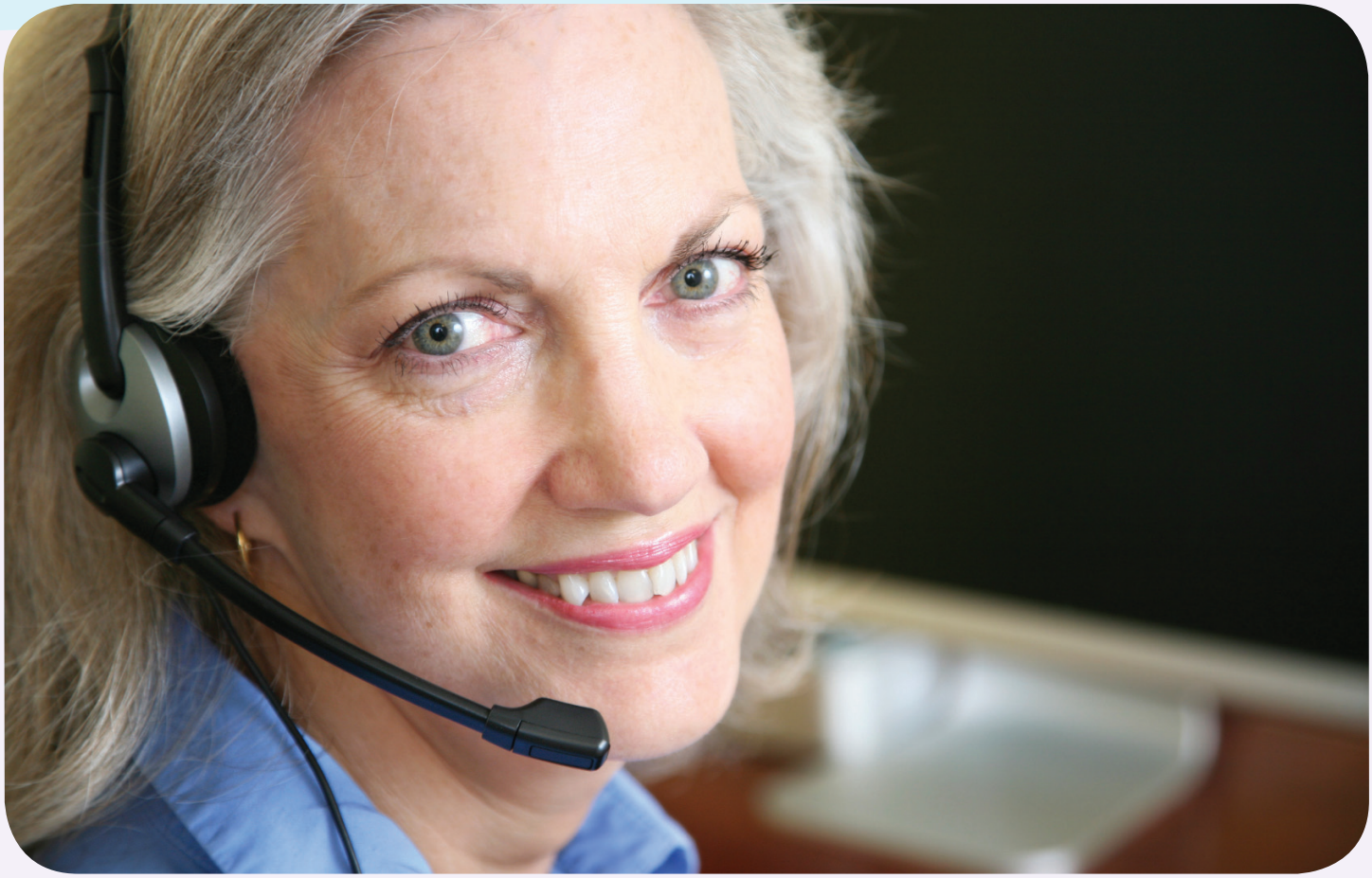
Any time a member misses three or more consecutive appointments, please notify our Care Management Department for assistance. Our outreach staff can assist you in educating the member about the importance of being on time for scheduled appointments and cancelling appointments at least 24 hours in advance. We can also help arrange transportation for members.

We ask that you make at least three attempts to educate the member about non-compliant behavior and document them in the patient's record. Thank you for your cooperation in helping our members receive the care they need.

November is Medicaid 'open enrollment' month in Ohio

Statewide open enrollment for Medicaid eligible consumers is here and those individuals under your care are able to change health plans. CareSource members have access to all Medicaid-approved benefits, plus many extras like no co-pays, transportation to medical care and WIC appointments.

Consumers can select CareSource as their health plan by calling 1-800-605-3040 or by visiting the Enrollment Center at www.ohiomcec.com.



The benefits of CareSource 24

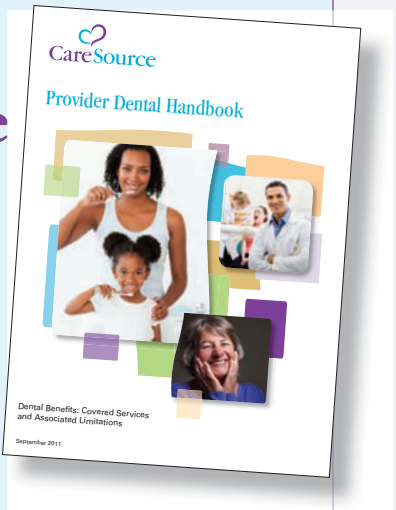
Did you know that **CareSource 24** provides 24/7/365 access to nurse triage, medical information and advice? This **free** member benefit can help your CareSource patients get the information they need to make better health care decisions. Our registered nurses average more than 25 years of nursing experience in a wide variety of clinical settings.

CareSource 24 can benefit your practice by:

- Appropriately directing patients from the emergency department to the physician's office
- Reinforcing the provider-patient relationship
- Teaching about a medical condition or recent diagnosis
- Encouraging patient compliance with the provider's treatment plan
- Teaching about nutrition and wellness topics

Please encourage your CareSource patients to use this valuable resource. The toll-free number can be found on the member's CareSource ID card.

Updated Dental Handbook now online



Our updated Dental Handbook is available online at **www.caresource.com**. Click the "Providers" tab and select "Provider Materials." Then choose "Dental Handbook" on the left navigation. If you have any questions, please contact your provider relations representative.

Pharmacy transition periods established

As you know, prescription drug coverage for CareSource members transitioned from Ohio Medicaid to CareSource on October 1.

To ensure continuity of service for members, CareSource members now receive their prescription drug coverage from CareSource.

Pharmacy Transition Periods for Prior Authorization: Please note the following transition periods listed below. These transition periods apply to members eligible with CareSource October 1, 2011.

- 30 days for controlled substances, e.g., narcotic analgesics (through 10/31/2011) These now require prior authorization
- 120 days for antipsychotics/ antidepressants (through 1/31/2012)
- 90 days for all other Medicaid covered medications (through 12/31/2011)

For members eligible with CareSource on November 1, 2011, or after, a 30 day transition applies for all medications previously approved by Medicaid Fee For Service (FFS). **If you are having any issues or need assistance during the upcoming Prior Authorization transition periods, please call us at 1-800-488-0134 and follow the prompts for pharmacy.**

Synagis season reminder

Respiratory Syncytial Virus (RSV) season is November 1 through March 31. Providers must obtain a prior authorization (PA) to administer Synagis to prevent RSV. All providers who are administering Synagis in a provider's office, a home setting, or outpatient clinical setting must submit a PA.

How to submit a PA request for Synagis

- **Online:** For faster processing, submit a PA request on our secure Provider Portal, https://providerportal.caresource.com/OH/
- **Fax:** Complete the Synagis PA form on our website and fax it to 1-888-399-0271
- **Phone:** 1-800-488-0134
- **Mail:** CareSource, Attn: Specialty Pharmacy, P.O. Box 1307, Dayton, OH 45401

Please include clinical documentation with prior authorization requests for Synagis. If you have questions, please call Provider Services at **1-800-488-0134** and choose the menu option for Pharmacy.

Abortion, sterilization and hysterectomy forms

ODJFS requires managed care plans (MCPs) ensure appropriate use of federal funds when paying for abortion or sterilization services. CareSource is making it easier for providers to complete these forms correctly and efficiently for claims payment by offering tutorials on our website, **www.caresource.com**. Click on "Provider," then "Forms" to view these brief tutorials online.

BMI: Weighing your patients' health risks

Measuring Body Mass Index (BMI) remains a quick and relatively simple way to gauge your patients' risk for obesity and other health problems. Routine BMI measurements can promote discussions that may influence healthier habits early on. BMI trending can also identify patients who are under weight and may be suffering from an eating disorder or other illness.

BMI should be calculated at least annually and documented in the patient's medical record. If needed, schedule a follow-up appointment dedicated to discussing weight concerns. Providers should use the appropriate CPT, HCPCS, ICD-9 codes.

A helpful resource

- **U.S. Department of Health and Human Services**
  3 Steps to Initiate Discussion about Weight Management with Your Patients
  http://www.nhlbi.nih.gov/health/prof/heart/obesity/aim_kit/steps.pdf

Severe mental illness and physical health

Are you seeing patients who have been diagnosed with a severe mental illness? Statistics show that these patients may be at risk for developing other chronic illnesses such as diabetes, hypertension and cardiovascular diseases.

Remember, CareSource has case managers who can help patients with severe mental illness. They can help:

- Explain physical and mental health care benefits
- Coordinate care among providers
- Assess social and support service needs
- Improve member compliance with recommended treatment options

CareSource is committed to improving health outcomes for members with severe mental illness.

Care management focuses on high-risk members

Over the next few months, CareSource will be implementing a new case management model based on the requirements of the Ohio Department of Job and Family Services (ODJFS). Under the new structure, our staff will:

- Use new criteria for high-risk care management. Current high-risk members who no longer meet these criteria will be safely transitioned to the appropriate level of case management
- Develop a focused, community-based program for high-risk members
- Schedule face-to-face meetings with our most at-risk members to help ensure their needs are being met. Ideally, this will be conducted at the point of care

Members in other care management programs, such as Care Transitions and Disease Management, will continue to be managed. Transition to the new model began in October and full implementation is scheduled to be complete by July 2012.

CareSource Advantage benefits updated for 2012

Benefits for members of CareSource Advantage® (HMO SNP), our Medicare Advantage Special Needs Health Plan, will change slightly in 2012. Highlights include:

- The vision benefit for hardware will increase to $125 annually
- A new over-the-counter benefit of $30 per month will be available for select health and wellness items

Starting in 2012, CareSource Advantage will be available in all counties throughout Ohio. For additional benefits, search "Evidence of Coverage" on our website, **www.caresource.com**.

ProviderSource

is a publication of CareSource, a non-profit, public-sector managed health care plan serving counties throughout Ohio.

Toll-free phone:
1-800-488-0134

P.O. Box 8738
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ACCREDITED
HEALTH PLAN (for Medicaid)
HEALTH CALL CENTER

OH-P-507
November 2011

Network Notification

Date: October 28, 2011 **Number: OH-P-2011-17a**
MI-P-2011-09a

To: Ohio & Michigan Providers

From: CareSource

Subject: Revised Clinical Supporting Documentation Policy

This outlines CareSource's requirements for acceptable supporting medical record documentation used to determine reimbursement.

These standards are designed to ensure that all providers are responsible for the maintenance and integrity of all medical documentation. Accurate, complete, accessible and comprehensible medical record documentation is crucial in providing patients with quality care and in determining proper claims reimbursement.

CareSource has an obligation to require reasonable documentation to validate the site of service, the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided and that the services provided have been accurately recorded.

The principles of medical record documentation are applicable to all types of medical and surgical services in all settings (e.g. chart notes, operative reports, etc). Regardless of whether the medical record is in the traditional paper format or electronic format, these steps should be taken to ensure the credibility of the medical record.

- The medical record should be complete and legible
- The documentation of each patient encounter should include:
    a. Name, address and birth date
    b. Date of each visit
    c. Presenting symptoms, condition and diagnosis
    d. Pertinent patient history, progress notes and consultation reports
    e. Results of examination(s)

f. Prior diagnostic test results not previously documented
g. Records of assistive devices or appliances, therapies, tests and treatments which are prescribed, ordered or rendered
h. A description of observations made by the clinical provider
i. Orders for diagnostic tests including labs
j. Written interpretations of tests including documentation that the patient was notified of the results
k. Records of medication prescribed including strength, dosage and quantity
l. Patient responses to or outcomes from prescribed medications
m. Patient-centered plan of care
n. Provider signature (see requirements below)

In accordance with CMS requirements, a valid signature and/or acceptable method of signing medical record documentation is as follows:

Paper:

- Handwritten
  a. Legible name and signature of prescribing and/or referring physician
  b. Per CMS transmittal 248, stamped signatures will not be accepted

EMR – Electronic:

- Electronic: Usually contains date, timestamps and printed statements. For example:
  a. "Signed before import by" with provider's name
  b. "Signed: John Smith, M.D." with provider's name
  c. "This is an electronically verified report by John Smith, M.D."
  d. "Authenticated by John Smith, M.D."
  e. "Authorized by: John Smith, M.D."
  f. "Digital Signature: John Smith, M.D."
  g. "Confirmed by" with provider's name
  h. "Closed by" with provider's name
  i. "Finalized by" with provider's name
  j. "Electronically approved by" with provider's name
  k. "Signature Derived from Controlled Access Password"
  l. "Signature on File"

Please note, this section is new

- Digitized: An electronic image of an individual's handwritten signature reproduced in its identical form.
- Initials: Permitted as long as the provider's name appears in printed form somewhere on the medical record documentation.
  - Note: Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature. Providers may also include in the documentation an attestation statement. In order to be considered valid for medical review purposes, the attestation

statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Additional Information:

- Pathology and Laboratory providers must provide the ordering physician's documentation.

- Unlisted Codes:
  Claims that are billed with unlisted CPT codes always require a signed copy of the chart notes/medical record/operative notes in order to determine what procedure was actually performed on the patient. Providers may choose to submit a letter of justification along with the signed copy of chart notes/medical record/operative notes to clarify the use of any unlisted CPT codes.

  Claims that are billed with unlisted HCPCS codes always require a signed copy of the chart notes/medical records or a manufacturer's invoice to determine what service or DME item was provided to the patient.

- Appeals:
  Any time a claim is appealed, the provider must submit supporting signed documentation such as chart notes, operative report, radiology reports, history and physical.

- Modifiers:
  Based on the modifier billed, the appropriate signed documentation (chart notes/medical records or operative notes) should be submitted with the claim. The documentation must support the usage of the modifier in question.

Table Key	
CH – chart notes/med records	**OP –** op notes

Modifiers			
• 22 – OP	• 24 - CH	• 25 - CH	• 57 - CH
• 58 – OP	• 59 - OP	• 62 - OP	• 77 – OP/CH
• 78 – OP/CH	• 79 – OP/CH	• 80 - OP	• 82 - OP

CareSource applies the 1995 and 1997 "Documentation Guidelines for Evaluation and Management Services" to all medical record documentation reviews.

CareSource's general principles are offered as reference information only and are not intended to serve as legal advice. CareSource recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.

Network Notification

Date: October 25, 2011 **Number: OH-P-2011-48**
MI-P-2011-25

To: Ohio & Michigan Providers

From: CareSource

Subject: CareSource Trading Partners Submitting EDI 837 Claims

CareSource has started to receive 4010 claims that have been stepped down from the new HIPAA 5010 format. Meaning, these claims submitted do not have a Tax ID in the rendering provider loop.

CareSource is not accepting 5010 transactions until January 1, 2012, which is the date directed by the U.S. Department of Health and Human Services (HHS). When submitting claims, please ensure all of the required information is included to populate a 4010 claim.

4010 claims that do not contain all of the necessary information for a 4010 format will be rejected at the gateway due to missing information. This affects all CareSource trading partners submitting EDI 837 professional, institutional or dental claims.

CareSource is actively preparing for the transition from 4010 to the new HIPAA 5010 format. All CareSource trading partners are highly encouraged to test the 5010 format prior to January 1, 2012. If you would like to submit a test for 5010 transactions, please email 5010testing@caresource.com and a CareSource representative will contact you.

Network Notification

Date: October 28, 2011 **Number: OH-P-2011-49**
MI-P-2011-26

To: Ohio & Michigan Providers

From: CareSource

Subject: Medically Unlikely Edit (MUE) Policy for code 88342

CPT Codes Involved: 88342

This document outlines CareSource's policy on Medically Unlikely Edits (MUE).

A Medically Unlikely Edit (MUE) is a unit of service edit for a Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code for services rendered by the same provider to the same patient on the same day.

Claim edits compare different values on a medical claim to a set of defined criteria to check for irregularities, often in an automated claims processing system.

Therefore, MUE's are designed to limit fraud and/or coding errors by representing a limit the provider can submit on the claim. If the provider must exceed the MUE set by CareSource, supporting documentation must be submitted with the claim in order to be considered for reimbursement.

CareSource MUE 7 for CPT 88342
For CPT 88342 (Immunohistochemisty – including tissue immunoperoxidase, each antibody), CareSource has established a MUE of 7.

Any claim billed with an excess of 7 units for this code will require clinical documentation to support the additional units.

Pilot project tests new EDI transaction

CareSource is committed to making it easier for health care providers to do business with us. We are currently conducting a pilot project to help improve the efficiency of prior authorization requests. The new Prior Authorization Request and Response Transaction for EDI (electronic data interchange) will be used to request and receive a response for referrals, certification and authorization of the following:

- Health care services
- Health care admissions
- Extensions of certifications

By allowing multiple requests and responses to be transmitted with one EDI file, we hope to help ease the administrative burden of the prior authorization process for providers. We are currently piloting this transaction for health care admissions with select facilities in the pilot project. Plans call for expanding use of the transaction to more providers in the future.

Coding Corner: Claims with unlisted procedure codes

Claims submitted with unlisted procedure codes require that operative and/or chart notes accompany the claim for review. And, in accordance with the American Medical Association's CPT reporting guidelines, a "special report" should also be submitted with the operative notes.

The special report is a letter of justification detailing the nature, extent and need for the procedure, as well as the time, effort and equipment necessary to provide the service(s). Please submit appropriate documentation to help ensure accurate and efficient claims processing.

Network Notification

Date: September 8, 2011 **Number: OH-P-2011-40**
MI-P-2011-20

To: Ohio & Michigan Providers

From: CareSource

Subject: Elective Labor and Delivery Prior to 39 Weeks Gestation

CareSource supports the recent article, “Doctors to Pregnant Women: Wait at Least 39 Weeks,” by National Public Radio (NPR) on elective labor and delivery prior to 39 weeks of gestation. The article specifically cites interviews from doctors in Cincinnati, Columbus and Cleveland campaigning to slow down the trend of women scheduling induction before 39 weeks.

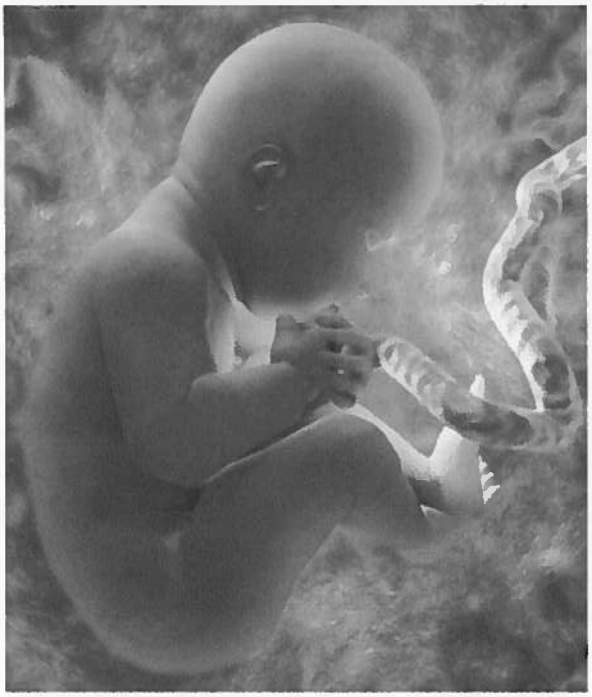
The article shares, "A full-term pregnancy lasts 40 weeks, but elective deliveries are often planned for two or three weeks earlier. And even though 37 weeks is also still considered full term, studies show that babies born even a few weeks too early are at greater risk for health problems than those who are born later. That has some doctors campaigning to curb the trend of scheduled labor and delivery."

The article cites various reasons, including better overall outcomes, when waiting until at least 39 weeks gestation:

- The Neonatal Intensive Care Unit (NICU) may be required with a delivery that may be only 2 weeks before the due date
- Organ systems mature at different rates; therefore, some may need more time in gestation than others to mature

Doctors To Pregnant Women: Wait At Least 39 Weeks

by GRETCHEN CUDA KROEN



Enlarge Photo Researchers

A rendering of a 36-week fetus in the womb.

July 18, 2011 text size A A A

In her living room, Caroline Nagy introduces the newest member of her family — the 6-week-old infant in a striped onesie cradled in her arms. "This is Alex Joseph. He was born May 24th — my birthday," she says.

Their shared birthday wasn't entirely a coincidence. Two weeks before her due date, Nagy was swollen, and uncomfortable. So she asked her doctor for relief.

"I was just miserable. It was like uncomfortable to walk; I couldn't sit on the floor and play; I felt like I was neglecting my first kid because I just couldn't move and I couldn't do anything," says Nagy. "So I asked, 'Is there any way I can speed this up and have a baby earlier?' "

For Jackie McGinty, it wasn't discomfort but timing that caused her to schedule her daughter's birth by C-section eight years ago. McGinty's first child was delivered by C-section for medical reasons, and although this time around she had hoped to deliver naturally, she had just moved out of state and wanted her family nearby to help with the baby.

"My mom was coming out and she was only going to come out for a few weeks. I needed her to be there after the birth. ... So having the option to schedule it was good for us," says McGinty.

Harm In Planning Too Far Ahead?

Stories like these are common. Statistics show that from 1990 to 2006 the percentage of women who induced labor more than doubled, and nearly a third of women were having cesareans.

The increase wasn't because of emergencies, says Jay Iams, a specialist in maternal fetal medicine at Ohio State University, but rather because women and doctors began scheduling deliveries for convenience — "convenience for the mother, for the family, for the physician," says Iams. Sometimes, Iams says, it's because patients say to themselves, " 'I want only my doctor to be there. I don't want the person who's

Caroline Nagy and her now 8-week-old infant in Youngstown, Ohio. Nagy says she had labor induced early at 39 weeks because she was uncomfortable and felt as though she was neglecting her other child.

on call.' "

Having a baby naturally requires lots of planning. But when it comes to the arrival date of your bundle of joy, experts now say that planning too far ahead can do more harm than good.

A full-term pregnancy lasts 40 weeks, but elective deliveries are often planned for two or three weeks earlier. And even though 37 weeks is also still considered full term, studies show that babies born even a few weeks too early are at greater risk for health problems than those who are born later. That has some doctors campaigning to curb the trend of scheduled labor and delivery.

Pediatrician Ed Donovan of Cincinnati Children's Hospital says data collected over the past several decades show those babies have an increased risk of complications compared with waiting until the mother goes into labor spontaneously.

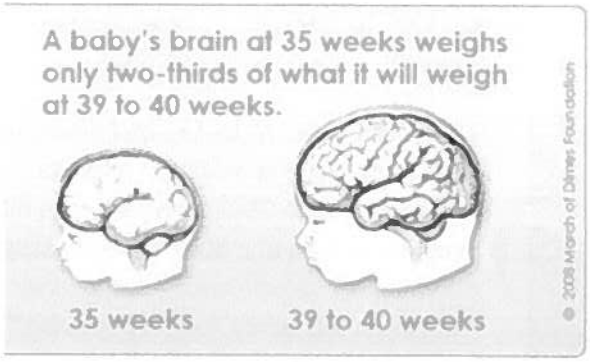
"It's now really well-documented in national studies that the risk of the baby having to require intensive care in a neonatal intensive care unit — even the risk of infant death — is increased when the baby is born as little as two weeks before the due date," says Donovan.

Organ Systems Maturing At Different Rates

The reasons for this are two-fold. First, without an ultrasound measurement in the first trimester, a woman's due date could be as much as two weeks off, making the fetus 35 weeks instead of 37. And second, Donovan says the brain, heart, lungs, and immune system all mature at different rates — and some may need a little more time than others.

"Just because the lungs are mature doesn't mean that the other organ systems are mature," says Donovan. "A baby born three weeks early with mature lungs may not be ready to eat because the brain's not fully developed."

According to Donovan, doctors realized they simply weren't very good at determining which babies were ready and which weren't. And Iams says the large numbers of sick babies made many doctors begin to think differently about early deliveries.



Courtesy of March of Dimes

A baby's brain still has a lot of growing to do between 35 and 39 weeks in the womb.

"Thirty-seven weeks is term, but they became the most common occupants of neonatal intensive care nurseries," says Iams. "And the pediatricians naturally said, 'They could have waited.' "

Still, many women and even many obstetricians remained unaware of the risks because it didn't fit with their experience.

"People see their friends having babies early, and sometimes women go into labor on their own at 37, 38 weeks — and that's not unusual and those babies are fine," says Jennifer Bailit, an

obstetrician at Metro Health Medical Center in Cleveland. "But those are babies that have told us that they're coming and that they're ready."

Convincing Mothers It's Worth The Wait

Bailit is part of an effort led by Iams and Donovan to reduce the number of scheduled deliveries before 39 weeks across the state of Ohio. Bailit says that she often has to explain to women the importance of those last few weeks — and that the discomfort is normal but something that needs to be endured for the sake of the baby.

"It's tough to be pregnant, and sometimes when you're in the moment it's hard to keep the big picture in mind," Bailit says. "When we guide people toward that kind of thinking it really helps them say, 'I'm doing this for my baby; it's worth it.' "

In addition to helping doctors like Bailit educate pregnant women, Iams and Donavan asked doctors at the 20 largest hospitals in the state to document a medical reason every time a woman was scheduled to deliver before 39 weeks. And much to their surprise, Iams says in under 15 months the rates of those deliveries dropped from 15 percent to under 5 percent. And more important, the number of babies admitted to neonatal intensive care also decreased.

Related NPR Stories

science and medicine

Rethinking SIDS: Many Deaths No Longer A Mystery

Group Prenatal Care: Finding Strength In Numbers
July 13, 2011

Drug Given To Moms After Childbirth Sparks Controversy
June 28, 2011

And the idea is catching on across the country. The March of Dimes has taken what began in Ohio and a few other select states and extended it nationwide in a campaign it's calling "Healthy Babies are Worth the Wait." Alan Fleischman of the March of Dimes says the rate of elective births in the hospitals the organization has surveyed is about 30 percent.

"Most hospital leaders don't believe they have this problem until they actually measure it," says Fleischman. "And when they do, they're surprised."

As in Ohio, their preliminary data show that in only a short period of time, even hospitals with very high rates of scheduled deliveries are able to reduce them to about 5 percent or less by making a few simple changes — and in turn, increase the likelihood of a healthy baby.

Although inductions at 39 weeks and beyond are considered safe, some doctors feel that unless there is a medical reason to deliver early, the best labor plan for women is an old-fashioned one: Hang in there and wait until labor starts on its own.

Electronic Health Records and fraud: Avoiding the pitfalls

Recent polls indicate that use of electronic health records (EHRs), also called electronic medical records (EMR), is on the rise in health care practices across the country. If you are using EHRs, you are maintaining the integrity and the quality of the health record.

EHR's have great advantages, but they can also have significant liabilities. EHR software can create potential fraud, waste and abuse consequences when the software lacks unique log on identifiers, has limited or no auditing controls, or when a few keystrokes generates an entire patient encounter record. All of these can lead to coding/payment errors, a lack of documentation for services provided and overpayment issues. Keep the following points in mind to help ensure the integrity of your health care data:

- **Unique Log on ID's.** Each individual who documents the EHR system should have a unique log on ID. ID's should never be shared or reused by employees. Unique log on ID's document who is entering information and who is providing the service. If only one ID is utilized for documentation it creates unusually large record volumes, which can lead to potential fraud, waste or abuse concerns.
- **Auditing.** EHR's have auditing capabilities that should be used in your everyday processes. Your organization should follow medical record documentation guidelines with respect to how information is added and changed within a medical record. Routine internal monitoring of your software to ensure accuracy is recommended. Our medical record requests can require you to submit the audit trail as part of our review criteria.
- **Charting.** An EHR software that gives you flexibility to uniquely chart your actual services is a more reliable and accurate system. Software that has standard "boiler plate" language that do not permit free text, and software that automatically generates a record in which you have to remove documentation that does not apply can lead to trouble.
- **Coding –** Each service performed has a unique billing code with specific guidelines that must be met for billing. For example, Evaluation & Management CPT codes have specific criteria that must be met or exceeded to bill each code. Software that drives inappropriate medical coding can lead to improper payments.

Please ensure that the documentation you keep on each and every patient reflects the actual service provided. You are ultimately responsible to oversee and audit your documentation and billing processes to ensure accuracy.

How to report any suspected fraud, waste or abuse concern:

Anonymous:

- **Fraud Hotline:** 1-800-488-0134 (TTY: 1-800-750-0750 or 711). Choose the menu option for providers, and then select the option to report fraud.
- **Written Report:** Use the Fraud, Waste and Abuse Reporting Form at www.caresource.com

  Send to:
  CareSource
  Attn: Special Investigations Unit
  P. O. Box 1940
  Dayton, OH 45401-1940

Not Anonymous:

- **Fraud E-mail:** fraud@caresource.com
- **Fraud Fax:** 1-800-418-0248

You can report information without leaving your name. If you choose to be anonymous, leave as many details as possible as we will not be able to contact you. You information is confidential to the extent permitted by law.

For information about CareSource's program to identify fraud, waste and abuse, please visit our website at **www.caresource.com**. Click on "Providers." Then, under "Quick Links," choose "Report Fraud."