Provider Manual

Ohio Medicaid

CareSource®

Dear CareSource Provider,

Thank you for your participation. CareSource values our relationships with our providers, and we are actively working to make it easier for you to deliver quality care to our members.

CareSource has provided managed health care services since 1989. Since our first Medicaid managed care pilot in collaboration with community leaders and health care providers like yourself, we have continued to drive innovation and transformation of Medicaid. CareSource has a strong history of serving under-resourced populations with health and life services, maintaining a unique understanding of our members' needs.

This manual is a resource for working with our plan. It communicates policies and information about our programs. This manual also outlines key information such as claims submission, reimbursement processes, authorizations, member benefits and more to make it more efficient for you to do business with us. This manual is available on **CareSource.com** > Providers > Tools & Resources > Provider Manual. You may also request a hard copy of the manual by calling Provider Services at **1-800-488-0134**. Our hours of operation are Monday through Friday, 7 a.m. to 8 p.m. Eastern Time.

CareSource communicates updates to our provider network regularly via network notifications available on the Updates & Announcements page at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements and on our secure Provider Portal at **CareSource.com** > Login > Provider.

To support our providers, we have dedicated Provider Services teams specialized with each plan to help assist with questions and concerns. Additionally, an external team of Provider Managers is available to provide onsite training and work with our providers in their communities.

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

Sincerely,

CareSource®

TABLE OF CONTENTS

SECTION I - INTRODUCTION

Welcome

Welcome, and thank you for participating with CareSource.

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 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.

Our goal is to create an integrated medical home for our members. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy. As a managed care organization (MCO), we improve the health of our members by utilizing a contracted network of high-quality participating providers. Primary 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 members have timely access to health care services and receive all appropriate preventive services.

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

- New members

- Existing members

- New providers

- Existing providers

2   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

About Us

CareSource was founded 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.

Vision and 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.

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 is the hallmark of our success.

Our Services

- Provider relations

- Provider services

- Member eligibility/enrollment information

- Claims processing

- Credentialing/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 with our benefit managers:

  - Dental: DentaQuest®

  - Vision: Superior Vision®

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

- Low, medium and complex case management – a "no wrong door" referral intake

- Telephonic case management

- Disease management

- Preventive health and wellness assistance with focused health needs/risk assessment

- Emergency department diversion – high emergency department utilization focus (targeted at members with frequent utilization)

- CareSource24®, nurse advice line

- Maternal and child health

    - Comprehensive prenatal, postpartum and family planning services

    - Outreach programs in partnership with community agencies to target members at greatest risk for preterm birth or complications

- Behavioral health (BH) and substance use disorder (SUD) management

- Collaboration with pharmacy and medication therapy management (MTM)

The CareSource Foundation

CareSource gets actively involved in the communities that we serve, from employees serving on hundreds of nonprofit boards to investing dollars back. We listen, we learn and we are driven to action. As a result, we launched the CareSource Foundation in 2006 to add another component to our professional services: community response. Focus areas of the CareSource Foundation are closely aligned with the greatest needs of our member demographics. Areas of emphasis include children's health, special populations such as seniors and individuals with disabilities, the uninsured and life issues such as hunger, domestic violence, SUD and homelessness.

The CareSource Foundation has awarded grants totaling over $16.4 million. Grants focus on issues of the uninsured, critical trends in children's health and special populations. Several large signature grants were made specifically to address issues of access to coverage in the new health care reform landscape and elevating children from the cycle of poverty through the power of education.

The CareSource Foundation believes in people, organizations and initiatives that actively work to improve the physical health and well-being of individuals residing in the CareSource service areas. We believe that passion, knowledge and vision generate positive, long-lasting change and that meaningful collaboration creates strong partnerships with grantees.

Compliance and 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 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

4   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

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 should conduct themselves. 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.

General Compliance and Ethics Expectations of Providers

- Act according to the compliance standards.

- Let us know about suspected violations or misconduct.

- Let us know if you have questions.

For questions about provider expectations, please call Provider Services at **1-800-488-0134**.

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: 844-784-9583 or http://caresource.ethicspoint.com

- Compliance Officer: 937-487-5110 or CorporateComplianceOfficer@caresource.com

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 Medicaid and 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.

SECTION II – BASIC PLAN INFORMATION

CareSource communicates with our provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSource.com** and network notifications. Please reach out to our Provider Services department with any questions.

Provider Services	
Provider Services Number	**1-800-488-0134**
Hours of Operation	7 a.m. to 8 p.m. Eastern Time (ET) Monday to Friday
Provider Portal	https://providerportal.caresource.com/OH

Member Services			
Member Services	**1-800-488-0134**	Monday to Friday	7 a.m. to 7 p.m. ET
CareSource24®, (nurse advice line for all plans)	1-866-206-0554	Seven days a week, 365 days a year	24 hours a day

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.

Department	Number
Provider Services	1-800-488-0134
Prior Authorizations	1-800-488-0134
Claim Inquiries	1-800-488-0134
Credentialing	1-800-488-0134
Member Services	1-800-488-0134
CareSource24 – Nurse Advice Line	1-866-206-0554
Fraud, Waste and Abuse Hotline	1-844-415-1272
TTY for the Hearing Impaired	1-800-750-0750 or 711

Fax

Department	Number
Credentialing	866-573-0018
Care Management Referral	877-946-2273
Contract Implementation	937-396-3632
Fraud, Waste and Abuse	800-418-0248
Medical Prior Authorization Form	888-752-0012
Pharmacy Prior Authorization Physician Administered Drugs (Outpatient Drugs Only)	888-399-0271
Provider Claim Disputes and Appeals	937-531-2398
Provider Maintenance	937-396-3076

Mail

CareSource
P.O. Box 8738
Dayton, OH 45401-8738

Member Appeals & Grievances

CareSource
P.O. Box 1947
Dayton, OH 45401-1947

Provider Claim Disputes & Appeals

CareSource
P.O. Box 2008
Dayton, OH 45401-2008

Claims

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

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.

Provider Representative Information

Our goal is to build collaborative and mutually supportive relationships with our network. CareSource's Provider Representatives are dedicated to helping your practice.

You can find your assigned Provider Representative <u>here</u> and by visiting **CareSouce.com** > Providers > Provider Overview > <u>Contact Us</u>.

SECTION III – PROVIDER RESOURCES

CareSource strives to make it easy for you to work with us. This section compiles resources you need for contacting CareSource, finding key information and monitoring updates.

Provider Services

Provider Services	
Provider Services Number	**1-800-488-0134**
Hours of Operation	7 a.m. to 8 p.m. Eastern Time (ET) Monday to Friday

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.

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 network announcements, our Provider Manual, claims information, frequently asked questions, clinical and preventive guidelines, CareSource preventive services member rewards information and much more.

Provider Portal

URL: https://providerportal.caresource.com/OH

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 to deliver better health outcomes for our members.

Provider Portal Benefits

- Easy access to a secure online (encrypted) tool with time-saving services and critical information
- Available 24 hours a day, seven days a week
- Accessible on any PC without any additional software

Provider Portal Tools

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

- **Payment history** – Search for payments by check number or claim number.

- **Claims features**

  - Claims submission – Submit or upload claims including corrected claims.

  - Claims status – Search for status of claims and claim disputes.

  - Claims attachments – Submit documentation needed for claims processing.

  - Rejected claims – Find claims that may have been rejected so that you can resubmit them.

- **Claim disputes** – Submit and review status of claim disputes and appeals.

- **Coordination of Benefits (COB)** – Confirm COB for patients.

- **Eligibility termination dates** – View the member's eligibility spans from the Member Information panel.

- **Care management referrals** – Submit automated care management forms on our portal for efficiency in enrolling members.

- **Benefit limits** – Track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy and speech therapy, and more.

- **Care treatment plans** – Providers can view care treatment plans.

- **Clinical Practice Registry (CPR)** – Filter patient data to identify opportunities for preventive health screenings.

- **Recovery letters** – View and download letters.

- **Review documents and letters** – View submitted claim documents in additional to dispute and appeal letters.

- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization.

- **File grievance**

- **Service plan** – Waiver providers can review, print, respond to and acknowledge approved services.

- **Redetermination Date** – View the date the member must prove their eligibility to ODM.

Provider Portal Registration

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

1. Visit **CareSource.com** > Providers > Ohio and click on "Provider Login."

2. Click on the "Register for an account" link and complete the three-step registration process. You will need your Tax ID number and your CareSource Provider Number, located in your welcome letter.

3. Click the "Continue" button.

10   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

4. Note the username and password you create so that you can access the portal's many helpful tools.

If you do not remember your username/password, please call Provider Services at **1-800-488-0134**.

Routine Dental Providers

Please use the **Providers > Dental Provider Login** menu option of the Provider Portal to access DentaQuest's capabilities specifically for routine dental services.

Routine Vision Providers

Please visit **CareSource.com** > Providers > Education > Patient Care > Vision to access the Superior Vision (Versant Health) provider website.

Forms

Providers may access Medicaid forms by visiting the Ohio Department of Medicaid (ODM) Medicaid Forms Library (https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/forms/forms).

- Medicaid Addendum
- ODM 03199: Acknowledgment of Hysterectomy Information
- OMB 0937-0166: Consent for Sterilization
- ODM 03197: Abortion Certification Form
- SUD Residential Admission Form
- Out-of-Network Provider Application
- Ohio Medicaid Provider Agreement

Providers may access plan forms at **CareSource.com** > Providers > Tools & Resources > Forms. Select forms are highlighted below and linked for your convenience:

- Provider Consent Form
- Standardized Appeal/Dispute Form
- Provider Specific Appeal Forms
  - Provider Standard Appeal Request Form
  - Consent for Provider to File an Appeal on Patient/Member's Behalf

SUD Residential Admission form (link to ODM website), https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM10294Fillx.pdf

Out of Network Provider Application (link to ODM website) https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM10282Fillx.pdf

Provider Agreement (link to ODM website), https://medicaid.ohio.gov/resources-for-providers/managed-care/mc-policy/managed-care-agreements/managed-care-agreements

Prior Authorization
https://www.caresource.com/oh/providers/provider-portal/prior-authorization/medicaid/

Provider Policies

CareSource maintains medical, pharmacy, reimbursement and administrative policies on our website. Approved policies may be found at **CareSource.com** > Providers > Tools & Resources > Provider Policies. Policies are regularly reviewed, updated, withdrawn or added; and therefore subject to change. CareSource provides notice to providers regarding a change in policy at least 30 calendar days prior to implementation.

Provider Trainings

CareSource encourages our providers to access our on-demand video trainings on topics related to your practice. These trainings provide key information for you to do business with us. Providers may access CareSource's trainings and events by visiting **CareSource.com** > Providers > Education > Training & Events. Providers may also contact their assigned Provider Representative for additional live training support. You can find your assigned Provider Representative here and by visiting **CareSouce.com** > Providers > Provider Overview > Contact Us.

Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway at CareSource. Newsletters are found on our website at **CareSource.com** > Providers > Tools & Resources > Newsletters & Communications.

Network Notifications

Network notifications are published for CareSource providers to regularly communicate updates to policies and procedures. Network notifications are found on our website at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements.

Listserv Subscriptions

CareSource subscribes to the appropriate distribution lists for notification of all Ohio Administrative Code (OAC) rule clearances and final rules published with medical assistance letters, Medicaid handbook transmittal letters and other transmittal letters affecting managed care program requirements. We encourage our network to subscribe and monitor updates.

Email distribution lists include:

- RuleWatch Ohio at www.rulewatchohio.gov

- ODM Rule Notification at https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/

To find news and updates directly from ODM, providers may sign up on the subscription form at https://medicaid.ohio.gov/home/govdelivery-subscribe.

Claims Payment Systemic Errors (CPSE) Report

A CPSE is defined as the MCO's claims adjudication incorrectly underpaying, overpaying, or denying claims that impact five or more providers. A report containing all active CPSEs is updated monthly and can be found on the CareSource Provider Portal. CareSource tracks and communicates statuses of claims payment systemic errors on our monthly CPSE report. Providers may use the report to view updates on status, target dates for reprocessing and resolutions. You can access the CPSE Report on CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

Clinical Practice Registry and Member Profile

Quick and easy to access on our secure Provider Portal, the CareSource Clinical Practice Registry helps primary care providers (PCP) improve patient health outcomes efficiently. The primary use of the Registry is to help PCPs manage their patient population.

PCPs can quickly sort their CareSource membership into actionable groups. The CareSource Clinical Practice Registry is a proactive approach to patient care and helps place emphasis on preventive care.

Key Benefits of the Registry

- The registry is color-coded, which provides easy identification of members in need of tests and/or screenings.

- The information can be downloaded as a PDF or in an Excel spreadsheet format (the Excel spreadsheet contains patient contact information).

- It provides direct access to the CareSource Member Profile feature for individual members of interest.

Information Included on the Registry

- Well-baby visits (zero to 15 months)
- Well-care (two to 21 months)
- Asthma
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening
- Lead screening
- Diabetes (e.g. cholesterol, eye exam, hematology, kidney)
- Emergency room visits

The CareSource Clinical Practice Registry is located on our secure Provider Portal.

Member Profile

With its comprehensive view of patient medical and pharmacy data, our Member Profile can help you improve health outcomes for your CareSource patients. The Member Profile can also help you determine an accurate diagnosis more efficiently, reduce unnecessary diagnostic tests and minimize emergency room visits.

Key Benefits of the Member Profile

- Provides medical history
- Identifies potential prescription non-adherence or abuse
- Identifies duplication of services
- Introduces disease or care management options

Please Note: The Member Profile tool can be found on the Eligibility and Prior Authorization screens of the Provider Portal.

Preventive Guidelines and Clinical Practice Guidelines

CareSource approves and adopts evidence-based nationally recognized standards and guidelines and promotes them to providers 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 appropriate 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 approved the guidelines and Quality Enterprise Committee (QEC) is 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 (e.g., hypertension and diabetes)
- Population health (e.g., obesity and tobacco cessation)

Guidelines are 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 CareSource Quality Improvement, please call Provider Services at **1-800-488-0134**.

14   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Provider Advisory Council

The purpose of the Provider Advisory Council is to provide a quarterly forum amongst market specific practicing health care providers and CareSource staff to discuss policy, programs and quality initiatives. The council is comprised of practicing market-specific providers who participate with CareSource and is representative of the major specialties that serve members. The objectives of the Provider Advisory Council include:

- Foster discussion among practicing health care providers
- Discuss CareSource new and revised medical policies, clinical practice guidelines and clinical operations decisions
- Provide a forum for practicing physicians and advance practice providers (APPs) to provide perspective regarding new programs and changes to existing programs, which helps assure clinical operations remain relevant to practicing clinicians
- Provide peer review and advice regarding CareSource provider quality of care concerns
- Review and acceptance of clinical practice guidelines (medical and behavioral health) at a minimum every two years or more often as necessary
- Address ad hoc emergent quality of care (health, safety and welfare) issues

The Ohio Market Medical Director/Chairperson appoints council members. CareSource will include the Ohio Department of Medicaid (ODM) as a participant in its Provider Advisory Council meetings in addition to reporting on its activities to ODM on a semi-annual basis.

SECTION IV – PROVIDER RESPONSIBILITIES

This section outlines key responsibilities for providers in the CareSource network. This section is alphabetized for your convenience.

16   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

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 office hours to their CareSource patients that are no less (in number of scope) than the hours of operation offered to non-Medicaid members. If a provider serves only Medicaid recipients, hours offered to Medicaid members must be comparable to those offered to Medicaid fee-for-service 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
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 6 weeks

Specialists

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine	Not to exceed 6 weeks

Behavioral Health

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Non-life-threatening emergency	Not to exceed 6 hours
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

*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 physical care providers and behavioral health providers.

Advanced 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.

Americans with Disabilities Act

Providers are required to comply with Americans with Disabilities Act (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 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.

CareSource network providers must make reasonable accommodations to ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. CareSource and its network providers 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/.

After-Hours Care

Telephone Arrangements

PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services. They must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.

- Answer the member's telephone inquiries on a timely basis.

- Prioritize appointments.

- Schedule a series of appointments and follow-up appointments needed by a member.

- Identify and reschedule broken and no-show appointments.

- Identify special member needs while scheduling an appointment (e.g. wheelchair and interpretive linguistic needs, non-compliant individuals or those people with cognitive impairments).

- Schedule continuous availability and accessibility of professional, allied and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provided coverage in the event of a provider's absence.

- After-hours calls should be documented in a written format in either an after-hour call log or some other method and then transferred to a member's medical record.

- During after-hours calls, a provider must have the arrangements for the following:

  - Office phone is answered after hours by an answering machine service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call.

  - Office phone is answered after hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the provider has directed to return the call.

  - Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner.

Enhanced Reimbursement for After Hours Care

CareSource can help you identify members from your primary care practice who are utilizing the emergency room frequently. We offer this service to help you manage your patients more easily, direct them to the appropriate setting for care and decrease inappropriate emergency room visits. We also offer enhanced reimbursement to primary care offices holding evening or weekend hours.

CPT Code	Days/Hours	Reimbursement
99050	Monday to Friday 5 p.m. to 10 p.m. Weekends and holidays: 8 a.m. to 10 p.m.	$16.50, plus office visit rate
99051	Seven days per week 10 p.m. to 8 a.m.	$22, plus office visit rate

Culturally Competent Care

Consistent with federal mandate 42 CFR 438.206 (2), Access and Cultural Considerations, CareSource participates in efforts to promote the delivery of services in a culturally competent manner to all members. Participating providers must also meet the requirements of this mandate and any applicable state and federal laws or regulations pertaining to provision of services and care.

CareSource prohibits its providers or partners from refusing to treat, serve or otherwise discriminate against an individual because of race, color, religion, national origin, sex, age, gender orientation (i.e. intersex, transgendered and transsexual) or disability. In consideration of cultural differences, including religious beliefs and ethical principles, CareSource will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the U.S. Department of Health and Human Services (HHS).

Health Equity Commitment

CareSource has a long-standing commitment to equitable health outcomes – also known as health equity. Health equity is achieved when every person has an equal opportunity to be healthy, regardless of their social position or circumstances (Centers for Disease Control). To achieve optimal health, individuals and families need access to social determinants of health (SDOH) – such as safe housing and neighborhoods, economic stability, quality education, health care, support for healthy behaviors and social and community cohesion.

Success within health equity is also dependent upon organizations, providers and caregivers being culturally competent. Culturally competent organizations incorporate and recognize the importance of one's culture at all levels. Cross-cultural relations are assessed, dynamics resulting from cultural differences are recognized and attended to, cultural knowledge is expanded and services are adapted to meet culturally unique needs. A culturally competent system also includes a mindfulness of how different patient populations' health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes intersect and influence one another.

CareSource recognizes that many of our members experience health disparities and come from cultural and ethnic backgrounds that may impede their ability to achieve positive health outcomes. We continuously

work to develop programs to address cultural and linguistic needs, provide education about cultural humility to our workforce and solicit feedback from providers about what is most needed. As Ohio's population grows and becomes more diverse, understanding what the changing needs of those that we serve are is of the utmost importance. We strive to continuously evolve.

CareSource considers equitable and culturally competent care a core value of our organization. According to the United States Department of Health and Human Services Office of Minority Health, the lack of culturally and linguistically appropriate services is one of the most modifiable factors in improving health care.

CLAS Standards: National Culturally & Linguistically Appropriate Services

CareSource adheres to the National Culturally & Linguistically Appropriate Standards (CLAS), which serve as a blueprint for health care providers and organizations to implement culturally and linguistically appropriate services. CLAS consists of 15 standards that encompass the following topic areas:

- Principal Standard: provision of effective, equitable, understandable and respectful quality care and services that are response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs

- Governance, Leadership and Workforce

- Communication and Language Assistance

- Engagement, Continuous Improvement & Accountability

Network providers must ensure that:

- Members understand that they have access to free medical interpreter services in their native language, including Sign Language. No cost TDD/TTY services are available to facilitate communication with hearing impaired members.

- Health care is provided with consideration of the members' cultural background, encompassing race/ethnicity, language and health beliefs. Cultural considerations may impact/influence member health decisions related to preventable disease or illness.

- The provider office staff makes reasonable attempts to collect race-and language-specific member data. Staff is available to answer questions and explain race/ethnicity categories to a member, to assure accurate identification of race/ethnicity for all family members.

- Treatment plans are developed based on evidence-based clinical practice guidelines with consideration of the member's race, country of origin, native language, social norms, religion, mental or physical 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 our participating providers to visit the Office of Minority Health, Cultural Competency Resources website found at: https://ThinkCulturalHealth.hhs.gov/ for toolkits and educational resources. Included on the site is a free nine credit Continuing Medical Education (CME) course, A Physician's Practical Guide to Culturally Competent Care. This self-directed e-learning program equips providers to better understand and treat diverse populations.

Provider Network Management System

Cultural competency information as well as languages spoken by office location will be collected in ODM's Provider Network Management (PNM) system and will be utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the managed care organizations on a weekly basis for them to align their directories with the information contained in the PNM.

Electronic Health Records

CareSource encourages, supports and facilitates provider adoption and the effective utilization of electronic health records (EHR), including for population health and quality improvement. For network providers who have not yet adopted EHR, while CareSource will not endorse a specific system, CareSource will help to educate providers on the opportunities for better integration, potential interoperability and quality gap closure stemming from EHR use. CareSource will also work with providers to align real-time sources to use EHR information within our organization and across care management entities within CareSource, providers and the State of Ohio's OhioRISE and Single Pharmacy Benefit Management (SPBM) programs.

Providers who are interested in these opportunities should contact the CareSource provider relations team in order to assess and coordinate engagement opportunities for EHR. You can find your assigned Provider Representative here and by visiting **CareSouce.com** > Providers > Provider Overview > Contact Us.

Fraud, Waste & Abuse Reporting

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.

The Program Integrity department routinely monitors for potential billing discrepancies or potential fraud, waste and abuse. When found, an investigation is initiated and if warranted, 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

- Contract termination

- Employee disciplinary actions

- Reporting to one or more applicable state and federal agencies

- Legal actions

22   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Definition of Terms

Fraud is knowingly and willfully executing attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

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.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider/member has not knowingly and/or intentionally misrepresented facts to obtain payment.

Improper Payments are 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. Anyone who identifies an improper payment should report it to CareSource using one of the reporting methods below.

Examples of Fraud, Waste and Abuse

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 forms to get more than the amount of medication prescribed by their physician

- Non-disclosure of other health insurance coverage

- Obtaining unnecessary equipment and supplies

- Identity theft/sharing ID cards – i.e., member receiving services under someone else's ID, sharing your ID with others, or submitting prescriptions under another person's ID

- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary

- Billing for services not provided

- Billing more than once for the same service

- Intentionally using improper medical coding to receive a higher rate of reimbursement

- Purchasing drugs from outside the United States

- Prescribing high quantities of controlled substances without medical necessity

- Unbundling services to obtain higher reimbursement

- Scheduling more frequent return visits than are needed

- Billing for services outside of your medical qualifications

- Using patient lists for the purpose of submitting fraudulent claims

- Drugs billed for inpatients as if they were outpatients

- Payments stemming from kickbacks or Stark Law violations

- Not reporting overpayments or overbilling

- Preventing members from accessing covered services resulting in underutilization of services offered

Pharmacy Fraud, Waste and/or Abuse:

- 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 or illegal drugs

- Billing prescriptions not filled or picked up

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

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

Vendor Fraud, Waste and/or Abuse:

- Falsifying business reports

- Not reporting or taking action on employees that are debarred

- Billing for services not rendered or products not received

- Billing for a more expensive services, but providing a less expensive service

Your provider agreement provides specific information on each type of termination/suspension. The Fair Hearing Plan, available at CareSource.com/documents/fhp, provides information on an appeal process for specific provider terminations.

Network providers are to report and return to CareSource any overpayment within sixty (60) calendar days of identification and notify CareSource in writing of the reason for the overpayment.

The Federal and State False Claims Acts and Other Fraud, Waste and Abuse Laws:

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.

The False Claims Act addresses those who:

- Knowingly* presents, or causes to be presented, 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 False Claims Act

- Has possession, custody or control of property or money used, or to be used, by the government 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 government, and intending to defraud the 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 government, or a member of the armed forces, who lawfully may not sell or pledge property

- Knowingly* makes, uses, 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 government, or knowingly conceals or knowingly and improperly avoids or decreases 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.

A violation of the federal Anti-Kickback Statute constitutes a false and fraudulent claim under the federal False Claims Act.

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 period for a claim to be brought under the False Claims Act is the later 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 Reporters of Fraud, Waste or Abuse

In addition, 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.

Additional information on the False Claims Act and our fraud, waste and abuse policies can be found on **CareSource.com** > Providers > Education > Fraud, Waste & Abuse.

Other Fraud, Waste and Abuse Laws

- 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.

- 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. §1395(a) and §1903(s).

- 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 (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.

Prohibited Affiliations

CareSource is prohibited from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities, this includes ineligibility to participate in federal programs by the U.S. Department of Health and Human Services (HHS) or another federal agency under 2 CFR 180.970 and exclusion by HHS's Office of the Inspector General or by the General Services Administration under 2 CFR 376.

Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation. If you become aware that your corporate entity, those with more than 5 percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us immediately by emailing providermaintenance@caresource.com.

26   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Disclosure of Ownership, Debarment and Criminal Convictions

Before CareSource enters or renews an agreement with your practice or corporate entity, you must disclose any debarment, proposed for debarment, suspension or declared ineligible status related to federal 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 Provider Maintenance at 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 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. Federal and state law and CareSource policy prohibit any retaliation or retribution against persons who report suspected violations. 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 1-844-415-1272 and tell our IVR system that you are calling 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

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.

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.

Thank you for helping CareSource keep fraud, waste and abuse out of health care.

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. As a reminder, providers should also continue to reference the requirements contained within the provider agreement. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Provider Responsibilities

- Providing CareSource with advance written notice of any intent to terminate an agreement with us. This must be done 90 days prior to the date of the intended termination and submitted on your organization's letterhead.

  - Minimum of 60-day notice is required if you plan to close your practice to new patients. If we are not notified within this period, you will be required to continue accepting CareSource members for a 60-calendar day period following notification.

- For primary care providers (PCPs) only: Providing 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or a taped message used after-hours, patients should be given the means to contact their PCP or a back-up provider 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 provider and only recommends emergency room use for after hours.

- Submission of claims or corrected claims should be submitted within 365 days of the date of service or discharge.

- Appeals involving medical necessity determinations must be received within 60 calendar days from the date of the denial. Claim disputes must be submitted no later than 12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely dispute submission, whichever is later.

- Keeping all demographic and practice information up to date. Information updates submitted on the CareSource Provider Portal at CareSource.com > Login > Provider Portal.

- Notify CareSource of change in member demographic circumstances. Information updates submitted on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

- Referring members to providers in the CareSource network.

CareSource Responsibilities

- Prompt Pay Requirements and Penalties:

- In accordance with 42 CFR 447.46 and this Agreement, except if the MCO and its network provider

28   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

has established an alternative payment schedule mutually agreed upon and described in the provider contract, the MCO must:

1. Pay or deny 90% of all submitted clean claims within 21 calendar days of the date of receipt;

2. Pay or deny 99% of clean claims within 60 calendar days of the date of receipt; and

3. Pay or deny 100% of all claims within 90 calendar days of receipt. Providing you with an appeal and dispute procedures for timely resolution of any requests to reverse a CareSource determination regarding a prior authorization request or claims payment. Our appeal and disputes process is outlined on page 67.

- 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 lessor 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.

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.

Examples:

- Participating providers, or their designee, are expected to make daily visits to their patients who have been admitted as inpatient to an acute care facility or 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.

- 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 member rights below for more information.

Member 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 and responsibilities, as stated in the Member Handbook, are as follows:

- Receive information about CareSource, our services, our network providers and member rights and responsibilities.

- Be treated with respect and dignity by CareSource personnel, network providers and other health care professionals.

- Privacy and confidentiality for treatments, tests and procedures you receive.

- Participate with your doctor in making decisions about your health care.

- Candidly discuss with your doctor the appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

- Voice complaints or appeals about the plan or the care it provides.

- Make recommendations regarding the plan's member rights and responsibilities policy.

- Choose an advance directive to designate the kind of care you wish to receive should you be unable to express your wishes.

- Be able to get a second opinion from a qualified provider. If a qualified network provider is not able to see you, CareSource will set up a visit with a provider not in our network.

Members of CareSource are also informed of the following responsibilities:

- Supply information needed, to the extent possible, that the organization and its doctors need to provide care.

- Follow the plans and instructions for care that you have agreed to with doctors.

- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

- Be enrolled and pay any required premiums.

- Pay an annual deductible, copayments and coinsurance.

- Pay the cost of limited and excluded services.

- Choose network providers and network pharmacies.

- Show your ID card to make sure you receive full benefits under the plan.

Notification of Practice Changes

Participating providers must provide CareSource with adequate notice of practice changes. 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.

Notice Requirements

Type of Change	Notice Required Please notify CareSource of the change prior to the time frames listed below.
New providers or deleting providers	Immediate
Providers leave the practice	Immediately upon provider notice
Phone number change	10 calendar days
Address change	60 calendar days
Change in capacity to accept members	60 calendar days
Provider's intent to terminate	90 calendar days

30   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

How to Submit Changes to CareSource

Information updates can be submitted on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

Other ways to submit changes include:

Email
ProviderMaintenance@caresource.com

Fax
937-396-3076

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

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 to guide that PII be appropriately protected wherever it is stored, processed and transferred while 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 it 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 HIPAA. CareSource's Notice of Privacy Practices 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 on how they may obtain a statement of disclosures or request their medical claim information and how they may file a complaint with the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) related to their privacy. CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, PHI of members.

As a provider, please remember:

- Follow the HIPAA regulations as required for all covered entities.

- Only make reasonable and appropriate uses and disclosures of PHI for treatment, payment and health care operations.

- 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

When a patient has a sensitive health diagnosis (e.g., treatment for drug/alcohol use, genetic testing, HIV/AIDS, mental health or sexually transmitted diseases), you should verify if the patient has granted consent to share health information.

Log in to the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal and search for the CareSource patient using the Member Eligibility option. A message displays if the patient has not consented to sharing sensitive health information. If the patient has not consented, you may not have access to all the patient's health information on the Provider Portal.

Please encourage your CareSource patients who have not consented to complete a Member Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located on **CareSource.com** > Members > Tools & Resources > Forms. The Member Consent/HIPAA Authorization Form can also be used to designate a person who can speak on the patient's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the patient specifies.

32   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Member Consent

When you check eligibility on the Provider Portal, you can also determine if a member has granted consent to share their health information with their past, current and future treating providers. A message displays on the Member Eligibility page if the member has not consented to sharing their health information.

Please encourage CareSource members who have not consented to complete our Member Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located at **CareSource.com** > Providers > Forms.

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 relative, a friend, a physician, an attorney or some other person that the member specifies.

Prenatal and Postpartum Care

Documentation

To ensure accurate documentation of prenatal and postpartum care, please be sure to document the following inpatient records:

- **Evidence of prenatal teaching** – This includes education on infant feeding; Women, Infants and Children (WIC); birth control; prenatal risk factors; dietary/nutrition information and childbirth procedures.

- **Components of the postpartum checkup** – This includes documenting the pelvic exam, blood pressure, weight, breast exam and abdominal exam.

Prenatal Risk Assessment Forms

CareSource is committed to helping providers manage the high-risk pregnancies of our members. We ask prenatal care providers to use Prenatal Risk Assessment Forms, located on our website to communicate critical information to us about our pregnant members. In turn, participating providers receive payment for submission of each Prenatal Risk Assessment Form. Payment is made according to the Ohio Medicaid fee schedule and your provider agreement with CareSource.

Guidelines When Submitting Prenatal Risk Assessment Forms to CareSource

You may use any form designed for prenatal risk assessment documentation, such as ODJFS Form 3535, the American College of Obstetricians and Gynecologists (ACOG) Form, the Hollister Form, or forms provided by CareSource. If you don't already have a supply of the CareSource forms, please visit our website. You may also use your own office's assessment form if you have one that captures the same information. We must receive the forms, filled out completely, no later than one week after the member's first prenatal visit. Please be sure to include the member's estimated delivery date on the form.

We accept copies or originals by fax or by mail.

Fax
937-487-1157

Mail
CareSource
Attn: Maternal Child Department
P.O. Box 8730
Dayton, OH 45401-8730

Email
MaternalChildHealth@CareSource.com

We accept up to three assessment forms per pregnancy in case additional forms are needed for changes noted at subsequent visits as the pregnancy progresses. Please use code H1000 on the associated claim to indicate that an assessment form was submitted. This will help ensure that you are reimbursed appropriately.

Well-Child Care/Early Periodic Screening, Diagnosis and Treatment Program (Healthchek)

Well-Child/Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a child health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. All children of these ages who are CareSource members must receive a well-child/EPSDT exam. It supports two goals:

- to ensure access to necessary health resources and to assist parents and guardians in appropriately using those resources.

- For the complete listing of the American Academy of Pediatrics Preventive Health Guidelines go to www.aap.org. For more information on Healthchek exam components, visit page 75.

High-Risk Children

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

Primary Care Providers

Primary Care Provider Concept

All CareSource members may choose a primary care provider (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 online Provider Directory available at **CareSource.com** > Members > Tools & Resources > Find a Doctor. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling Member Services.

Primary Care Provider Roles and Responsibilities

Primary Care Providers 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.

- Identifying the member's health needs and taking appropriate action.

- Providing phone coverage for handling patient calls 24 hours a day, seven 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 plans outlined in this manual.

34 Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

- 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.

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

Immunization Schedule

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

Sign and Language Interpretation Assistance

CareSource offers on-site sign and language interpreters as well as over-the-phone (OPI) and video remote interpreting (VRI) when appropriate, for medical appointments outside of the surgical, hospital or emergency room setting*. These services are available to CareSource members who are hearing impaired, do not speak English or have limited English-speaking proficiency. 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.

To arrange services, please contact our Provider Services department at **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711). 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.

*CareSource requires hospitals, emergency rooms and skilled nursing facilities, at their own expense, to offer sign and other language interpreters for members who are deaf or hard of hearing, do not speak English or have limited English-speaking proficiency. This includes providers that perform in-office surgeries. These services should be available at no cost to the member.

36   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Quality Improvement

CareSource is committed to providing evidence-based care in a safe, member-centered, timely, efficient and equitable manner. The scope of the CareSource Quality Improvement (QI) Program is comprehensive and inclusive of both clinical and non-clinical services, as well as health, safety, and/or welfare concerns. CareSource uses a population health lens to monitor and evaluate the quality of the care and service delivered to our members emphasizing:

- Equitable delivery of service

- Accessibility and availability to medical, behavioral health and other care

- Quality of care and member safety

- Internal evaluation of program areas, including Utilization Management, Care Management and Pharmacy

Population Health Management and Quality Improvement Program

CareSource administers our Ohio Medicaid business in an efficient and effective manner and assures an organizational focus on Population Health Management (PNM) and continuous QI and learning. CareSource has an integrated comprehensive Population Health Management (PHM) model that utilizes quality improvement (QI) science techniques designed to maintain and improve physical and psychosocial well-being and address health disparities through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.

Population Health Strategy

CareSource's population health program encompasses the covered services and programs listed in this manual (including, but not limited to prenatal postpartum, behavioral health, care coordination, utilization management, quality improvement, HealthChek, annual physicals/well visits, immunizations, and health equity.

An annual PHM strategy is designed to directly impact the health of our member populations through programmatic design, implementation, evaluation, and continuous improvement. It is comprehensive and includes data collection and monitoring; assessing population level and individual member health risks and health-related social needs; creating wellness, prevention, case management and care transitions programs to address identified risks and needs, using stratification to identify and connect adult and pediatric members to the appropriate programs, and using predictive analytics to identify which patients, communities or populations are emerging as high-risk.

Program Scope:

- Improve the health outcomes of identified communities and groups

- Utilize data to analyze community and population level health and health-related social needs and set measurable goals for improvement

- Utilize initial and continuous assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted health improvement activities

- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes and slow the progression of disease or disability

- Coordinate care across the continuum of medical, behavioral health, oral health and preventive screenings

- Deploy strategies to drive improvements in health specifically for populations proactively identified as experiencing health disparities

- Partner with appropriate community-based providers to support individual members, families, and caregivers in managing care

- Utilize a person-centered and family-centered approach for care planning

- Continually evaluate and improve on the strategic plan on an ongoing basis through meaningful quality measurement

Member and provider satisfaction and health outcomes are monitored through:

- Quality improvement activities

- Routine health plan reporting

- Annual HEDIS®—measures the quality of our health plan

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Enrollee Experience Survey scores

- Member feedback captured via surveys, inclusion in advisory workgroups and collection by member-facing employees

- Review of accessibility and availability standards

- Utilization trends

CareSource assesses our performance against goals and objectives that are in keeping with industry standards. We complete an annual evaluation of our QI Program.

Program Scope

CareSource supports an active, ongoing and comprehensive quality improvement program across the enterprise. To maintain a robust QI program, our scope includes:

- Advocate for members across settings, including review and resolution of quality-of-care issues

- Meet member access and availability needs for physical and behavioral health care

- Determine interventions for HEDIS overall rate improvement to improve preventive care scores and

- facilitate support of members' 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 experiences

- Demonstrate enhanced care coordination and continuity across settings

- Meet members' cultural and linguistic needs, encompassing the social determinants of health

- Ensure CareSource is effectively serving members with complex health needs

- Assess member population characteristics and needs

- Assess geographic availability and accessibility of primary care providers and specialists

- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings

38   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

- Determine practitioner adherence to clinical practice guidelines
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies
- Ensure regulatory and accrediting agency compliance, including:
  - All federal requirements as outlined in 42CFR Part 438, Managed CareSource Perform HEDIS
  - Compliance audit and performance measurement
  - Ensure compliance with NCQA accreditation standards

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, as well as the Institute for Healthcare Improvement Quadruple Aim for Populations.

The Institute for Healthcare Improvement Quadruple Aim Framework

CareSource aligns with the IHI framework to:

- Improve the member experience of care (including clinical quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care
- Improve provider satisfaction (professional wellness)

In addition, CareSource uses Six Sigma tools, when indicated, to focus on improving member experience, member safety and enduring 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 outcomes. CareSource uses HEDIS measures to monitor the quality of care delivered to our members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA). The HEDIS tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence-based care and address the most significant areas of care. Potential quality measures:

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer, chlamydia)
- Well-child
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure

- Behavioral Health
  - Follow up after hospitalization for mental illness
  - Antidepressant medication management

Patient Safety Program

CareSource recognizes that patient safety is the cornerstone of high-quality health care, contributing to the overall health and welfare of our members. Our CareSource Patient Safety program evaluates patient safety trends with the goal of reducing avoidable harm. Our patient safety program is developed in the context of our population health management approach and includes regulatory/accreditation, policies and procedures, training and implementation, continuous monitoring and program evaluation and improvement. Safety events are monitored through retrospective review of quality-of-care concerns and real-time reporting of claims data. Data analysis of our provider and health system network ensures situational risks can be identified in a timely manner, reviewed and mitigated by a proactive corrective action, or performance improvement steps.

Preventive Guidelines and Clinical Practice Guidelines

CareSource approves and adopts evidence-based nationally accepted standards and guidelines and promotes them to practitioners and members 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 topics. Guidelines are reviewed at least every two years or more as often as appropriate, 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 its impact on member health outcomes. Review and approval of the guidelines are completed by the CareSource Provider Advisory Committee (PAC) and Enterprise PAC. The Quality Enterprise Committee (QEC) is notified of guideline approval. Topics for guidelines are identified through analysis of Marketplace plan members. Guidelines may include, but are not limited to:

- Behavioral health (e.g., depression)
- Adult health (e.g., hypertension and diabetes)
- Population health (e.g., obesity and tobacco cessation)

Guidelines may be promoted to practitioners and providers through 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 may be made available to members via member newsletters, the CareSource member website, or upon request.

If you would like more information on CareSource Quality Improvement, please call Provider Services.

HEDIS is a registered trademark of the NCQA.

Confidentiality

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.

40 Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

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. Participating providers are expected to have procedures in place to see patients within these timeframes and to offer office hours to their CareSource patients that are at least the equivalent of those offered to any other patient. Please keep in mind the following access standards for differing levels of care.

For taped messages used after hours, patients should be given the means to contact their PCP or a back-up provider 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 provider and only recommends emergency room use for after-hours. For the best interest of our members and to promote positive health care outcomes, CareSource supports and encourages continuity of care and coordination of care between medical care providers as well as between physical care providers and behavioral health providers. 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.

Submitting Changes to CareSource

Online
Visit **CareSource.com** > Login > Provider Portal

Fax
937-396-3076

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

CareSource continually assess 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.

Quality-of-Care Reviews

CareSource ensures the provision of safe and quality care to members by investigating and mitigating potential quality of care concerns, that include:

- Inappropriate or inconsistent treatment

- Delay in receipt of care

- Compromising member health, safety or welfare

- Having the potential to limit functional abilities on a permanent or long-term basis

In order to properly assess quality of care concerns CareSource Enterprise Quality Improvement initiates contact with providers to request medical records using established processes and timelines. As per our policies and provider contracts, we are authorized to ask for protected health information for health care operations, which includes quality issue reviews. Medical record requests are forwarded to providers via

mail, e-mail or fax and may be returned to CareSource via these same mechanisms as detailed in the medical record request document.

All providers are expected to return medical record requests related to quality-of-care concerns within 14 days from initial receipt of the request, unless otherwise defined by program guidelines or state or federal law requirements. In the event that a state, federal or regulatory agency, or if the health and safety of a member requires that medical records must be submitted under a shorter timeframe, providers are expected to comply with the shorter turnaround time. Providers and facilities that utilize third party health information management vendors are responsible for providing medical records to CareSource or facilitating delivery of medical records to CareSource by the identified contractor. We are legally bound to interact with providers only and CareSource is not subject to any fees charged by health information management companies for medical record retrieval or submission.

Your health partner representative may contact you if medical records are not received within the 14-day timeframe to ensure you received the request. In addition, our market Chief Medical Officer may also be in contact to facilitate and ensure receipt of the required medical records to complete the quality-of-care reviews. Providers or facilities who repeatedly fail to return requested medical records are reported to the Credentialing Committee and may face other directed intervention or penalties up to and including contract termination.

SECTION V – PROVIDER ENROLLMENT, CREDENTIALING AND CONTRACTING

Provider Enrollment
(Administered by the Ohio Department of Medicaid)

Overview

Pursuant to 42 Code of Federal Regulations (CFR) 438.602, the ODM is required to screen, enroll and revalidate all managed care organization (MCO) network providers. This provision does not require MCO network providers to render services to fee-for-service (FFS) beneficiaries.

There are many resources available on the ODM website about the requirements to become a participating provider. Please visit https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/ enrollmentand-support/enrollment-and-support for several useful documents that answer relevant questions.

Organizational provider types will be required to pay a fee. The fee does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFR 455.460 and in OAC 5160-1-17.8. The fee for 2024 is 709 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, Ohio Medicaid will require that the enrolling organizational providers submit proof of payment with their application. (See OAC 5160-1-17.8(A)(1))

Termination, Suspension, or Denial of ODM Provider Enrollment

For a list of termination, suspension and denial actions initiated by the state against a provider or applicant that allow for hearing rights please refer to Ohio Revised Code 5164.38.

For a list of termination, suspension and denial actions initiated by the state Medicaid agency against a provider or applicant that allow for reconsideration please refer to Ohio Administrative Code 5160-70--02.

Loss of Licensure

In accordance with Ohio Administrative Code 5160-1-17.6, a Medicaid provider agreement will be terminated when any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

Enrollment and Reinstatement After Termination or Denial

If a provider's Medicaid provider agreement is terminated or an applicant's application is denied, the applicant/provider should contact Ohio Medicaid via the Provider Enrollment Hotline (1-800-686-1516) to discuss the requirements to reapply. This process may include conversations with the ODM Compliance unit who will provide specific instruction on re-instatement requirements, if applicable.

Provider Maintenance

The PNM system serves as the system of record for provider data for ODM and the MCOs. As a result, data in the PNM system is used in both claims payment, the MCO's provider directory, and ODM provider directory. To ensure provider information remains current it is important for providers to keep their information up to date in the PNM system. Please remember, as an ODM provider and in accordance with your provider agreement, providers are responsible to notify ODM of changes within 30 days (see OAC 5160-1-17.2 (F).

Updating the PNM system: When there is a change in a provider's information, please log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update. Self-service functions include, but are not limited to: location changes, specialty changes, and key demographic (e.g., name, NPI, etc.) changes. Once information is accepted into the PNM system, accepted information is sent to the MCOs daily for use in their individual directories. The provider must update their information in the PNM system first. The MCOs are required to direct providers back to the PNM system if there are changes.

ODM Provider Call Center

If you have questions or need assistance with your Ohio Medicaid enrollment, call the ODM Integrated Help Desk at 800-686-1516 through the interactive voice response (IVR) system. It provides 24 hour, 7 days a week access to information regarding provider information. Provider representatives are available via the IVR system weekdays from 8:00 a.m. through 4:30 p.m.

Helpful Information

Medicaid Provider Resources: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support

Federal guidelines for enrollment and screening (42 CFR 455 Subpart E): https://www.law.cornell.edu/cfr/text/42/part-455/subpart-E

Ohio Revised Code:https://codes.ohio.gov/ohio-revised-code/chapter-5160

https://codes.ohio.gov/ohio-revised-code/chapter-3963

Ohio Administrative Code: https://codes.ohio.gov/ohio-administrative-code/5160

44   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Provider Contracting (Administered by CareSource)

Contracting Process

If you offer medical services and want more information about becoming a participating provider, please submit the online New Health Partner Contract Form.

Once you submit your request, you will receive a confirmation email. **Please save this email, as it will contain your Application ID.**

We verify the following documentation and or items from the documentation you submitted.

- ✓ Complete W9 to include signed and dated
- ✓ IRS name matches IRS name on W9
- ✓ Debarment Form (Disclosure of Ownership)
- ✓ Group NPI
- ✓ Medicaid number
- ✓ CAQH number (if applicable)

If any items are missing, CareSource will contact you to request you resubmit missing documents to complete the contracting request.

Once we receive completed copies of all the above documents, CareSource will pull your CAQH application or state approved application (Provider) or outreach to you for an organization application (facility/ancillary). To shorten the onboarding timeline, we send the contract to you for your review and signature while your credentialing application is being processed.

Once your credentialing application is approved, CareSource will configure your contract in our internal systems. **Please allow 45 calendar days for the credentialing and loading to be complete.**

If a provider is contracting with a managed care organization for Medicaid-only credentials or MyCare credentials, the credentialing process will be done through ODM (PNM module). Providers who participate in Medicaid's fee-for-service model also must complete this process. Providers will not be credentialed at the MCO level.

Get Started Today

Providers can visit **CareSource.com** > Providers > Education > Become a Participating Provider to initiate the contracting process.

Sample Contract/Provider Agreement

Providers can view a sample contract **CareSource.com** > Providers > Education > Become a Participating Provider.

Sample Network Provider Agreement

We have provided sample copies of our provider agreement and addendum.

CareSource Provider Agreement – View the CareSource Provider Agreement

Appendix C – Ohio Medicaid Provisions – view provisions applicable to health services rendered to Ohio Medicaid managed care covered persons

Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organization and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachments are only needed when providers are offering different services or practitioners through this plan contract than are identified in the PNM system. Attachment A is needed for all PCPs to identify the providers' capacity and service location. Attachment A is also required when a provider has specific practitioner affiliates identified in the PNM who are agreeing to provide services under this plan contract. Attachment C is only required when the contract between the managed care entity and the provider includes particular specialties rather than all specialties the provider identified in the PNM system. The most current Medicaid Addendum is posted on the ODM website here:

https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managedcare-program-appendix/managed-care-program-addenda.

The addendum must be completed along with the MCO provider contract.

Termination, Suspension or Denial of Contract

CareSource may decide that an applying or participating provider may pose undue risk to our members and should be denied participation or be removed from CareSource's network. If this happens, the applying or participating provider will be notified in writing.

Appeals Process

Reconsideration and appeal opportunities are available unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan. To submit a request, the following steps apply:

Step 1

Submit to the Vice President/Senior Medical Director a reconsideration request in writing, along with any other supporting documentation:

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

All reconsideration requests must be received by CareSource within 30 calendar days of the date the provider is notified of the decision. The request, along with any supporting information, will be presented to the credentialing committee for review at the next meeting. The committee will respond within 30 calendar days of that meeting, and the provider will be notified in writing of the committee's decision.

46   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Step 2

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 Should Be Sent To:

> CareSource
> Attn: 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.

Provider Disputes

Provider disputes for issues related to quality, professional competency or conduct should be sent to:

> CareSource
> Attn: Quality Improvement
> P.O. Box 8738
> Dayton, OH 45401-8738

Provider disputes for issues that are contractual or non-clinical should be sent to:

> CareSource
> Attn: Provider Relations
> P.O. Box 8738
> Dayton, OH 45401-8738

Summary Suspensions

CareSource reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating provider who, in the opinion of the CareSource Vice President/Senior Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our members. Any participating provider that is subject to a suspension or termination may dispute the action and request a hearing through the CareSource Fair Hearing Plan unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan.

Out-of-State/Non-Contracted Providers

Non-participating providers require a prior authorization for any services rendered to CareSource members, except in cases of emergency. Please reference the prior authorization procedures on page 90 for more information.

Contracting and enrollment are two separate processes. Both should be completed if you want to provide services to managed care enrolled Medicaid beneficiaries. Contracting is the process a provider completes with the MCO whereas enrollment is a process completed with the ODM. All providers who are billing for services for Medicaid managed care enrolled beneficiaries should enroll with ODM through our PNM system. 42 CFR § 438.602 requires ODM to "screen and enroll, and periodically revalidate, all network providers of MCOs". Federal regulations allow for a 120-day temporary agreement for providers who require more time to enroll in the PNM System. To complete the temporary 120 agreement while you wait for your ODM enrollment to process you must complete the ODM 10295 form.

Provider education and training resources for PNM, including how to enroll, are located here: PSE Provider Registration Portal - Resources (maximus.com)

Provider Services

Providers may contact CareSource's Provider Services with any questions by calling **1-800-488-0134**. Our hours of operation are 7 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET).

48   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Credentialing/Recredentialing Process

ODM is responsible for credentialing all Medicaid Managed Care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the Provider Network Management system. This process adheres to NCQA and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.

Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. Medical students, residents, fellows and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with each Managed Care Organization (MCO) you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOs.

When you submit your initial application to be an Ohio Medicaid provider, you can designate managed care organization interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOs so they can start contracting with you.

SECTION VI – COVERED SERVICES

This section describes enrollment and covered services and exclusions to benefits to our CareSource members, as well as appeals rights. CareSource covers all medically necessary Medicaid-covered services. This section is alphabetized for your convenience.

50   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Abortion and Sterilization

CareSource covers abortions, hysterectomies and sterilizations in very limited circumstances. Please review the information below for specific information. Visit the "Forms" section of our website for all appropriate forms to complete for an abortion, hysterectomy or sterilization. For your convenience, CareSource also has tutorials on how to complete these forms on our website. Providers can also submit these forms on the Provider Portal at **CareSource.com** > Login > Provider.

Abortion

Abortion services are covered in the following circumstances with PA:

- Instances in which the woman 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, as certified by a provider, place the woman in danger of death unless an abortion is performed.

- Instances in which the pregnancy was the result of an act of rape and the patient, the patient's legal guardian or the person who made the report to the law enforcement agency, certifies in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the provider performing the abortion.

- Instances in which the pregnancy was the result of an act of incest and the patient, the patient's legal guardian or the person who made the report certifies in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or in the case of a minor, with a county children services agency established under Chapter 5153 of the Revised Code, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the provider performing the abortion.

Certification Form for Reimbursement of Abortion

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 Ohio Department of Job and Family Services (ODJFS) Abortion Certification Form (JFS 03197 Form). The provider's signature must be in the physician's own handwriting. All certifications must contain the name and address of the patient. The certification form must be attached to the claim.

The certification must be as follows:

I certify that, on the basis of my professional judgment, this service was necessary because:

- The woman 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, as certified by a provider, place the woman in danger of death unless an abortion is performed.

- The pregnancy was the result of an act of rape and the patient, the patient's legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction.

- The pregnancy was the result of an act of incest and the patient, the patient's legal guardian or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or in the case of a minor, with a county children services agency established under Chapter 5153 of the Revised Code.

- The pregnancy was the result of an act of rape or incest, and in my professional opinion the recipient was physically unable to comply with the reporting requirement.

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.

- 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.

- Informed consent is obtained on the Consent to Sterilization Form (HHS-687 (5/2010), which is located on our website, with legible signature(s) and submitted to our health plan with the claim.

- 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 procedure is scheduled at least 30 days, but not more than 180 days, after the consent is signed.

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

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. A wellness exam may be performed annually and consists of the following:

- Routine physical exam, including (but not limited to) urinalysis, Pap smear, hemoccult, general health screen panel and other lab tests as indicated

- Screening which consists of the following, as appropriate:
  - Mammography performed at intervals recommended by the American Cancer Society and American College of Obstetrics and Gynecology for age and risk factors
  - Prostatic-specific antigen for males
  - Flexible sigmoidoscopy every three years beginning at age 40
  - Colonoscopy as indicated for patients with high risk factors
  - Flu shots, as appropriate
  - Vision exams through a primary care provider or vision vendor
  - Hearing exams

Please visit the Provider Portal on our website for up-to-date clinical and preventive care guidelines.

52   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Benefit Managers

Dental

CareSource's covered routine dental benefits are administered by DentaQuest®. Dental providers may find more information on **CareSource.com** > Providers > Education > <u>Dental</u>.

DentaQuest Phone: **1-855-208-6575**

Vision

CareSource's covered routine vision benefits are administered by Superior Vision® (Versant Health®). Vision providers may find more information on **CareSource.com** > Providers > Education > <u>Vision</u>.

Superior Vision/Versant Phone: **1-877-235-5317**

Laboratory

CareSource's laboratory testing services are administered by Avalon Healthcare Solutions. Laboratory service providers may find more information on **CareSource.com** > Providers > Education > <u>Laboratory</u>.

Phone: **1-844-227-5769**

Covered Services and Exclusions

For the most up-to-date list of CareSource's plan covered benefits, please visit **CareSource.com** > Ohio > Medicaid > Benefits and Services. You will find information on services, including dental services, the member's coverage status and other information about obtaining services.

- CareSource is not required to cover behavioral health services for members enrolled in the OhioRISE Plan, except for certain behavioral health services in accordance with the OhioRISE Mixed Services Protocol developed by ODM.

The single pharmacy benefit manager (SPBM) covers covered pharmaceuticals that are billed by a provider type 70 (Pharmacy). The MCE will cover covered pharmacy services billed by other provider types per OAC rule 5160-26-13.

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 to be sure the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Provider Services at **1-800-488-0134**.

Non-Covered Services

CareSource will not pay for services or supplies received that are not covered by Medicaid:

- *Services that are experimental in nature and are not performed in accordance with standards of medical practice.*

- *Services that are related to forensic studies.*

- *Autopsy services.*

- *Services for the treatment of infertility.*

- *Abortion services that do not meet the criteria for coverage in accordance with Ohio Administrative Code rule 5160-17-01.*

- *Services pertaining to a pregnancy that is a result of a contract for surrogacy services.*

- *Assisted suicide and other measures taken actively with the specific intent of causing or hastening death; and*

- *Services that do not meet the criteria for coverage set forth in any other rule in Ohio Administrative Code Agency 5160.*

54   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

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.

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 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 care services are covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition. PA is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a participating provider. PA is required for post-stabilization services in an inpatient setting.

To request PA for observation services as a nonparticipating provider or to request authorization for an inpatient admission, please visit the Provider Portal at **CareSource.com** > Login > Provider Portal.

You can also request a PA by calling our Provider Services and selecting the option to request a PA. During regular business hours, your call will be answered by our Utilization Management department. If calling after regular business hours, the call will be answered by CareSource24, our nurse advice line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

If you have questions related to post-stabilization service, please call the Provider Services lines listed above.

Enrollment & Eligibility

The ODM is responsible for determining member eligibility and sending the information to CareSource monthly. ODM notifies CareSource of some eligibility changes throughout the month. New members are effective on the first day of the month except for babies born to existing members.

Member Eligibility Verification

Except for emergency services, providers are expected to verify member eligibility before providing services:

- Log on to **CareSource.com** and select Provider Portal from the menu options. Using our secure Provider Portal, you can check CareSource member eligibility up to 24 months after the date of service.

- You can search by date of service plus any one of the following: member name and date of birth, case number, Medicaid (MMIS) number or CareSource member ID number. You can submit multiple member ID numbers in a single request.

- Call Provider Services at **1-800-488-0134** and tell our IVR system you want to verify member eligibility. You will be directed to our automated member-eligibility verification system. The automated system, available 24 hours a day, will prompt you to enter the member ID number and the month of service to check eligibility.

Each month, PCPs can view a list of eligible members who have chosen them or are assigned to them as of the first day of that month. The list also includes other important information, such as date of birth and indicators for patients who are due for a Healthchek exam. Log onto our secure Provider Portal to view or print your list.

Eligibility changes can occur throughout the month, and the member list does not prove eligibility for benefits or guarantee coverage. Please use one of the above methods to verify member eligibility on date of service.

56   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Member ID Cards

All new CareSource members receive a membership ID card, which replaces the state Medicaid card. New CareSource ID cards are not issued monthly like the state Medicaid ID cards. A new card is issued only when the information on the card changes, if a member loses a card or if a member requests an additional card.

The member ID card is used to identify a CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their previous ID card. Likewise, members may lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to each service rendered.

Providers may use our secure Provider Portal to check member eligibility or call the Provider Services department at **1-800-488-0134** and follow the prompts to check member eligibility.

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.

Front of Ohio Medicaid ID Card

ID Card Elements

CareSource®

Member Services | **Phone:** 1-800-488-0134
(TTY: 1-800-750-0750 or 711)
CareSource24® | **Phone:** 866-206-0554
(TTY: 1-800-750-0750 or 711)

Member Name
Jane
Doe

Member ID Number
123456789012

Plan ID Number
123456789012

Primary Care Provider
Dr. John Doe
Phone: 123-456-7890

Issuance Date: 01/01/2023

Pharmacy Benefit
gainwell
Rx Bin: 024251
Rx PCN: OHRXPROD
Phone: 833-491-0344
CSP Enrolled
Use Member ID for Billing

Back of Ohio Medicaid Member ID card

ID Card Elements

Member Services | **Phone:** 1-800-488-0134 (TTY: 1-800-750-0750 or 711)
CareSource24® | **Phone:** 866-206-0554 (TTY: 1-800-750-0750 or 711)

Information for Members
Please show your ID card to providers before you receive care. Never let anyone else use your ID card. In case of emergency, call 911 or go to the nearest emergency room (ER). If you are not sure if you need to go to the ER, call your primary care provider (PCP) or call CareSource24, our Nurse Advice Line. Learn more at **CareSource.com**.

Coordinated Services Program (CSP)
The CSP program coordinates treatment for members who have high patterns of utilization of both medications and services. Except in pharmacy emergencies, CSP enrollees:
 • Must choose one pharmacy to fill their prescriptions
 • May be assigned to one PCP who will coordinate care with other providers

Information for Providers
Please verify member eligibility on the Date of Service via the ODM provider portal before rendering services. Please visit **CareSource.com** for detailed billing instructions or call 1-800-488-0134 for assistance. Providers may also call the ODM IHD at 800-686-1516 for assistance.

Ohio | Department of Medicaid

OH-MED-M-998050

Please note: CareSource may be notified by ODM that a member has lost eligibility retroactively. This occurs occasionally, and in those situations, CareSource will take back payments made for dates when a member lost eligibility. The take-back code will appear on the next explanation of payment (EOP) for any impacted claims.

New Member Welcome Kits

Each household received a new member kit, in addition to a welcome letter and an ID card for each person in the family who has joined CareSource.

New Member Welcome Kit Elements

- A CareSource 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

Newborns whose mothers are members of the CareSource Ohio Medicaid plan on the newborn's date of birth, normally are covered by CareSource effective on their date of birth. The newborn will appear on the PCP's member eligibility list after they are added to the CareSource system.

To verify eligibility for a newborn, please use the secure Provider Portal at **CareSource.com** > Login > Provider. Once you enter the mother's case number, you can view all eligible members of the household.

58   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Member Disenrollment

Members may disenroll from CareSource for several reasons. If members lose Medicaid eligibility, they lose eligibility for CareSource benefits. Disenrollment may be initiated by the member, CareSource or ODM.

Reasons for Member Disenrollment

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to provide services to the member or others

Please notify the CareSource Care Management department if any of the situations listed above occur. Please see the section below for procedures for dismissing non-compliant members from your practice. We can counsel the member, or in severe cases, initiate a request to ODM for disenrollment. ODM will review each of our requests for member disenrollment and determine if the request should be granted. Disenrollment from CareSource will always occur at the end of the effective month.

Procedures for Dismissing Non-Compliant Members

Participating health care providers can request that a CareSource member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include non-compliance with medication schedules, skipping scheduled appointments or failure to modify behavior as requested. Any time a member misses three or more consecutive appointments, providers are asked to notify our Care Management department for assistance.

CareSource requires that a provider's office make at least three attempts to educate the member about non-compliant behavior and document them in the patient's record. Please remember that CareSource's outreach staff can assist you in educating the member. After three attempts, providers may initiate the dismissal by following the guidelines below.

- The provider office must notify the member of the dismissal by certified letter.
- A copy of the letter must be sent to CareSource at the following address:

    CareSource
    Attn: Member Services Manager
    P.O. Box 8730
    Dayton, OH 45401-1947

    Fax: (937) 396-3095

- For PCPs only, the letter must contain specific language stating that:
    - The member must contact the Member Services department to choose another PCP.
    - The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal.
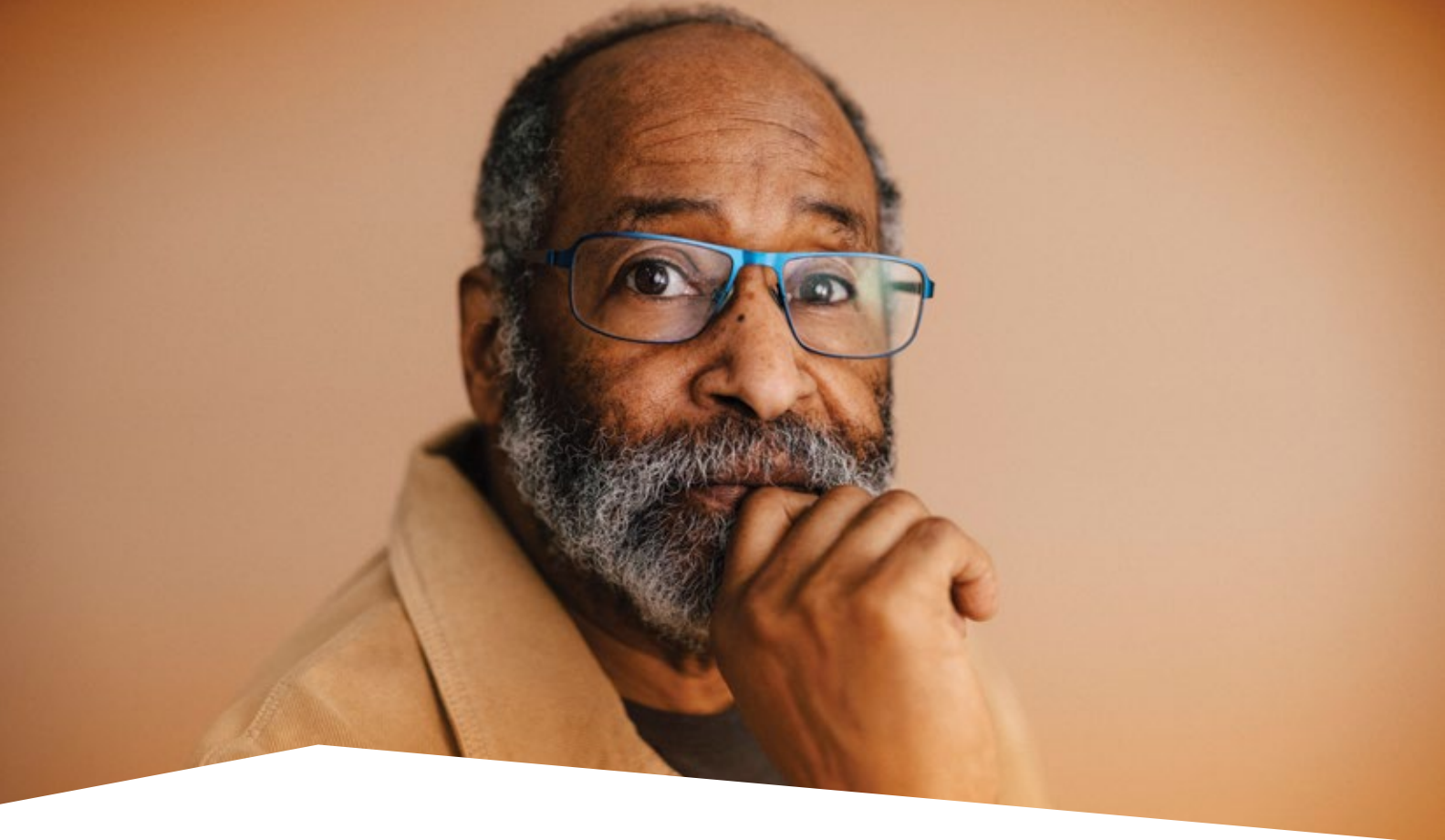
Eyeglass Frames

Members of our health plan can choose from a large selection of eyeglass frames, in addition to those approved by Medicaid, at no cost to them. These frames must be ordered through one of CareSource's contracted optical labs. Please refer to **CareSource.com** > Medicaid > Benefits and Services > <u>Additional Services</u> for more information about vision services.

Grievances, Appeals and State Hearing Procedures and Timeframes

Member Grievance and Appeals Procedure

As a CareSource provider, we may contact you to obtain additional documentation when a member has filed a grievance or appeal or has requested a State Hearing. State and federal agencies require CareSource to comply with all requirements, which include aggressive resolution time frames.

Members or providers, when designated as the authorized representative by the member, may file a grievance or appeal with CareSource. Detailed grievance and appeal procedures are explained in the member handbook. Members or providers can contact CareSource at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) to learn more about these procedures.

60   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Member Grievances

Any time a member informs us that they are dissatisfied with CareSource, or one of our providers, it is a grievance. CareSource investigates all grievances. If the grievance is about a provider, CareSource calls the provider's office to gather information for resolution.

- If a member's grievance is about not being able to get medical care, CareSource responds within two business days
- For grievances about getting a bill for care the member received, CareSource responds within 60 calendar days
- CareSource responds to all other grievances within 30 calendar days

If members are not satisfied with our response to a grievance, they can ask us to reconsider it by sending us a letter within 60 calendar days.

Member Appeals

CareSource notifies members in writing when the following decisions are made:

- Deny or limit authorization of a requested service, including the type or level of service
- Reduction, suspension or termination of services prior to the member receiving the services previously authorized
- Denial, in whole or part, of payment for a service
- Failure to provide services in a timely manner
- Failure to act within the resolution time frame

Members have the right to appeal the actions listed in the letter if they contact CareSource within 60 calendar days. CareSource has one (1) level of internal appeal. CareSource will respond to the appeal in writing within 15 calendar days of when it was received.

Per OAC 5160-26-08.4 (section H): Unless a member requests that previously authorized benefits not be continued, CareSource shall continue a member's benefit when an appeal or state hearing has been filed and all the following conditions are met:

i. The member or authorized representative requests an appeal within 15 days of CareSource issuing the NOA.;

ii. The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services.

iii. The services were ordered by an authorized provider; and

iv. The authorization period has not expired (9)

Per OAC 5160-26-08.4 (section H): If CareSource continues to reinstate the member's benefits while the appeal is pending, the benefits shall be continued until one of the following occurs:

i. The member withdraws the appeal

ii. The member fails to request a state hearing within 15 days after CareSource issues an adverse appeal resolution; or

iii. The bureau of state hearings issues a state hearing decision upholding the reduction, suspension, or termination of service.

Expedited Appeals

An expedited appeal should be considered if the member's life or health is at risk, if a decision about care is not made in a timely manner. Providers may submit a verbal request for an expedited appeal by calling **1-800-488-0134**. Members can ask a provider to appeal on their behalf with their written consent.

CareSource will make a determination within one working day of the expedited appeal request whether to expedite the appeal resolution. CareSource will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal resolution. This attempt will be made by phone. If the member is in a facility, the provider or facility will be notified on the same business day of the decision. The member will be informed of the limited time available for presentation of evidence and allegations of fact or law in person or in writing.

The member and provider will be notified in writing of the determination to process as a standard appeal within two calendar days of receipt of the appeal, including information that the member can appeal the decision. If CareSource denies the request for an expedited appeal, the appeal will be resolved within 15 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

Expedited appeals will be resolved and verbal notification will be made within 72 hours of receipt of the appeal or as expeditiously as the medical condition requires, unless the resolution time frame is extended.

State Hearings

CareSource members can request a state hearing through the Ohio Department of Job and Family Services (ODJFS) if CareSource decides to deny, reduce, suspend or stop care for a member. CareSource members can also request a state hearing if the resolution to a grievance is to uphold the denial, reduction, suspension, or termination of a service or billing of a member due to the denial of payment for that service. CareSource members are required to exhaust CareSource's grievance or appeal process before requesting a state hearing.

If a member would like a state hearing, they are asked to sign and return a state hearing form within 90 calendar days of the appeal decision. CareSource will assist the member with filing this action, if needed. If CareSource proposes to reduce, suspend or terminate a service already approved, members may request continuation of benefits until a state hearing is held; however, the member may be liable for the cost. Providers have the right to participate in the state hearing process if the member has authorized them to act as their authorized representative or requested that provider attends as a witness. A hearing officer will consider the case and render a determination based upon information presented and whether state regulations were followed.

Provider Grievances, Appeals and State Hearing Procedures and Timeframes

If in your capacity as a member's provider you file an appeal on behalf of a member, please refer to the procedures set forth in this manual.

Please note: If time frames in this manual differ from the provider agreement, the agreement will be the presiding authority.

62   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Provider Claim Disputes – Clinical and Non-Clinical (Post Service Only)

Provider claim disputes are defined as any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial.

- This includes post service provider claim disputes involving disagreements with the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity that are subject to external medical review that has already been completed.

- They do not include inquiries that come through ODM's Provider Web portal (HealthTrack).

Provider claim disputes can be submitted either verbally or in writing and must be received at CareSource within 12 months (365 calendar days) from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later (ex: claim recovery/recoupments.) Disputes submitted after the required timeframe has expired will be dismissed for untimely filing.

Submitted disputes should include:

- The member's name, CareSource member ID number, and date of birth.

- The provider's name, CareSource provider billing number and rendering National Provider Identifier (NPI).

- The claim number, date, type, and place of service.

- Code/Service in dispute

- Reason(s) for the dispute request and reconsideration

- Copy of the EOP and any other documentation to support the dispute

- All clinical documentation pertinent to a Medical Necessity review of a denied authorization

Claim Disputes may be submitted via:

- **Online:** Provider Portal

- **Fax:** 937-531-2398

- **Verbally:** via Provider Services

- **In writing:** CareSource Provider Claim Disputes and Appeals, P.O. Box 2008, Dayton, OH 45401

Providers will be notified that a dispute has been received within 5 business days from receipt.

CareSource will make a determination for provider claim disputes within the following time frames:

- Clinical Claim Disputes – 30 business days from receipt of the dispute

- Non-clinical Claim Disputes – 15 business days from receipt of the dispute

If additional time is needed to resolve a dispute beyond the 15th business day,

- Clinical Disputes – a status update will be provided via US Mail on the 15th business day.

- Non-Clinical Disputes – the provider will be updated via US Mail every 5th business day starting on the 15th business day until the complaint is resolved.

Providers will be notified of the dispute decisions in writing, unless verbally resolved. If the dispute is approved, we will reprocess and pay disputed claims within 30 calendar days of the written notice of resolution unless a system fix is needed, then addition time is allotted.

Claim Disputes for Recovery Actions

Providers will receive notification in writing of any recovery action that CareSource will be taking due to identified overpayments. Utilize the dispute process described above if you do not agree with action being taken.

After the provider receives their dispute resolution, the provider will receive appeal rights to appeal the action to CareSource.

When the resolution determines claims were paid or denied incorrectly, CareSource will:

- Reprocess and pay disputed claims within 30 calendar days of the written notice of resolution unless a system fix is needed, then addition time is allotted; and

- Automatically apply the corrective action or claims resolution to correctly adjudicate all other provider claims affected by the same issue.

Provider Appeals (Pre-Service)

Pre-Service Appeal: any provider disagreement with the decision to deny, limit, reduce, suspend, or terminate a covered service for the lack of medical necessity prior to being completed.

Standard (Non-Urgent) Provider Clinical Appeals

Pre-Service appeals may be submitted either verbally or in writing. The request must be received at CareSource within 60 calendar days from the date that the adverse benefit determination was issued.

Submitted appeals should include:

- The member's name, CareSource member ID number, and date of birth.

- The provider's name, CareSource provider billing number and rendering National Provider Identifier (NPI), if available.

- Code/Service being appealed

- All clinical documentation pertinent to a Medical Necessity review of a denied authorization

Appeals submitted after the required timeframe has expired will be dismissed for untimely filing.

Pre-Service appeals may be submitted via:

- **Online:** Provider Portal
- **Fax:** 937-531-2398
- **Verbally:** via Provider Services (expedited requests)
- **In writing:** CareSource Provider Claim Disputes and Appeals, P.O. Box 2008, Dayton, OH 45401

64 Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Providers will be notified in writing that an appeal has been received within three business days from receipt.

All pre-service appeals will be completed within 10 calendar days from the receipt of the request unless resolution time is extended by an additional 14 calendar days.

Providers will be notified of the appeal decisions in writing via US Mail.

Expedited (Urgent) Provider Clinical Appeals

Pre-Service Expedited Appeal may be submitted either verbally or in writing when a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

The request must be received at CareSource within 60 calendar days from the date that the adverse benefit determination (NOA) was issued and must be clearly identified as Expedited or Urgent.

Submitted complaints should include:

- The member's name, CareSource member ID number, and date of birth.
- The provider's name, CareSource provider billing number and rendering NPI if available.
- Code/Service being appealed.
- Reason(s) for the appeal.
- All clinical documentation pertinent to a medical necessity review of a denied authorization.

CareSource will evaluate and determine within one business day of receipt whether to expedite the appeal resolution and make reasonable efforts to provide prompt oral notification of the decision to review expeditiously or convert to a standard.

- If CareSource denies a request for expedited resolution, the case will be reviewed and resolved with 10 calendar days from the date of receipt, unless resolution time frame is extended.

Expedited appeals will be completed within 48 hours from the receipt of the request unless resolution time is extended by an additional 14 calendar days.

Providers will be notified of the appeal decisions in writing via US Mail.

External Medical Review

Providers who disagree with CareSource's determination on appeal to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity may request an External Medical Review with Permedion. Services denied, limited, reduced, suspended, or terminated for reasons other than lack of medical necessity and for which no clinical review was completed by CareSource are not subject to External Medical Review. The request for External Review must be submitted to Permedion within 30 calendar days of the date of the internal appeal notification.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located at www.hmspermedion.com (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from CareSource (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing case.

Providers need to upload the request form and all supporting documentation to Permedion's provider portal located at ecenter.hmsy.com/ (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal access).

For more information about the External Medical Review, please contact Permedion at 1-800-473-0802, Option 2.

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.

Online Health Engagement

CareSource uses innovative technology to engage members to manage their own health. MyHealth is a technology-enabled enterprise solution to improve population health and well-being. It provides personalized wellness tools for all CareSource members. Through MyHealth, CareSource members have access to tools to help them manage health topics specific to their needs. MyHealth includes:

- Interactive health assessment
- Condition specific digital health tools
- Multi-dimensional daily wellness tracker
- Small steps guides

All the tools are accessible via web or mobile.

Healthchek

Healthchek is the state of Ohio's name for Early Periodic Screening Diagnosis and Treatment (EPSDT) services. This is a federally mandated program developed for babies, kids and young adults younger than age 21 who are enrolled in Ohio Medicaid. All CareSource members under the age of 21 should receive Healthchek exams. The purpose of the program is to discover and treat health problems early. If a potential health problem is found, further diagnosis and treatments are covered by Medicaid.

Healthchek Examinations

Exam Components

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

- Medical history
- Complete unclothed exam (with parent approval)
- Developmental screening (to assess if a child's physical and mental abilities are age appropriate)
- Vision screening
- Dental screening
- Hearing assessment
- Immunization assessment (making sure child received them on time)
- Lead screening; and
- Other services or screenings as needed

Healthchek Exam Frequency

The recommended schedule for Healthchek exams is as follows:

- Birth
- 3-5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- after 30 months, one exam per year until age 21

Providers can access a list of eligible CareSource members who have been chosen or assigned to the provider via the portal. The list also includes indicators for patients who are due for a Healthchek exam. If there is a "Y" in the Exam Due column, that member is due to receive a Healthchek exam in the following month. You can find this list on our website at **CareSource.com** > Medicaid > Benefits and Services > EPSDT.

68   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Healthchek Documentation and Billing

Healthchek Form

Please document all required components of the Healthchek exam in the member's medical record. We encourage you to use a form to ensure that you capture all the needed data. Please use the Healthchek Form on the ODM Medicaid Forms page at medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-andpartners/legal-and-contracts/forms/forms.

Healthchek Codes

To receive proper payment for EPSDT/Healthchek 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.**

Healthchek Electronic Claims

Completion of CR02 and CR03 are required for electronic claims. Select the response in Loop 2300 Segment CRC02, 'Was an EPSDT referral given to the patient?" as follows:

- Enter "Y" in Loop 2300 Segment CRC02 if the service was an EPSDT, follow up is required and a referral is made
- Enter "N" in Loop 2300 Segment CRC02 if the service is an EPSDT and no follow-up services were required

Select the condition indicators in Loop 2300 Segment CRC03. If response to CRC02 is "N", use NU (Not Used). If response to CRC02 is "Y", use one of the following:

- AV (Available – not used)
- S2 (Under treatment)
- ST (New services requested)

In addition, completion of SV111 is required for electronic claims to indicate the service rendered was the result of an EPSDT referral.

- Enter "Y" in each Loop 2400 Segment SV111 if the service was rendered as the result of an EPSDT referral.
- Enter "N" in each Loop 2400 Segment SV111 if the service was not rendered as the result EPSDT referral.

Healthchek Paper Claims

Report the referral field indicator in field 24h for EPSDT services as follows:

Lower, Unshaded Area:

- Enter "Y" if the service was related to EPSDT.
- Enter "N" if the service was not related to EPSDT

Upper, Shaded Area:

If "Y" is entered in the lower, unshaded area, add the appropriate condition indicator in the upper, shaded area using one of the following:

- NU (No EPSDT referral was given)
- AV (Referral was offered, but the individual refused it)
- ST (New services requested)
- S2 (Under treatment)

No value in the upper shaded area is needed if the value in the lower shaded area is "N."

Sick and Well Visit Billing

If it is the first time a patient is seen in a provider office, only one of the two billed visits can be billed a new patient visit. For example, if a new patient is seen for both a well visit and a sick visit, only one service is a new patient visit while the other is considered an established visit. If the provider's documentation supports services for a well visit and sick visit (no overlapping documentation components), then separate reimbursement is warranted and supported.

When billing a "sick visit" on the same day as a "well visit," ensure the appropriate Evaluation & Management code with modifier and preventive code is used:

- Codes: 99201-99215
- Modifier: -25
- Preventive codes: 99381-99397

Healthchek Exam Referrals

If the PCP is unable to provide all the components of the Healthchek 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.

Blood Lead Level Testing

The Ohio Medicaid program requires that children receive a blood lead level test at one and two years of age. This is a required part of the Healthchek exam provided at these ages. Filter paper testing is an accepted method for obtaining blood lead levels and is approved by the Ohio Department of Health (ODH).

The filter paper method offers fast, quantitative results from two drops of blood obtained through a finger stick capillary puncture. Lead levels that exceed 5 ug/dL with this sampling method must be confirmed with venous draw according to ODH guidelines.

For more information, please contact The Ohio Department of Health, Ohio Healthy Homes and Lead Poisoning Prevention Program at 1-877-LEADSAFE (532-3723).

Immunizations

Immunizations are an important part of preventive care for children and should be administered during Healthchek exams as needed. CareSource endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. The recommended schedule is included in this section of the manual. This schedule is updated annually and the most current updates are located on www.aap.org.

Immunization Codes

Effective Oct. 1, 2015, CareSource requires providers to use ICD-10-CM Codes and CPT Codes on claims. Please refer to the Code Tables located on the CMS website at https://www.cms.gov/medicare/coding-billing/icd-10-codes.

You can also get CMS Coding Guidelines at www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf.

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 19 who are eligible for Medicaid. CareSource members under the age of 19 are eligible for these vaccines. This program in Ohio is administered by ODH.

CareSource encourages providers to participate with the VFC program. Vaccines administered to children under the age of 19 must be obtained through the VFC program, which supplies vaccines to program participating providers at no cost.

Providers will be reimbursed to administer vaccines to enrollees under the age of 19.

CareSource will not reimburse costs for vaccines obtained outside the VFC when provided to children under age 19.

Please bill CareSource with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. CareSource will pay for the administration of the vaccine only. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

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

Immunization Program

Ohio Department of Health
246 N. High Street
Columbus, OH 43215

Email

immunize@odh.ohio.gov

Phone

1-800-282-0546 or 1-614-466-4643 (ask to speak with the VFC representative for your county)

CareSource members may also obtain immunizations from their local pharmacy. For coverage information of vaccines, please refer to Gainwell Technologies, the single pharmacy benefit manager for all Ohio Medicaid members. Visit spbm.medicaid.ohio.gov for more information.

Statewide Web-Based Immunization Registry

CareSource encourages all participating providers to take advantage of the statewide web-based immunization registry called IMPACT SIIS, found at ohioimpactsiis.org/siisprod

The registry consolidates immunizations from multiple providers into one central record and provides reliable immunization history that is electronically accessible from multiple health care practice sites. It also facilitates the introduction of new vaccine protocols and sends immunization reminder/recall notices automatically. The system is designed to save time and money, reduce paperwork and provide quick and efficient tracking of immunizations. It also streamlines inventory reporting required by the VFC program.

72   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Member Rewards

MyKids Program

MyKids is a free program offered to newborns, youths and teens. Through this program, members can earn rewards on a My CareSource Rewards® card. The program focuses on encouraging well-baby visits as recommended, to help ensure mom and baby will be as healthy as possible; as well as 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, CVS 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 MyKids by completing the form at **CareSource.com** > Benefits and Services > Additional Services > Rewards or call Member Services at **1-800-488-0134**.

Also see the Provider Portal for details on the different rewards members can earn.

MyHealth Program

CareSource offers the MyHealth rewards program to both men and women for completing preventive screenings including annual physicals, dental exams, mammograms and colon cancer screenings. Members are automatically enrolled in the program and rewards are automatically added to their rewards account each time they complete an eligible healthy activity. Members can see a complete list of all eligible activities through MyCareSource.com. Earned reward can be redeemed for gift cards to retailers including TJ Maxx, Panera Bread, iTunes, the CareSource Online Store and more. Program information is available through MyCareSource.com or by calling Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711).

Also see the Provider Portal for details on the different rewards members can earn.

Pharmacy

Effective October 2022, Gainwell Technologies is the Single Pharmacy Benefit Manager (SPBM) for ODM's pharmacy program. All CareSource members receive pharmacy benefits through the SPBM.

CareSource is not required to cover pharmacy services other than the limited pharmacy services described in this manual. All other pharmacy benefits are covered by ODM's single pharmacy benefit manager (SPBM).

CareSource continues to provide coverage for provider-administered drugs under the medical benefit with the exception of provider-administered drugs for members with coverage under the OhioRISE program and those dispensed by a pharmacy.

For prescriptions and products covered through the SPBM, prior authorization may be required before a claim will be accepted. Refer to the United Preferred Drug List (UPDL) located at spbm.medicaid.ohio.gov to determine which drugs need prior authorization. Providers may submit a prior authorization directly to Gainwell Technologies through one of the following methods:

Phone:
1-833-491-0344 The Call Center is open 24 hours per day and seven days per week.

Fax:
833-679-5491

Mail:
Gainwell Technologies
OH SPBM
P.O. Box 3908
Dublin, OH 43016-0472

Portal:
spbm.medicaid.ohio.gov

74   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Medications Administered in the Provider Setting

Medications that are administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center will be billed per Ohio Administrative Code 5160-26-13.

For claims for pharmaceuticals that are dispensed by pharmacy providers, prior authorization and claims billing should be through the SPBM. For all other provider types, claims for pharmaceuticals are billed through CareSource for CareSource members or in accordance with rule 5160-59-03 of the Administrative Code for individuals enrolled in the OhioRISE plan.

Prior authorization (PA) requirements exist for drugs administered in the provider setting. Refer to the Procedure Lookup Tool to determine which drugs need prior authorization. The Procedure Code Lookup Tool is located at
CareSource.com > Providers > Provider Portal > Prior Authorization.

Prior Authorization

Prior authorization (PA) requests for provider-administered drugs billable to CareSource may be submitted electronically through the CareSource Provider Portal or by fax at 888-399-0271.

CareSource processes Medicaid prior authorization requests in accordance with Ohio Medicaid regulations. A prior authorization requires that a drug be preapproved for it to be covered under a health benefit. CareSource's Pharmacy staff will adhere to the Ohio Administrative Code (OAC) and determine medical necessity for requests that will be reviewed based on drug-specific prior authorization criteria. Providers will be required to submit pertinent medical or drug history, prior treatment history and any other necessary supporting clinical information with the request.

Medication Therapy Management Program

CareSource offers a medication therapy management (MTM) program for all members. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs and provide health care to patients in a cost-effective manner. You may be contacted by a pharmacist to discuss your patients' medications. We also encourage members to talk with their pharmacist about their medications, as we want to make sure they are getting the best results from the medications they are taking.

Specialist Referrals

Generally, CareSource does not require referrals or PA before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, PAs are needed before CareSource will pay for services from out-of-network providers, except in cases of emergency.

Referral Procedures

Any treating doctor can refer CareSource members to specialists. Simply put a note about the referral in the patient's chart. Please remember, nonparticipating specialists require PA for any services rendered to CareSource members.

A referral is required for specialty services not listed below and for plan members to be evaluated or treated by most specialists. Any treating provider can refer CareSource members to specialists. Please refer to our website for more information on services that require a referral. Simply put a note about the referral in the

patient's chart. Please remember, nonparticipating specialists must request PA for any services rendered to CareSource patients.

You can submit a PA request on the CareSource Provider Portal at **CareSource.com** > Login > Provider.

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: **1-800-488-0134**.

Services That Do Not Require a Referral

Some health care services provided by specialists do not require a referral from a PCP or dental provider. Members may schedule self-referred services from participating providers themselves, provided the service is covered under their specific plan. Note that although CareSource does not require members obtain referrals for the providers below, some 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 benefits limits have not been exhausted. These include the following:

- Certified nurse midwife services
- Certified nurse practitioner services
- Chiropractic care (within benefit limits)
- Dental care (excluding oral surgery and orthodontics)
- Services to treat an emergency
- Family planning services (e.g., Planned Parenthood)
- Laboratory services (must be ordered by a participating provider)
- Podiatric care
- Psychiatric care at Community Behavioral Health Centers (CBHCs) only
- Psychological care (from private providers or at CBHCs)
- 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)
- Routine eye exams (at participating vision centers, within benefit limits)
- Care from obstetricians (OBs) and gynecologists (GYNs)
- Care at urgent care centers after hours
- Services for children with medical handicaps

Please visit **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization for the most up to date list of services requiring prior authorization.

Members May Go to Nonparticipating Providers For:

- Emergency care
- Family planning services provided at qualified family planning providers (e.g., Planned Parenthood)
- Care at CBHCs and RHCs
- Care at Ohio Department of Mental Health and Addiction Service (ODMHAS) facilities that are Medicaid providers

76   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Referral Requirements

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.

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. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period must be at least one year to be considered a standing referral. Members who meet the definition of Children with Special Health Care Needs (CSHCN) may access specialty care providers directly by a standing referral.

Referrals to Out-of-Plan Providers – A member may be referred to out-of-plan providers 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 PA from our health plan 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. However, providers or members may request a second opinion at no additional cost to the member if the service was obtained in network.

The following criteria should be used when selecting a provider for second opinion:

- The provider must be a participating provider. If not, PA 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.

Transportation

Contact Information

CareSource provides our Medicaid members transportation services through Provide A Ride. To arrange transportation for a Medicaid member, providers may call Provider A Ride's Facility Line at 1-833-297-3064 (TTY 1-800-750-0750).

Members should contact CareSource's member services by calling **1-800-488-0134** (TTY 711) to schedule rides.

Policies and Coverage

Transportation can be provided for covered appointments, Women, Infants and Children (WIC) appointments and Medicaid redetermination appointments with the County Department of Job and Family Services (DFJS). If a member must travel 30 miles or more to a covered appointment, CareSource will provide transportation. The enhanced transportation benefit is limited to 15 round-trip visits (30 one-way trips) annually per member for Medicaid. Members who have exhausted their transportation benefit are referred to their county's non-emergency transportation (NET) program for future trip needs. Transportation is provided at no cost to the member. Members can arrange transportation by calling the Member Services phone number on their ID card and requesting transportation. Members receive information upon enrollment that indicates how far in advance they need to plan.

78 Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Transportation Services for Members Enrolled in OhioRISE

CareSource must arrange and provide transportation for members who are enrolled with the OhioRISE plan in a manner that ensures that children, youth, and their families served by the OhioRISE plan do not face transportation barriers to receive services regardless of Medicaid payer. CareSource is responsible for arranging transportation in cases where transportation of families, caregivers, and sibling(s) (other minor residents of the home) is needed to facilitate the treatment needs of the member, even when the member is not being transported.

SECTION VII – UTILIZATION MANAGEMENT

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The UM department performs activities such as: PA, preservice review, urgent concurrent review, post-service 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 and refer members to CareSource's case management, if needed. CareSource's UM criteria are available in writing by mail, fax or email and via the web.

Phone
1-800-488-0134

Fax
888-752-0012

Mail
CareSource
P.O. Box 1307
Dayton, OH 45401

Services that Require Prior Authorization

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.

Inpatient psychiatric prior authorization requests for members under the age of 21 should be submitted to the OhioRISE Plan. CareSource will deny these authorization requests because this service is covered by another payer.

Ordering physicians must obtain a PA for the following outpatient, non-emergent diagnostic imaging procedures:

- MRI/MRAs

- CT/CTA scans

- PET scans

These services require a PA from NIA Magellan. Providers can obtain PA from NIA Magellan for an imaging procedure in the following ways:

- Online – www.radmd.com

- By Phone – 1-800-424-5660 (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.

In addition, any provider who is not a participating provider with CareSource must obtain PA for all nonemergency services provided to a CareSource member.

CareSource does require PA for unlisted procedure CPT codes. It requires a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code. Submission of clinical information does not guarantee payment.

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. To avoid claim denials providers need to submit supporting clinical documentation with the claim submission.

Synagis Prior Authorization

CareSource's 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 an extension possible if RSV is still in the community. Requests for Synagis injections can be submitted on our secure provider portal.

Prior Authorization Process

CareSource utilizes the Provider Portal for the prior authorization process. Visit **CareSource.com** > Login > <u>Provider Portal</u>.

Authorization Determination Time Frames

CareSource's time frames to make authorization determinations vary depending upon the member's health condition, completeness of submission information and state requirements.

Review Type	Determination Time Frame	Extension	Notification Time Frame
Initial Inpatient	72 hours/3 calendar days from receipt of request		72 hours/3 calendar days from receipt of request
Concurrent/ Continued Stay Review	72 hours/3 calendar days from receipt of request		72 hours/3 calendar days from receipt of request
Pre-Service Urgent	48 hours from receipt of request	May extend the time frame for 14 calendar days for the member or member's representative to provide additional information in cases where the information provided initially fails to provide sufficient information to determine whether or to what extent, benefits are covered or payable. Notification of the benefit determination is made as soon as possible but no later than 14 calendar days after the earlier of the receipt of the additional information or the end of the period afforded the member or member's representative to provide the specified additional information.	Within 48 hours of receipt of request. Within 14 calendar days of receipt of request when an extension is taken.
Standard Pre-Service	10 calendar days from receipt of the request	May extend time frame once due to lack of information, for up to 14 calendar days, if the member requests the extension. Must notify the member and member's authorized representative of decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension time frame.	Within 10 calendar days of receipt of request. Within 14 calendar days, if extension is granted
Retrospective	Within 30 calendar days from receipt of request		Within 30 calendar days of receipt of request

Peer-to-Peer Consultations

Providers may request a peer-to-peer consultation when CareSource denies a prior authorization request. The peer-to-peer consultations will be conducted amongst health care professionals who have clinical expertise in treating the members' condition, with the equivalent of higher credentials as the requesting/ordering provider. The peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon the accepted clinical guidelines.

CareSource provides the opportunity for providers to discuss the UM medical necessity determination of a denial or decrease in level of care with CareSource's Medical Director/Behavioral Health Medical Director or designee within five business days of the notification of the determination. The peer-to-peer process is independent of the process and does not impact the time frame a member and/or provider has to appeal.

To initiate the peer-to-peer process, please call CareSource's Utilization Management team at **1-833-230-2168**.

Provider Appeals

Providers may request a provider appeal if CareSource denies a prior authorization request in accordance with ORC 5160.34. The provider appeal is separate from the peer-to-peer or member appeal processes. Provider appeals will be responded to within forth-eight hours for urgent care services and within ten calendar days for all other matters.

External Medical Review

The review process is conducted by an independent, external medical review entity that is initiated by a provider who disagrees with a managed care organization's (MCO's) decision to deny, limit, reduce, suspend, or terminate a covered service for a lack of medical necessity.

In the Next Generation Medicaid managed care program, the EMR will be conducted by Permedion. This vendor has a contract with ODM to perform the EMR.

To request an EMR, providers must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the MCO's internal provider appeal or claim dispute resolution process. Failure to exhaust the MCO's internal appeals or claim dispute resolution process will result in the provider's inability to request an EMR.

EMR is only available to providers for services delivered to members enrolled in Medicaid managed care and/or OhioRISE. The EMR process is not currently available in the MyCare Ohio and Single Pharmacy Benefit Manager (SPBM) programs.

An EMR can be requested by a provider as a result of:

- An MCO's service authorization denial, limitation, reduction, suspension, or termination (includes pre-service, concurrent, or retrospective authorization requests) based on medical necessity; or

- An MCO's claim payment denial, limitation, reduction, suspension, or termination based on medical necessity.

Denials, limitations, reductions, suspensions, or terminations based on lack of medical necessity include, but are not limited to decisions made by the plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent, and retrospective reviews).

- Clinical judgment or medical decision making (i.e., referred to a licensed practitioner for review) is involved.

- A clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC 5160-1- 01, including EPSDT criteria, and/or the MCO's clinical coverage or utilization management policy or policies) is not met.

MCOs are required to notify providers of their option to request an EMR as part of any denial notification.

Requesting EMR:

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or provider claim dispute process has been exhausted.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located at www.hmspermedion.com (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from MCO (initial and appeal)

- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing case.

Providers must upload the request form and all supporting documentation to Permedion's provider portal located at ecenter.hmsy.com (new users will send their documentation through secured email at IMR@ gainwelltechnologies.com to establish portal access).

Note: When requesting an EMR, providers may submit new or other relevant documentation as part of the EMR request.

If the MCO determines the provider's EMR request is not eligible for an EMR and the provider disagrees, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with the provider's right to request a peer-to-peer review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions.

Once the provider has submitted the EMR request, they do not need to take further action.

The EMR Review:

After the EMR request has been submitted, Permedion will share any documentation from the provider with the MCO. Following its review of this information the MCO may reverse its denial, in part or in whole. If the MCO reverses any part of its decision the provider will receive a written decision within one business day for expedited prior authorization requests and five business days for standard prior authorization requests and notify the EMR entity. If the MCO decides to reverse its decision in part, the remaining will continue as an EMR.

Permedion has 30 calendar days for a standard request and three business days for an expedited request to perform its review and issue a decision.

- If the decision reverses the MCO's coverage decision in part or in whole, that decision is final and binding on the MCO.

- If the decision agrees with the MCO's decision to deny, limit, reduce, suspend, or terminate a service, that decision is final.

For reversed service authorization decisions, the MCO must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the MCO receives the EMR decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the MCO must pay for the disputed services within the timeframes established for claims payment in Appendix L of the Provider Agreement.

For more information about the EMR, please contact Permedion at 1-800-473-0802, and select Option 2.

How to Request External Medical Review

External review requests can be submitted in writing through the Provider Portal or via fax.

- **Provider Portal:** Log into the Provider Portal and go to the Appeals page

- **Fax:** 844-676-0366

Medical Necessity Criteria

CareSource utilizes nationally recognized criteria, MCG, to determine medical necessity and appropriateness of services. These criteria are designed to assist providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients. CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services.

CareSource also has a medical policy developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the applicable criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available within five business days of decision to discuss individual cases with attending physicians upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward 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 may request the information by calling or faxing the CareSource UM department. If you would like to discuss an adverse decision with CareSource's physician reviewer, please call the UM department within five business days of the determination at **1-800-488-0134.**

Access to Staff

Providers may call Provider Services to contact UM staff with any questions at **1-800-488-0134**.

Staff Availability

- Staff members are available via the toll-free telephone line or direct dial telephone number from 8 a.m. to 5 p.m. Eastern Time (ET) Monday through Friday for inbound calls regarding UM issues.

- Staff members can receive inbound communication regarding UM issues after normal business hours. Providers may leave voice mail messages on these telephone lines after business hours, 24 hours a day, seven days a week. A dedicated fax line and Provider Portal for medical necessity determination requests are available 24 hours a day, seven days a week.

- 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.

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 physical and behavioral health care providers.

SECTION VIII – CLAIMS INFORMATION

Process and Requirements for the Submission of Claims and Link to PNM System

ODM Provider Network Management System Direct Data Entry

Before submitting claims, it is critical to validate the eligibility of the member receiving service and verifying that provider information is accurately reflected in ODM's PNM system. Information such as provider enrollment status and the association with the billing group.

Providers may submit eligibility inquiries through the Provider Network Management (PNM) system: managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing.

ODM's expectation is that for each Medicaid provider, CareSource, system and data are current and consistent with information held by ODM's system of record, the PNM system. Therefore, it is important that providers keep their records up to date in ODM's PNM system. With the PNM system as the ODM's system of record, MCOs have been instructed to direct providers to update their ODM record in the PNM system when discrepancies are identified between the MCO's data and the PNM PMF. CareSource is instructed by ODM to not accept changes from providers into their own systems that are inconsistent with PNM system data shared through the PNM for their Medicaid line of business.

Electronic Date Interchange (EDI) Submission of Provider Claims

Providers may submit claims, eligibility inquiries, claim status inquiries and using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM-authorized TP: medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners.

Providers submitting claims through an ODM-authorized TP must utilize the CareSource ODM Payer ID, '0003150' to ensure appropriate routing of the claim records.

Portal Submission of Provider Claims

Providers may also electronically submit claims through CareSource Provider Portal. The portal provides the ability to manually key claim data elements through its intuitive screen layout or upload claims written or keyed into a standard claim form that is saved on the user's computer network. In addition to the first claim entry, providers can submit claim corrections and void request through the interface.

CareSource Portal Access: Claims | Ohio – Medicaid | CareSource

Paper Submission of Provider Claims

Providers unable to submit electronically can submit claims via mail using standard claim billing forms. The CMS-1500 claim form is utilized for submission of Professional claims while the UB-04 (also known as the CMS-1450) form is used for Institutional claims. Paper claims may be sent using standard or certified mail to:

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

Timely Filing Requirements

Providers will have 365 days to timely file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim.

For claim denials, providers must adhere to the following time frames for submitting a dispute:

- If the claim is denied, providers may file a claim dispute. Refer to the Claim Dispute Process section for further information.

Claim Processing Guidelines

- Providers have 365 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after 365 calendar days, the claim will be denied for timely filing.

- If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment within 365 calendar days of the original date of service.

- 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 90 calendar days 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.

Monitoring Claims

Per 42 CFR 455.20, CareSource has a responsibility to monitor services billed by providers and to verify the receipt of such services with our members. This is accomplished through various methods included Explanation of Benefit mailings, data analytics and follow up calls to members when discrepancies are found. Providers should ensure they are billing for services appropriately to support this process.

Checking Claim Statuses

Claim statuses are updated daily on our Provider Portal, 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 or patient number.

Additional Claim Enhancements on the Provider Portal

- Claim history available up to 24 months from the date of service
- Submission of claim appeals
- Reasons for payment, denial or adjustment
- Checking for numbers and dates
- Procedure/diagnostic
- Claim payment date
- Dental claim information
- Submission of attachments for denied claims
- Easy submission for corrected claim when the claim was submitted online via the portal
- Accessibility to claim recovery letters

Electronic Funds Transfer

CareSource offers electronic funds transfer (EFT) as a payment option. We work with ECHO Health Inc. as our claims processing vendor. Visit the Provider Portal for additional information about the program and to enroll in EFT. Providers who elect to receive EFT payment will receive an EDI 835 (electronic remittance advice). Providers can download their explanation of payment (EOP) from the Provider Portal or receive a hard copy via the mail.

Benefits of EFT:

- **Simple** – Receive fully reconciled remittances electronically; eliminate paper checks and EOPs, which will increase efficiency with payment processing.

- **Convenient** – Available 24/7; free training is also offered for providers.

- **Reliable** – Claim payments electronically deposited into your bank account.

- **Secure** – Access your account through CareSource's secure Provider Portal to view (and print if needed) remittances and transaction details.

- **Enhanced Information** – Receive member specific third-party liability (TPL) information.

Please Note: TPL/coordination of benefits (COB) information can be found in loop xxx/segment xxx on the 835 file.

CareSource provides TPL/COB information for EFT. This can be found in segment 2100 Claim Payment Information and loop 2110 Service Payment Information on the 835 file in this format:

- NM1*PR*AETNA US HEALTHCARE
- NM1*GB*1*YARBORO*JUSTIN

90   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

- REF*6P*W246632770

- The NM1*PR (COB carrier), NM1* GB (other subscriber information from other payer) and REF*6P (other insurance group number)

To enroll in EFT, complete the enrollment form, available on **CareSource.com** > Providers > <u>Claims</u> and fax it back to our payment processing vendor, ECHO Health Inc. Providers may also call ECHO support at 1-888-834-3511 for assistance with registration.

Member Billing Policy

State and federal regulations prohibit providers from billing CareSource Medicaid members for services provided to them except under limited circumstances. CareSource monitors this activity based on reports of billing from members. We will implement a stepped approach in working with our providers to resolve any member billing issues that includes notification of excessive member complaints and education regarding appropriate practices.

A Medicaid recipient cannot be billed when a medical claim has been denied for any of the following reasons: unacceptable or untimely submission of a claim; failure to request a prior authorization; or a retroactive finding by a peer review organization (PRO) that rendered services was not medically necessary.

Failure to comply with regulations after intervention may result in potential termination of your agreement with CareSource.

Regulations on Billing Medicaid Members

Federal regulations as well as the Medicaid Addendum, part of your executed contract with CareSource, prohibit providers from billing members except in very limited situations. To bill a member all the following must have occurred:

- Provider has submitted a prior authorization request to CareSource and CareSource has denied the prior authorization request.

- After receipt of denial and prior to rendering the services the provider has notified the member, in writing, of the financial liability to the member should member elect to proceed with the services.

- The written notification must be specific to the services to be provided and clearly state the member is financially responsible for the specific service. A general patient liability statement signed by all patients at your practice does not meet this requirement.

- The written notification must be signed and dated by the member; date must be prior to date of service.

In compliance with federal and state requirements, CareSource Medicaid members cannot be billed for missed appointments. CareSource encourages members to keep scheduled appointments and call to cancel, if needed. CareSource provides transportation for many doctor's visits to help ensure our member make it to needed appointments.

Providers should call Provider Services for guidance to determine if billing members for any services is appropriate. You can reach Provider Services by calling **1-800-488-0134**.

Payment in Full

CareSource requires providers to accept the amount paid by CareSource or the denial made by CareSource, and in addition, any applicable co-payment or patient liability amount due from the member as payment in full for the service. Except for collecting member copayments, providers may not charge members or ODM any additional copayment, cost sharing, down payment or similar charge, refundable or otherwise.

A provider may bill a Medicaid recipient for a Medicaid covered service in lieu of submitting a claim to the Ohio Department of Medicaid (ODM) only if all of the following conditions are met:

(1) The provider explains to the Medicaid recipient that the service is a covered Medicaid service and other Medicaid providers may render the service at no cost to the individual;

(2) Prior to each date of service for the specific service rendered, the provider notifies the Medicaid recipient in writing that the provider will not submit a claim to ODM for the service;

(3) The Medicaid recipient agrees to be liable for payment of the service and signs a written statement to that effect before the service is rendered; and

(4) The Medicaid covered service is not a prescription for a controlled substance as defined in section 3719.01 of the Revised Code.

(D) Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by ODM, may be billed to a Medicaid recipient when the conditions in paragraphs (C)(2) t o (C)(4) of this rule are met.

(E) Any individual not covered by Medicaid on the date of service is financially responsible for those services unless the individual qualifies for the hospital care assurance program (HCAP) in accordance with section 5168.14 of the Revised Code.

Claim Dispute Process

• Provider claim disputes are any provider inquiries, complaints, appeals, or requests for reconsideration ranging from general questions about a claim to a provider disagreeing with a claim denial. Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. Providers may submit claim disputes verbally or in writing, including through the Provider Portal.

External Medical Review After exhausting CareSource's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of this manual.

92   Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

SECTION IX – CARE COORDINATION/ CARE MANAGEMENT

Care Management/Outreach

CareSource offers members the ability to direct their own care with the support of effective case management, a diverse provider network and an enhanced system of community stakeholder relationships specially crafted to a member's unique needs. CareSource's model of care focuses on an empowerment approach to improve quality, access and effectiveness that coordinates comprehensive care needs and preferences to improve member health outcomes. CareSource empowers members of all ages to direct their own care through provision of on-demand tools to learn about a condition, connect with local services and resources, and by streamlining support through care coordination.

The purpose of the CareSource Integrated Care Management (CM) program is to proactively identify and manage members with a mixed acuity of needs; including members who prospectively need to address preventive health/wellness opportunities to those at high risk for complex, chronic, and costly physical health, behavioral health and psychosocial needs. Regardless of a member's biopsychosocial needs or placement on the care continuum, our Integrated Care Management program builds on strength-based capabilities to enable members to improve their own quality of life.

CareSource encourages you to take an active role in your patient's care management program through the Member Profile feature of the provider portal. The profile provides information on pharmacy 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 participate in the development of a care plan individualized to the needs of your patient. We believe communication and coordination are integral to ensure the best care for these patients.

We offer individualized education and support for many conditions and needs, including, but not limited to:

- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Members with special health care needs
- Behavioral health needs

To make a patient referral to the CareSource Care Coordination team, please call 1-844-438-9498.

Care Management

CareSource provides care management services, delivered by medical and behavioral health nurses, social workers counselors, community health workers 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 non-compliant patients, reinforcing medical instructions and assessing social and safety needs, as well as educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many conditions.

Direct Access for Medicaid

Direct access for care management referrals and assistance with member needs is available at 1-800-993-6902.

Care Management of Complex Members

CareSource provides a community-based care coordination model for our highest-risk members. Utilizing nurses, social workers and community health workers, this multi-disciplinary approach integrates the Case Management Society of America (CSMA) Standards of Practice utilizing "Community Health Workers" to help patients overcome health care access barriers. It also strengthens our provider and community resource partnerships through collaboration.

Our services include face-to-face meetings, when appropriate, 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 complex-risk members served by this model may have multiple medical issues, socioeconomic challenges and behavioral health care needs.

CareSource encourages you to take an active role in your patients' care coordination programs and participate in the development of individualized care plans to help meet their needs. You are also encouraged to participate in interdisciplinary care team (ICT) meetings to coordinate the self-identified member care preferences and goals. Together, we can make a difference.

94   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Perinatal Care Management

CareSource's perinatal and neonatal care management programs utilize a multi-disciplinary team with extensive OB and 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.

We encourage our prenatal care providers to notify our care management department at 1-833-230-2034 when a member with a high-risk pregnancy has been identified. Care Management staff is notified of medically complex infants at the time of admittance to the neonatal intensive care unit.

Disease Management Program

Our free disease management programs help 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

- Materials with helpful tips and information to manage their condition

- Coordination with outreach teams

- One-to-one care management (if they qualify)

Members with specific disease conditions such as asthma, diabetes or hypertension are identified by criteria or triggers, such as emergency room visits, hospital admissions or the health assessment. These members are automatically mailed 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 and outreach.

Benefits to Members and Providers

Members identified in a 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. Programs improve the percentage of CareSource members who receive their recommended screenings.

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 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 provided.

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.

96   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

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. Members are informed to call 911 or go to the nearest emergency room (ER) if they feel they have an emergency. CareSource covers all emergency services.

We instruct members to call their primary care provider (PCP) or the CareSource24 nurse advice line if they are unsure if they need to go to an ER. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. We offer enhanced reimbursement to PCP offices for holding evening or weekend hours to help ensure that our members have alternatives other than the ER available to them when they need medical care outside of normal business hours.

Member ER utilization is tracked closely. If there is frequent ER 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.

Provider Care Coordination Roles and Responsibilities

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 case management

Care Coordination Delegation

CareSource remains accountable for all delegated functions and performs oversight of the arrangement. Through ongoing market review of best-in-class community and provider-based services, we will identify potential delegates for incorporation into the model.

When a delegate is identified and contracted, a pre-delegation assessment is the process by which CareSource evaluates a potential vendor or provider's capability to manage and perform delegated functions in accordance with state and federal laws, rules and regulations; accreditation organization standards; and CareSource business requirements. The evaluation is done prior to the effective date of the delegation and assess multiple areas including but not limited to the vendor's infrastructure, policies and procedures and tools and systems.

Upon delegation, oversight includes review and evaluation of monthly reports and quarterly Joint Operating Committee meetings. A complete evaluation of the delegate is conducted annually or more frequently as needed to review the overall quality of care coordination. Any opportunities for improvement identified during the annual review require a corrective action plan or ongoing oversight. Care coordination oversite audits are conducted monthly upon initial delegation, then quarterly once proficiency is obtained. Delegation oversight is provided through the Enterprise Quality team and Oversight team, as well as Ohio Market Care Coordination. Audit findings, care coordination operational reports, and corrective actions are reported to the Ohio UM CM Committee.

Upon receipt, CareSource will adhere to timelines for the development of collaborative agreements aligning with the requirements and stipulations set by ODM.

Coordinated Services Program (CSP)

CSP is a health and safety program in which use of abuse potential drugs is monitored and member claims are reviewed for potential assignment to a designated pharmacy. Please visit https://medicaid.ohio.gov/stakeholders-andpartners/phm/csp/csp for additional information.

98   Visit CareSource's provider portal for many time-saving,
self-service features at **ProviderPortal.CareSource.com**

CareSource.com

SECTION X – REPORTING

Member Medical Records

Confidentiality

CareSource complies with the Privacy Rule and the HITECH Act which relate to the privacy and security of protected health information, as well as all related regulations, including 45 CRF Parts 160 and 164. In compliance with federal law, CareSource is required to comply with the provisions of this policy so that the rights afforded to members under HIPAA are provided to them.

Access to Medical Records

Member Rights

CareSource members are informed of how CareSource uses and discloses member Protected Health Information (PHI) in accordance with the CareSource Notice of Privacy Practices (NPP). Members are informed via the NPP of their rights, including the right to get a copy of health and claim records and the right to ask us to fix their health and claim records.

Except in certain circumstances, members have the right to review and obtain a copy of their PHI. Because there are some exceptions to the member's right to have access to PHI, CareSource may deny a member access in those specified situations. Requests must be received in writing, and members are informed of this requirement upon their request.

Personal Representatives

The HIPAA Privacy Rule requires CareSource and its business associates to treat a personal representative the same as the member, with respect to uses and disclosures of the member's PHI, as well as the member's right to access. However, CareSource and its business associates do not have to treat the personal representative the same as the member for purposes of access in the situation where CareSource has reasonable belief that the personal representative may be abusing or neglecting the member or treating the person as the personal representative could otherwise endanger the member.

Response

When a written request for access is received, notice of approval or denial of the request must be sent to the requestor no later than 30 days from receipt of the request. When a written request for access is received, the reviewer must, to the extent possible, grant the member's request for access to the information sought after excluding or redacting the information for which there is a ground to deny access.

If CareSource is unable to process a request for access within the required 30 days, CareSource may take one 30-day extension. The member must be notified of the extension in writing, and the notice must be sent before the original 30 days have lapsed. CareSource can only take one extension and the notice must inform the member of the reasons for the extension and the date by which CareSource intends to respond.

After review and within the applicable response time defined above, the requestor shall be notified of the determination.

Grounds to Deny in Whole or Part

If, after review of the request, any of the following circumstances exist, the request should be denied in part or in total, as appropriate, and notice provided accordingly:

- Part or all of the access request relates to a record that is not maintained by CareSource.

- Part or all of the access request relates to information or a record that is not part of the member's designated record set.

- Part or all of the access request relates to psychotherapy notes.

- Part or all of the access request relates to information that has been compiled in anticipation of or for use in a civil, criminal or administrative proceeding. This would include any documents marked "Attorney-Client Privileged" or similar.

- Part or all of the access request relates to information that is not accessible pursuant to the Clinical Laboratory Improvements Act.

- Part or all of the access request relates to information created or obtained by us in the course of research still in progress that includes treatment of the member and the member agreed to the denial of access when consenting to participate in the research.

- Part or all of the access request relates to information obtained by us from a non-health care provider under a promise of confidentiality and access would likely reveal the source of the information. Part or all of the access request to Protected Health Information is contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, if the denial of access under the Privacy Act would meet the requirements of that law.

- A licensed health care professional has determined that part or all of the access requested is reasonably likely to endanger the life or physical safety of the member or another person.

- Part or all of the access request relates to information that refers to another person (unless such other person is a health care provider) and a licensed health care professional has determined that the access requested is reasonably likely to cause substantial harm to such other person.

- The request for access is made by the member's personal representative and a licensed health care professional has determined that access by such personal representative is reasonably likely to cause substantial harm to the member or another person.

100 Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Providing the Information

Under certain circumstances, members may request a review of the denial of their request. All such member requests for review should be directed to the Privacy Office.

Providing the Information. CareSource shall provide the approved access request in the form or format requested by the member, if readily producible in such form.

Otherwise, CareSource shall provide the information in a readable hard copy or such other form as is agreed to by the member. The member has the right to receive a copy by mail, by email upon request, may request to pick up at their nearest CareSource office. The member also has the right to come the nearest CareSource office to inspect their information.

The member has the right to direct that the copy be transmitted directly to an entity or person designated by the member, provided that any such designation is clear, conspicuous and specific with complete name and mailing address or other identifying information. If the copy is to be picked up onsite by the designee, full identification must be provided. If the copy is to be emailed, the email address must be verified before the transmission, either by sending a test email or telephoning the recipient to verify the address.

Amendments and Corrections to Medical Records

Members' requests to amend information contained in their designated record set will be honored in accordance with the HIPAA Privacy regulations.

Requests for amendments, whether from the member or another covered entity (provider, pharmacy, etc.) must be submitted in writing.

CareSource is not required to approve amendments in certain circumstances:

- **Amendment Request Form Not Signed and/or Does Not State a Reason for the Amendment Request.** In these cases, the request will not be further processed. The form should be noted accordingly, logged and tracked electronically. Notice of denial must be provided to the requestor within 60 days of the receipt of the amendment request.

- **Amendment Request Form Signed by a Member's Representative and Authority Not Documented.** If the amendment request is signed by a member's representative, the representative must include documentation or information to support his/her authority to act for the member. If such information, in accordance with our HIPAA Privacy- Uses and Disclosures of PHI, is not included, the request does not need to be further processed. The form should be noted accordingly, logged and tracked electronically. A denial notice must be provided to the requestor within 60 days of the receipt of the amendment request.

- **The Amendment Request Relates to a Record that was Not Created by CareSource.** It must be determined whether the amendment request relates to a record that was created by CareSource. If it was not created by CareSource, the form should be noted accordingly, logged and tracked electronically. The requestor must be notified of the denial within 60 days of the receipt of the amendment request. The denial notice should indicate to the member where the amendment request should be sent (i.e. the creator of the record), if known. Note that in those cases where the record was not created by CareSource, we will process the request if the member has provided credible information that the originator of the record is no longer available to act on the request.

- **The Amendment Request Relates to Information or a Record that is Not Part of the Designated Record Set.** If the amendment request relates to information or a record not within the member's Designated Record Set, the form should be noted accordingly, logged and tracked electronically. The requestor must be notified of the denial within 60 days of the receipt of the amendment request indicating that the record is not part of the Designated Record Set.

- **The Amendment Request Relates to Information that the Member is not Authorized to Inspect by Law.** If the amendment request relates to information or a record that the member is not authorized by law to inspect, the form should be noted accordingly, logged and tracked electronically. The requestor must be notified of the denial within 60 days of the receipt of the amendment request indicating that because the record is not available by law for the member to inspect, it is also not available for amendment. CareSource is not required to accept amendments to records that the member would not have the right to inspect. These include psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.

If, after consultation with the author of the record or information in question, it is determined that the record is accurate or complete as written and does not require amendment, that fact should be noted on the form accordingly. The requestor must be notified of the denial within 60 days of the receipt of the amendment request indicating that the record is complete and accurate as written.

If, after consultation with the author of the record, it is determined that the amendment request is appropriate, that fact should be noted on the form. The requestor must be notified of the approval within 60 days of receipt of the amendment request indicating that the amendment has been accepted and the records amended as requested.

Reporting Provider Preventable Conditions/Health Care-Acquired Condition

Definition

CareSource defines health care-acquired conditions (HACs) and provider preventable conditions (PPCs) according to 42 CFR § 447.26.

Identification of PPCs

CareSource identifies PPCs/health care acquired conditions from claim reporting and reviews a list on a quarterly basis. The events confirmed by medical records not to be present in admission, get submitted to the Provider Advisory Council (PAC) for review and potential development of Corrective Action Plans (CAPs). Providers are expected to submit their PPCs utilizing a form on the CareSource Provider Portal. You can access the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

Reimbursement of PPCs

CareSource does not use Medicaid funding to pay for services resulting from a PPC, in accordance with 42 CFR 447.26. Diagnoses identified as PPCs (based on present on admission data) are excluded from calculation of the claim DRG and are thereby excluded from reimbursement. These claims are also subject to post-payment review during DRG Validation audits. CareSource ensures that the prohibition on payment for PPCs does not result in a loss of access to care or services for our members.

102 Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

Reporting PPCs

In accordance with 42 CFR 438.3(g), CareSource identifies and reports all PPCs, regardless of the provider's intention to bill for that event, to ODM in the manner specified by ODM.

Response to Undelivered, Inappropriate or Substandard Health Care Services

CareSource's Enterprise Quality Improvement (EQI) department is responsible for investigating, processing and tracking quality of care (QOC) issues. EQI maintains policies and procedures to address quality of care issues which have the potential to negatively impact member health, safety and welfare. These events include:

- Inappropriate, inconsistent, substandard and delayed delivery of health care treatment and services

- Adverse events or outcomes

- Sentinel events which occur in facilities that cause death, permanent harm or severe temporary harm

The EQI Clinical Quality Analyst team consists of registered nurses who collect and review relevant data and evaluate a potential quality of care issue. The Analyst often assigns a severity level using CareSource's internal severity leveling system. When review of a case determines proper standards of care were not met, or determines the case to be complex in nature, the Analyst refers the case to a designated panel of Medical Directors for review.

Medical Director review may result in CareSource initiating mitigation with the provider, including:

- Review at the Ohio Provider Advisory Committee (PAC)
  - Institution of peer review activities, for example correction action plans (CAPs) or performance improvement projects (PIPs)

- Notification of the Credentialing committee

- Reporting of findings to the Program Integrity department

- Reporting to regulatory agencies or other appropriate authorities, if required

CareSource's EQI tracks QOC issues and documents case outcomes. Information is shared on a regular basis with the appropriate internal quality committees.

Health, Safety and Welfare

The CareSource HSW Program ensures that member safeguards and processes are in place that detect, prevent and mitigate member harm and/or risk factors. The HSW Rapid Response Team (RRT) exists to mitigate and resolve urgent and emergency HSW events.

CareSource employees who identify an HSW risk situation, involving a member, will take steps to initiate services to mitigate and address the identified issues as expeditiously as the situation warrants.

Upon identification of a health, safety or welfare concern, team members follow department-specific procedures for intervention and documentation.

Incident Reporting

Providers are required to assure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500 and accidental/unnatural deaths. If actions were not taken to assure the immediate health and safety of the member, the provider will do so immediately. Such actions may include calling police or EMS, reporting to county Adult Protective Services (APS), the county Public Child Services Agency (PCSA) or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to CareSource within 24 hours of becoming aware of the incident in accordance with OAC rule 5160-44-05.

How to Submit an Incident to CareSource

Any provider-related concerns are relayed to the member's assigned Care Manager, who will report the incident per CareSource's internal processes. Per provider conditions of participation rules, providers are required to report any health and safety issues involving our waiver members within 24 hours of occurrence or discovery.

104 Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

SECTION XI – NEXT GENERATION MANAGED CARE PROGRAM

OhioRISE

OhioRISE (Resilience through Integrated Systems and Excellence) is a Medicaid managed care program for children and youth with complex behavioral health and multisystem needs. Children and youth with multisystem needs are often involved multiple community systems such as juvenile justice, child protection, developmental disabilities, education, mental health addiction, and others. OhioRISE aims to support these children and youth succeed in their schools, homes, and communities. This support is provided through care coordination and specialized services that are provided in-home or in the young person's community. An individual enrolled in OhioRISE has their physical health services covered by their managed care ganization or fee-for-service Medicaid. OhioRISE plan, Aetna Better Health of Ohio, covers their behavioral health services. The MCO is included in the child or youth's care coordination team, whenever their inclusion is requested by the member and mily. OhioRISE care coordinators can also help OhioRISE members and families access support from their MCO. CareSource is not required to cover behavioral health services for members enrolled in the OhioRISE Plan, except for certain behavioral health services in accordance with the OhioRISE Mixed Services Protocol developed by ODM.

OhioRISE Eligibility:

- Enrolled in Ohio Medicaid – either managed care or fee-for-service.

- Be twenty years of age or younger at the time of enrollment.

- Not be enrolled in a MyCare Ohio plan.

- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment or be inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder.

OhioRISE Services:

In addition to the behavioral health services provided through chapter 5160-27 of the Administrative Code, the following new services available through OhioRISE include:

- Care Coordination: Depending on a child or youth's needs, they will receive one of the three levels or "tiers" of care coordination. This service is delivered by Aetna or their care management entities (CMEs) in a child or youth's community. OhioRISE members are assigned a care coordinator who has experience working with children, youth, and their families. Care coordinators assist young people and their families with:

  - Making a care plan to ensure the young person's behavioral health needs are met.

  - Helping young people access services and resources.

  - Talking to and providing information to other providers who are involved in the child or youth's care.

- Intensive Home-Based Treatment (IHBT): Provides intensive, time-limited behavioral health services for children, youth, and families in their home. IHBT helps stabilize and improve a young person's behavioral health. Psychiatric Residential Treatment Facility (PRTF): PRTFs are facilities, other than hospitals, that provide inpatient psychiatric services to individuals 20 years or younger. Ohio's PRTF service aims to keep young people with the most intensive behavioral health needs in-state and closer to their families and support systems. Behavioral Health Respite: Provides short-term, temporary relief to a child or youth's primary caregiver(s) in a home or community-based environment.

- Flex Funds: Provides funding of $1,500 in a 365-day period to purchase services or items that address a need in a child or youth's service plan. These items should otherwise not be provided through Medicaid. Funds must be used to purchase services or items that will:

  - Reduce the need for other Medicaid services,

  - Keep young people and their families safe in their homes, or

- Help a child or youth be better integrated into the community. For additional services available for youth enrolled in the OhioRISE waiver see Ohio Administrative Code Rule 5160-59-05.

Additional information on the OhioRISE services is available in chapter 5160-59 of the Ohio Administrative Code.

Additional information regarding billing for behavioral health services provided to youth who are enrolled in the OhioRISE plan and information for providers to determine to which entity to submit claims is located in

106 Visit CareSource's provider portal for many time-saving, self-service features at **ProviderPortal.CareSource.com**

CareSource.com

the OhioRISE Provider Enrollment and Billing Guidance and the OhioRISE Mixed Services Protocol on the OhioRISE website.

Resources for Community Partners and Providers | Ohio Medicaid Managed Care

Aetna Better Health of Ohio can be reached by calling 833-711-0773 or emailing OHRise-Network@aetna.com.

Single Pharmacy Benefit Manager (SPBM)

The Single Pharmacy Benefit Manager is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that provides pharmacy benefits for the entire Medicaid Managed Care population (excluding MyCare members). ODM selected Gainwell Technologies to serve as the SPBM. An additional integral component to the new pharmacy model is the Pharmacy Pricing and Audit Consultant (PPAC), which conducts Ohio actual acquisition cost surveys, cost of dispensing surveys and perform oversight and auditing of the SPBM. ODM selected Myers and Stauffer, LLC to serve as the PPAC.

The SPBM consolidates the processing of retail pharmacy benefits and maintains a pharmacy claims system that integrates with the Ohio Medicaid Enterprise System (OMES), new MCOs, pharmacies and prescribers. The SPBM also works with pharmacies to ensure member access to medications, supporting ODM's goals of providing more pharmacy choices, fewer out-of-network restrictions and consistent pharmacy benefits for all managed care members. SPBM also reduces provider and prescriber administrative burden, by utilizing a single set of clinical policies and prior authorization procedures, as well as a single pharmacy program point of contact for all members.

All Medicaid managed care members are automatically enrolled with the SPBM under a 1915(b) waiver. Additionally, Gainwell Technologies is required to contract with all enrolled pharmacy providers who are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that will ensure access for all members statewide.

SPBM provides coverage for medications dispensed from contracted pharmacy providers. Provider-administered medications supplied by non-pharmacy providers (such as hospitals, clinics, and physician practices) will continue to be covered by the MCOs or the OhioRISE plan, as applicable.

For more information about the SPBM or PPAC initiatives, please visit managedcare.medicaid.ohio.gov/managed-care/single-pharmacy-benefit-manager/odm-spbm-ppac or email: MedicaidSPBM@medicaid.ohio.gov.

For more information on Gainwell Technologies SPBM services and processes for Ohio Medicaid, please visit: spbm.medicaid.ohio.gov.

For more information on the Pharmacy Pricing and Audit Consultant, please visit myersandstauffer.com/client-portal/ohio.

CareSource®