CareSource®

OHIO
HEALTH PARTNER MANUAL

MEDICAID AND CARESOURCE® MYCARE OHIO (MEDICARE-MEDICAID PLAN)

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

CareSource®
Health Care with Heart

DEAR CARESOURCE® HEALTH PARTNER,

Welcome to CareSource, and thank you for your participation. CareSource values our health partners and is actively working to strengthen our relationship to make it easier for you to deliver quality care to our members.

The CareSource Health Partner Manual is intended as a resource for working with our plan. The manual communicates policies and information about our programs. This manual also outlines key information such as claim submissions, reimbursement processes, authorizations, member benefits and more to make it easier for you to do business with us.

CareSource communicates updates with our network regularly on our secure Provider Portal at https://providerportal.caresource.com/OH/.

In an effort to better support our health partners and offer an immediate response to questions, concerns and inquiries, our organization offers claim, policy and appeals assistance through our call center by calling **1-800-488-0134**. If you have additional questions or concerns, you may ask to speak to a member of our Health Partner Services team by calling our toll free number. In addition, we offer face-to-face training on our health plans and health partner tools, as well as education on our quality metrics and value based reimbursement through our field-based Health Partnership team. You can schedule a visit from one of our Health Partnership team members with your organization by contacting us at HPSupport@caresource.com.

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

Sincerely,
CareSource

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CHAPTER 1: ABOUT CARESOURCE

Welcome, and thank you for participating with CareSource.

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

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

We are a nonprofit, community-based health plan that serves consumers of:

- Ohio Medicaid, including families with low incomes, children, pregnant women and people who are aged, blind or have disabilities. Ohio Medicaid also includes Healthy Start and Healthy Families.
- CareSource® MyCare Ohio, a managed care plan coordinating physical, behavioral and long-term care services for individuals over the age of 18 who are dually eligible for both Medicaid and Medicare.

Our goal is to create an integrated medical home for our members. We focus on prevention and partnering with local health partners to offer the services our members need to remain healthy.

As a managed health care organization, we improve the health of our members by utilizing a contracted network of high-quality participating health partners. 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. They ensure members have timely access to health care services and receive all appropriate preventive services.

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

- New members
- Existing members
- New practitioners
- Existing practitioners

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 health partners.

Vision and Mission

- Our vision is transforming lives through innovative health and life services.
- Our mission is to make 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 Include:

- Health partner services and support
- Member eligibility/enrollment information
- Claims processing
- Credentialing/recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory/compliance
- Special investigations for fraud, waste and abuse
- Member services call center

In addition to the above, our Care Management programs include the following:

- CareSource24® (nurse advice line)
- High-risk care management
- Onsite care management (clinics and facilities)
- Emergency department diversion
  - High emergency department utilization focus (targeted at members with frequent utilization)
- Health care home

- Maternal and healthy baby program
  - Dedicated neonatal intensive care unit (NICU) care management nurses
  - Outreach programs in partnership with community agencies to target members at greatest risk
- Care Transitions
  - Bridge to Home® (discharge planning and transitional care support)
- Disease management program for asthma and diabetes management

For more information on these programs, see the "Member Support Services and Benefits" section.

CareSource Service Area

CareSource serves Medicaid members in all counties in Ohio:

Ohio Medicaid

- **Central/Southeast Region:** Athens, Belmont, Coshocton, Crawford, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Knox, Lawrence, Licking, Logan, Madison, Marion, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington counties
- **Northeast Region**: Ashland, Ashtabula, Carroll, Columbiana, Cuyahoga, Erie, Geauga, Holmes, Huron, Lake, Lorain, Mahoning, Medina, Portage, Richland, Stark, Summit, Tuscarawas, Trumbull and Wayne counties
- **West Region:** Adams, Allen, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Defiance, Fulton, Greene, Hamilton, Hancock, Hardin, Henry, Highland, Lucas, Mercer, Miami, Montgomery, Ottawa, Paulding, Preble, Putnam, Sandusky, Seneca, Shelby, Van Wert, Warren, Williams, Wood and Wyandot counties

CareSource MyCare Ohio

CareSource plan serves CareSource MyCare Ohio members in 12 counties in Ohio:

- **Northeast Region:** Cuyahoga, Lake, Medina, Geauga and Lorain counties
- **Northeast Central Region:** Columbiana, Trumbull and Mahoning counties
- **East Central Region:** Portage, Summit, Stark and Wayne counties

CareSource Foundation

CareSource has a close connection to our members. We listen, we learn and we are driven to action. As a result, the CareSource Foundation was launched in 2006 to add another component to our professional services: community response. Areas of focus are closely aligned with the greatest needs of our member demographic including children's health, special populations such as seniors and individuals with disabilities, the uninsured and life issues such as hunger, domestic violence and homelessness.

Since its inception, the Foundation has responded at significant levels and created strategic partnerships with hundreds of nonprofit organizations and other charitable funders who were equally committed to better health for all communities. We are addressing tough issues together.

The CareSource Foundation has awarded grants totaling over $13.7 million to nonprofit organizations throughout our service area.

Corporate Compliance

At CareSource, we serve a variety of audiences – members, health partners, 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.

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 health partners, consultants and vendors.

Health Partner Expectations

- Act according to these standards.
- Let us know about suspected violations or misconduct.
- Let us know if you have questions.

For questions about health partner expectations, please call Health Partner Services at **1-800-488-0134**.

The CareSource Corporate Compliance Plan is posted at **CareSource.com**.

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

Personally Identifiable Information

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

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace and shred this content when no longer needed.
- Encrypt laptops and other portable media like CD-ROMs and USB flash drives.
- 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.

Accreditation

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for Ohio Medicaid. 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.

CHAPTER 2: CLAIMS

In general, CareSource follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. For expedited claims processing and payment delivery, please ensure your address(es) and phone number(s) on file with CareSource are up to date. You can email ProviderMaintenance@caresource.com or go to the Provider Portal at **CareSource.com** to update this information.

Billing Methods

CareSource accepts claims in a variety of formats, including paper and electronic claims. We encourage health partners to submit routine claims electronically to take advantage of the following benefits:

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

Electronic Funds Transfer

CareSource offers electronic funds transfer (EFT) as a payment option. Visit the Provider Portal for additional information about the program and to enroll in EFT. Health partners who elect to receive EFT payment will receive an EDI 835 (electronic remittance advice). Health partners can download their Explanation of Payment (EOP) from the Provider Portal or receive a hard copy via 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 health partners.
- **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.

Simply complete the enrollment form, available on the "Claims Payment" page of **CareSource.com**, and fax it back to InstaMed, who will work directly with health partners to enroll in EFT. Free EFT training is also available to CareSource health partners through InstaMed during the enrollment process. You view the training by visiting www.instamed.com/aha-eraeft.

Electronic Claims Submission

Electronic Data Interchange (EDI) is the computer-to-computer exchange of business data in ANSI ASC X12 5010 standard formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). CareSource has invested in an EDI system to enhance our service to participating health partners. Our EDI system complies with HIPAA standards for electronic claims submission.

EDI Clearinghouses

To submit claims electronically, health partners are strongly encouraged to work with an electronic claims clearinghouse. CareSource currently accepts electronic claims from Ohio health partners through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claims submission.

Please provide the clearinghouse with the CareSource payer ID number: 31114

Clearinghouse	Phone	Website
Alveo	800-327-1213	www.alveohealth.com
Availity	800-282-4548	www.availity.com
Change Healthcare	800-845-6592	www.changehealthcare.com
Consolidated Pro Systems (CPS)	888-255-7293	www.changehealthcare.com
Dyserv	614-294-6078	www.dyserv.com
Manacon	937-746-6685	N/A
Practice Insight	832-476-9030	www.practiceinsight.com
Quadax	440-777-6305	www.quadax.com
RelayHealth	800-527-8133	www.relayhealth.com
ZirMed	877-494-7633	www.zirmed.com

File Format

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

5010 Transactions

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

Transactions Covered Under the 5010 Requirements

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

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

NPI and Tax ID Numbers

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

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

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

Location of Provider NPI, TIN and Member ID Number on Professional Claims

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

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

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

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

Institutional Claims

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

- 2010AA Loop – Billing health partner name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing Provider NPI

The billing health partner TIN must be submitted as the secondary provider identifier using a REF segment, which is either the EIN for organizations or the SSN for individuals, see below:

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

On all electronic claims, the CareSource member ID number should go on:

- 2010BA Loop – Subscriber Name
- NM109 = Member ID Number

Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. Paper claim forms are encouraged for services that require clinical documentation or other forms to process. If you submit paper claims, please submit on one of the following claim form types:

- CMS 1500, formerly HCFA 1500 form – AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental claim form
- CMS 1450 (UB-04), formerly UB92 form for Facilities

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

In accordance with Ohio Department of Job and Family Services (ODJFS) guidance and to improve efficiency and accuracy in claim processing, we cannot accept handwritten claims or SuperBills. Detailed instructions for completing each form type are available at the websites below:

- CMS 1500 Form Instructions: www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf
- UB-04 Form Instructions: www.nucc.org

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

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

All claims (EDI and paper) must include the following information:

- Patient (member) name.
- Patient address.
- Insured's ID number – Be sure to provide the complete CareSource member ID number of the patient.
- Patient's birth date – Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service – Use standard CMS (HCFA) location code.

- ICD-10 diagnosis code(s).
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable.
- Units, where applicable (anesthesia claims require minutes).
- Date of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain From/To formats. Please enter each date individually.
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information.
- Federal Tax ID number or physician Social Security number – Every health partner practice (i.e., legal business entity) has a different Tax ID number.
- Signature of physician or supplier – The health partner's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

Claims can also be submitted online through the Provider Portal at https://providerportal.caresource.com/OH/.

Medicaid Only

Medicaid Health Partners

Additional information required for the following services:

For prenatal or delivery services, the last menstrual period date* is required on claims. For delivery services, the birth weight is required.

- NDC code required when submitting Drug J code.
- NDCs are required for any drug covered by Medicaid for all professional and outpatient facility claims.
- The specific code may be included in one of the following groups:
  - HCPCS codes in the J series J0120-J9999
  - HCPCS codes in the Q or S series that represent drugs
  - CPT codes in 90281-90399 series

* Last menstrual period may be calculated – For Medicaid health partners, CareSource must include the last menstrual period (LMP) date for the mother when we submit encounter data (paid claims information) to regulatory entities. We understand that this information may not always be available to the provider who delivers the baby, especially if the member received prenatal care from another provider or facility. Please remember that participating providers may estimate the LMP on delivery claims based on the gestational age of the child at birth.

This will help ensure that your delivery claims do not go unpaid because of missing claim information.

What to Include on Claims That Require NDC

1. NDC and unit of measure (e.g., pill, milliliter (cc), international unit or gram)
2. Quantity administered – number of NDC units
3. NDC unit price – detail charge divided by quantity administered
4. HCPCS codes that will require NDCs on professional claims (submitted on the 837P format)

Instructions for NDC on Paper Claims

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

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable).
- 11-digit NDC (this excludes the N4 qualifier).

A unit of measurement code – F2, GR, ML or UN (only acceptable codes)

- The metric decimal or unit quantity that follows the unit of measurement code.
- Do not enter a space between the qualifier and the NDC, or qualifier and quantity.
- Do not enter hyphens or spaces with the NDC.
- Use three spaces between the NDC number and the units on paper forms.

Tips for Submitting Paper Claims

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

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

To Ensure Optimal Claims Processing Timelines:

- EDI claims are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current form version as designated by CMS, NUCC and the ADA.
- No handwritten (including printed claims with any handwritten information) claims or SuperBills will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Fonts should be 10 to 14 point (capital letters preferred) with printing in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- It is recommended that you submit your 12-digit CareSource provider ID in conjunction with your required NPI number. (Please refer to sections for Professional and Institutional claim information).
- Federal Tax ID number or physician SSN is required for all claim submissions.

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

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

Claim Submission Timely Filing

Claims must be submitted within 365 calendar days of the date of service or discharge. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim. If this happens, health partners have 365 calendar days from the date of service or discharge to submit a corrected claim or file a claim appeal.

Claims Processing Guidelines

- Health partners 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 you do not agree with the decision of the processed claim, you will have 365 calendar days from the date of service or discharge to file an appeal.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a member has other insurance and CareSource is secondary, the health partner 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 health partner 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.
- There will be times when a member is hospitalized for a longer period of time. The health partner will be able to submit interim bills, which CareSource will pay at 30 percent of the billed charges submitted. When the patient is discharged, the health partner will be required to submit a final bill, which includes the entire bill from date admitted to date discharged. CareSource is not able to determine correct payment unless the full, final bill is submitted. The health partner will have 365 calendar days from the date of discharge to submit the complete bill. If this information is not submitted within the timely filing guidelines, the claim will be denied and previous payments will be recouped.
- All claims for newborns must be submitted using the newborn's CareSource ID number. Do not submit newborn claims using the mother's CareSource ID number; the claim will be denied. Claims for newborns must include the birth weight.

Claims that Require Completed Consent Forms

- Abortion – This type of service requires a completed Abortion Certification Form and prior authorization. Please refer to the "Referrals and Prior Authorizations" section of this manual for information on the prior authorization process.
  - JFS 03197
- Hysterectomy – This type of service requires a completed Acknowledgment of Hysterectomy Information Form.
  - JFS 03199 (Rev. 4/2011)
- Sterilization – This type of service requires a completed Consent for Sterilization Form.
  - HHS-687

For additional information please see the Covered Services and Exclusions Section of this Health Partner Manual. The forms referenced above are available on our health partner website at **CareSource.com**.

Searching for Claims Information Online

Claim status is 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 number.

Additional claims enhancements on the Provider Portal:

- Claim history available up to 24 months from date of service
- Reason for payment/denial
- Check numbers/date
- Procedure/diagnostic
- Claim payment date
- Dental claims information
- Vision claims information

Procedure and Diagnosis Codes

HIPAA specifies that the health care industry use the following four code sets when submitting health care claims electronically. CareSource also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on health partners and health plans. Local or proprietary codes are no longer allowed.

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM). Available from the U.S. Government Printing Office at 1-202-512-1800, 1-202-512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page.
- HCFA Common Procedure Coding System (HCPCS). Available at http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/ MedHCPCSGeninfo/ http://www.cms.hhs.gov/default.asp%20 Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or http://www.ada.org/en/.
- National Drug Codes (NDC). Available at http://www.fda.gov/.

Procedures That Do Not Have a Corresponding CPT Code

- If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
  - A full, detailed description of the service provided.
  - A report, such as an operative report or a plan of treatment.
  - Any information that would assist in determining the service rendered. For example, 84999 is an unlisted lab code that would require additional explanation.
- Drug injections that do not have specific J code (J3490 through J3999) and any assigned HCPCS J code that is not listed on the Medicaid fee schedule require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.
- Abortion Sterilization and Hysterectomy procedures – Consent forms must be attached (please go to the “Forms” section of **CareSource.com** for these forms).
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report plus any other documentation that will assist in determining reimbursement.
- Coordination of Benefits (COB) claims require a copy of the Explanation of Payment (EOP) from the primary carrier.

Code Editing

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

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

Health Partner Coding and Reimbursement Guidelines

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

Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, ICD-10 and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored as would be any aspect of a provider contract. When referenced in a contract, ODM reimbursement rules should be followed as set forth in the Ohio Administrative Code (OAC). In addition, the Center for Medicare and Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed. Finally, generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

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

- Medicare: http://www.cms.hhs.gov/home/medicare.asp
- Ohio Medicaid: http://medicaid.ohio.gov/providers/FeeScheduleAndRates.aspx

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

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

CareSource seeks to apply fair and reasonable coding edits. We maintain a health partner appeals function that will review, upon request, any claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review will take into consideration all the previously mentioned ODM, Medicare, CCI and national commercial standards when considering the appeal. In order to ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the CareSource appeals team to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

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

Explanation of Payment (EOP)

Explanation of Payments (EOPs) are statements of the current status of your claims that have been submitted to CareSource and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated depending on your claims activity. Health partners who receive EFT payments will receive an Electronic Remittance Advice (ERA) and can access a "human readable" version on the Provider Portal.

Information Included on EOPs

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

Check Claim Status Online

Please remember that you can track the progress of your submitted claims at any time through our Provider Portal. Check **CareSource.com** for a sample EOP.

Pended Claim Report

Pended claims have been entered into our system, but have not yet been processed completely.

CareSource is responsible for resolving any pended claims, not the health partner. The report may be sent to you merely to acknowledge receipt. Please do not resubmit pended claims; this may further delay processing. A Pended Claim Explanation report may be sent on the first and third check write of the month.

Coordination of Benefits

CareSource collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately, and in general we are required to comply with the federal regulations that Medicaid programs serve as the payer of last resort.

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

Search COB on the Provider Portal By:

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

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

Claims involving COB will not be paid until an Explanation of Benefits/Payment or EDI payment information has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (zero balance) must still be submitted to CareSource for processing. This is due to regulatory requirements.

COB Overpayment

If a health partner receives a payment from another carrier after receiving payment from CareSource for the same items or services, this is considered an overpayment.

Adjustments to the overpayment will be made on subsequent reimbursements to the health partner. Health partners should not refund any money received from a third party to a member.

Workers' Compensation

Claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The health partner will be advised to submit the charges to Workers' Compensation for reimbursement.

Third-Party Liability/Subrogation

Claims indicating the provided services were the result of an injury will be considered as a case of possible subrogation. Any third-party liability will be determined. CareSource will pay the health partner for all covered services. Then, we will pursue recovery from any third parties involved.

Medicaid Member Billing Policy

State and federal regulations prohibit health partners 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 health partners to resolve any member billing issues that includes notification of excessive member complaints and education regarding appropriate practices.

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 health partners from billing members except in very limited situations. To bill a member all of the following must have occurred:

- Health partner has submitted a prior authorization request to CareSource and CareSource has denied the prior authorization request; and
- After receipt of denial and prior to rendering the services the health partner has notified the member, in writing, of the financial liability to the member should member elect to proceed with the services; and
- 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; and
- 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 members make it to needed medical appointments. Please call our Care Management Department at **1-888-882-3614** if you are concerned about CareSource members who miss appointments.

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

CHAPTER 3: COMMUNICATING WITH CARESOURCE

CareSource communicates with our health partner network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSource.com** and network notifications.

CareSource Hours of Operation

Health Partner Services

Ohio Medicaid Monday to Friday 8 a.m. to 6 p.m.

Member Services

CareSource24® (All Plans) 24/7/365
Ohio Medicaid Monday to Friday 7 a.m. to 7 p.m.

Please visit **CareSource.com** for the holiday schedule or contact Health Partner Services for more information.

Phone

Our interactive voice response system, Katie, 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.

Phone Numbers

Health Partner Services	1-800-488-0134
Prior Authorizations	1-800-488-0134
Claims Inquiries	1-800-488-0134
Credentialing	1-800-488-0134
Ohio Medicaid Member Services	1-800-488-0134
CareSource24 - Nurse Advice Line (Medicaid)	1-866-206-0554
CareSource24 - Nurse Advice Line (MyCare Ohio)	1-866-206-7861
Fraud, Waste and Abuse Hotline	1-800-488-0134
TTY for the Hearing Impaired	1-800-750-0750 or 711

Fax Numbers

Care Management Referral	877-946-2273
Credentialing	866-573-0018
Contract Implementation	937-396-3632
Fraud, Waste and Abuse	800-418-0248
Medical Prior Authorization Form	888-752-0012
Health Partner Appeals	937-531-2398
Health Partner Maintenance (e.g., office changes, adding/deleting health partners)	937-396-3076

Website/Online Provider Portal

Accessing our website, **CareSource.com**, is quick and easy. Find commonly used forms, newsletters, updates and announcements, our Health Partner Manual, claims information, frequently asked questions, clinical and preventive guidelines and much more. Health partners can also find information on our product lines.

Provider Portal: https://providerportal.caresource.com/OH/

Our secure online Provider Portal allows you instant access at any time to valuable information, tools including the Member Profile and CareSource Clinical Practice Registry, various self-service options, clinical and preventive guidelines and other resources. Simply enter your username and password (if already a registered user), or submit your information to become a registered user. Assisting you is one of our top priorities in order to deliver better health outcomes for our members.

Provider Portal Benefits

- Free
- A secure online (encrypted) tool that allows you to easily access 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 – Value to You

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

- **Payment History** – Search for payments by check number or claim number.
- **Claim Status** – Search for status of claims and claim appeals.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior Authorization** – Medical inpatient/outpatient, home health care and Synagis®.
- **Eligibility Termination Dates** – View the member's termination date (if applicable) under the eligibility tab.
- **Care Management Referrals** – The care management form is now automated on our Portal for efficiency in enrolling members.
- **Benefit Limits** – Health partners can track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy and speech therapy.
- **Care Treatment Plans** – Health partners now have the option to view care treatment plans for their patients on our Provider Portal.

- **Claim History for Vision Benefits** – View a member's vision history and utilization of benefits.
- **Monthly Membership Lists** – PCPs can view and download current monthly membership lists.
- **Member Profile** – Comprehensive view of patient medical/pharmacy utilization.
- **CareSource Clinical Practice Registry** – Innovative tool for PCPs that helps easily view and sort CareSource members into actionable groups for improved focus on preventive care (e.g., well-baby visits, diabetes, asthma). Look on the "Member Eligibility" page for alerts to notify you what tests a patient needs.

Dental health partners, please refer to the Dental Handbook or **CareSource.com** for information about the Provider Portal capabilities specifically for dental health partners.

Portal Registration

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

1. Click on the "Register Now" button and complete the three-step registration process. You will need to have your Tax ID number, provider ID number (found in your welcome letter) and nine-digit ZIP code.
2. Click the "Continue" button.
3. 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 the Health Partner Services department at **1-800-488-0134**.

How to Communicate With CareSource by Mail

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

Health Partner Appeals Mailing Address (Medicaid/Medicare)

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

You may also submit appeals through the Provider Portal.

Member Appeals and Grievances Mailing Addresses (Medicaid/Medicare)

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

Medicare Pharmacy Appeals

CVS Caremark MC 109
P.O. Box 52000
Phoenix, AZ 85072-2000

Medicare Pharmacy Grievances

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

Claims Mailing Addresses (Medicaid/Medicare)

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

Fraud, Waste and Abuse Address (Medicaid/Medicare)

CareSource
Attn: Special Investigations Department
Box 1940
Dayton, OH 45401-1940

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

Newsletters

CareSource communicates with health partners in a variety of ways. Our newsletter, produced three times a year, is available online and contains operational updates, clinical articles and new initiatives underway at CareSource. Please visit **CareSource.com** to access the current and past editions.

Network Notifications

Network notifications are published for CareSource health partners to regularly communicate updates to policies and procedures. Network notifications are found on the Updates & Announcements page of our website.

Health Partner Demographic Changes and Updates

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a health partner to your practice helps us keep our records current and are critical for claims processing.

Email: ProviderMaintenance@caresource.com

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

Fax: 937-396-3076

CHAPTER 4: COVERED SERVICES AND EXCLUSIONS

Covered Services

Please visit the CareSource website at **CareSource.com** for information on services, including dental services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Referrals and Prior Authorizations" section of this manual for more information about referral and prior authorization procedures.

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 the Health Partner Services department at **1-800-488-0134**.

This section describes the services and exclusions to benefits that are provided to our CareSource members. CareSource covers all medically necessary covered services for members. These services are available to our health plan members at no charge. Covered services may require prior authorization. Please visit our website at **CareSource.com** for the most up-to-date list of services that require prior authorization. Under the Provider section, click on "Ohio Providers," then "Member Care," and then "Prior Authorization."

Medical Necessity Determinations

Some services require prior authorization. CareSource reviews all service requests for Medicaid members under the age of 21 for medical necessity. If a request for authorization is submitted, CareSource will notify the health partner and member in writing of the determination. If a service cannot be covered, health partners and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Appeal Procedures" section of this manual for information on how to file an appeal.

Medicaid Only

Medicaid Covered Benefits and Services for Medicaid Members

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.

Abortion – Abortion services are covered in the following circumstances with prior authorization:

- 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 health partner, 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 health partner 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 health partner performing the abortion.

Medicaid Only

Certification Form for Reimbursement of Abortion

Before reimbursement for an abortion can be made, the health partner 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 health partner'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:

a. 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 health partner, place the woman in danger of death unless an abortion is performed.

b. 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.

c. 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.

d. 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.

Reimbursement will not be made for associated services, such as anesthesia, laboratory tests or hospital services if the abortion service itself cannot be reimbursed. The health partner performing the abortion must certify in writing to one of these circumstances by completing the JFS 03197 Abortion Certification Form, which is located at **CareSource.com**.

Medicaid Only

Requirements for 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.

Immunizations

Health partners may administer immunizations obtained through the Vaccines for Children (VFC) program to CareSource members. The vaccines are available free of charge through the VFC program.

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

Please see the "Member Support Services and Benefits" section for more details on immunizations. CareSource will not reimburse costs for vaccines obtained outside the VFC program when provided to children under age 19.

Medicaid Only

Annual Wellness Exams for Adults

All adults are eligible to receive a wellness exam from a primary care provider 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.

CHAPTER 5: CREDENTIALING AND RECREDENTIALING

CareSource credentials and recredentials all licensed independent practitioners including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action. **There are no distinctions in our credentialing and recredentialing policies and procedures for Medicaid and Medicare health partners.**

Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners. Our Vice President/Senior Medical Director is responsible for the credentialing and recredentialing program.

Ohio Revised Code Chapter 3963 requires that you submit a complete and current Council for Affordable Quality Healthcare (CAQH) Application (referred to as Part A), Standardized Credentialing Form Part B Agency/Program/Organization health partners or CAQH number and National Provider Identifier (NPI) number via one of three vehicles:

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

CAQH Application

CareSource is a participating organization with CAQH. Please make sure that we have access to your health partner application prior to submitting your CAQH number as referenced above by:

1. Logging onto the CAQH website at www.CAQH.org, utilizing your account information
2. Selecting the Authorization Tab
3. Making sure CareSource is listed as an authorized health plan
   a. If not, please check the Authorized box to add

It is essential that all documents are complete and current. Otherwise, CareSource will discontinue the contracting and credentialing process in order to maintain compliance with Ohio Revised Code Chapter 3963 requirements.

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current)
- Clinical Laboratory Improvement Amendment (CLIA) certificate (if applicable)
- Standard care arrangement (if an advanced practice nurse)

Ohio Debarred Health Partner Employee Attestation

As required by its contract with the State of Ohio, CareSource must verify that its health partners and the health partners' employees have not been debarred or suspended by any state or federal agency. CareSource must also require that its health partners and the health partners' employees disclose any criminal convictions related to federal health care programs. "Health partner employee" is defined as directors, officers, partners, managing employees or persons with beneficial ownership of more than 5 percent of the entity's equity.

CareSource Debarment/Criminal Conviction Attestation

Health partners must offer a list that identifies all health partner employees, as defined above, along with the employee's Tax ID or Social Security numbers.

Health partners and health partner employees must execute the attestation titled, "CareSource Debarment/Criminal Conviction Attestation" (in addition to being subject to and cooperating with CareSource verification activities) as a part of the credentialing and recredentialing process.

CareSource conducts credentialing and recredentialing activities utilizing the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) and the Ohio Department of Medicaid (ODM).

Contracted Health Partners Listed in the Provider Directory and the Following Are Credentialed:

- Practitioners who have an independent relationship with CareSource. This independent relationship is defined through contracting agreements between CareSource and a practitioner or group of practitioners and is defined when CareSource selects and directs its enrollees to a specific practitioner or group of practitioners.
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Practitioners who are hospital-based, but see the organization's members as a result of their independent relationship with the organization.
- Dentists who provide care under the organization's medical benefits.
- Non-physician practitioners who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.
- Covering practitioners (locum tenens).
- Medical directors of urgent care centers and ambulatory surgical centers.

The Following Health Partners Listed in the Provider Directory Do Not Need to Be Credentialed:

- Practitioners who practice exclusively within the inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting.
- Practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the CareSource Provider Directory.
- Pharmacists who work for a Pharmacy Benefit Management (PBM) organization.
- Practitioners who do not provide care for members in a treatment setting (e.g. board-certified consultants).

Health Partner Selection Criteria

CareSource is committed to providing the highest level of quality of care and service to our members. Our health partners are critical business partners with us in that endeavor. As a result, we have developed health partner selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our health partners.

Quality of care delivery, as defined by the Institute of Medicine, states: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

CareSource has developed comprehensive care management and quality improvement programs to facilitate this level of quality-of-care delivery, as well as a comprehensive credentialing program to ensure that our health partners have the appropriate training and expertise to serve our members from a care delivery and service perspective. CareSource bases selection on quality-of-care and service aspects, in addition to business and geographic needs for specific health partner types in a nondiscriminatory manner.

The following selection criteria have been put in place and are assessed during the credentialing and recredentialing process in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

Selection Criteria:

a. Active and unrestricted license in the state issued by the appropriate licensing board.

b. Current DEA certificate (if applicable).

c. Successful completion of all required education.

d. Successful completion of all training programs pertinent to one's practice.

e. For MDs and DOs, successful completion of residency training pertinent to the requested practice type.

f. For dentists and other health partners where special training is required or expected for services being requested, successful completion of training.

g. Board certification is not required for primary care specialties. PCPs who are approved by the CareSource Credentialing Committee will appear in CareSource Provider Directories.

h. Health partners approved by the CareSource Credentialing Committee in non-primary care specialties will be listed in the Provider Directory as specialists if certified by a specialty board, which is recognized by the CareSource Credentialing Committee.

i. A certified nurse practitioner may be credentialed as a primary care provider if that nurse practitioner:
    i. Holds a valid certificate of authority issued by the Ohio Board of Nursing in accordance with section 4723.42 of the Revised Code
    ii. Is certified by a national certifying organization approved by the Ohio Board of Nursing
    iii. Holds a current "certificate to prescribe"
    iv. Has a signed standard care arrangement with a collaborating health partner who is a participating health partner with CareSource
    v. Requests in writing to CareSource designation as a primary care provider (PCP) via submission of an Attachment B of the Medicaid Addendum in Ohio and via letter in other states
    vi. Practices within a health partner based practice as defined by OAC 5160-8-22

j. A certified nurse practitioner may be credentialed as a PCP and as an "independent practitioner" if the above criteria (i) through (vi) are met and the nurse practitioner's practice type is independent as defined by OAC 5160-8-22.

k. Education, training, work history and experience are current and appropriate to the scope of practice requested.

l. Malpractice insurance at specified limits established for all practitioners by the credentialing policy.

m. Good standing with Medicaid and Medicare.

n. Medicaid Number or state-specific Provider Reporting Number (Ohio).

o. Quality of care and practice history as judged by:
    i. Medical malpractice history
    ii. Hospital medical staff performance
    iii. Licensure or specialty board actions or other disciplinary actions, medical or civil
    iv. Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
    v. Other quality of care measurements/activities
    vi. Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
    vii. Lack of issues on HHS-OIG; SAM/ EPLS or ODM site (fraud and abuse)

p. Signed, accurate credentialing application and contractual documents

q. Participation with Care Management, Quality Improvement and Credentialing programs

r. Compliance with standards of care and evidence of active initiatives to engage members in preventive care

s. Agreement to comply with plan formulary requirements or acceptance of plan Preferred Drug List as administered through the Pharmacy Benefit Manager

t. Agreement to the access and availability standards established by the health plan

u. Compliance with service requirements outlined in the provider agreement and health partner manual

Organizational Credentialing and Recredentialing – The following organizational health partners are credentialed and recredentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers

Additional Organizational Health Partners Are Also Credentialed:

a. Hospice health partners

b. Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting

c. Urgent care facilities, free-standing and not part of a hospital campus

d. Dialysis centers

e. Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities

f. Free-standing facilities that provide outpatient, non-emergent advanced radiology services (including MRI/MRA, CT and PET scans)

In addition to the urgent care and ambulatory surgical facilities being credentialed, the Medical Director or senior health partner responsible for medical services will be credentialed using the standard credentialing and recredentialing processes.

The following elements are assessed for organizational health partners:

- Health partner is in good standing with state and federal regulatory bodies
- Health partner has been reviewed and approved by an accrediting body
- Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body
- Liability insurance coverage is maintained
- Clinical Laboratory Improvement Amendments (CLIA) certificates are current
- Completion of a signed and dated application

Health partners will be informed of the credentialing committee decision within 10 business days of the committee meeting. Health partners will be considered recredentialed unless otherwise notified.

Medicare Only

Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Health Partner Checks (Rev. 24, 06-06-03)

Excluded Health Partners

The Office of the Inspector General (OIG) maintains a sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. CareSource checks the sanction list with each new issuance of the list, as we are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. CareSource checks the OIG website at http://exclusions.oig.hhs.gov/ for the listing of excluded health partners and entities. The OIG has a limited exception that permits payment for emergency services provided by excluded health partners under certain circumstances.

Opt-Out Health Partners

If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of two years. The only exception to that rule is for emergency and urgently needed services where a private contract had not been entered into with a beneficiary who receives such services. CareSource pays for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in our CareSource plan who has not signed a private contract with a beneficiary, but does not otherwise pay opt-out health partners. Information on health partners who opt out of Medicare may be obtained from the local Medicare Part B carrier. CareSource checks this list on a regular basis.

Practitioner Rights

- Practitioners have the right to review information submitted to support their credentialing application upon request to the CareSource Credentialing department. CareSource keeps all submitted information locked and confidential.
- Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing department prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner will be notified and given the opportunity to correct this information prior to presenting to the credentialing committee.
- Practitioners have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department.

Health Partner Responsibilities

Health partners are monitored on an ongoing basis to ensure continuing compliance with participation criteria. CareSource will initiate immediate action in the event that the participation criteria are no longer met. Health partners are required to inform CareSource of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification, or any event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

Health partners are recredentialed a minimum of every three years. As part of the recredentialing process, CareSource considers information regarding performance to include complaints, and safety and quality issues collected through the Quality Improvement program, in addition to information regarding sanctions collected from the NPDB, Medicare and Medicaid Sanctions and Reinstatement Report, Medicare Opt-Out and the HHS/OIG. Health partners will be considered recredentialed unless otherwise notified.

Board Certification Requirements

Effective Jan. 1, 2003, physicians applying to become participating health partners must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board, with the exception of general dentists who will have board certification requirements waived in lieu of adequate education and training.

Effective Sept. 10, 2010, primary care providers may be exempted from the board certification requirement if they have successfully completed a primary care residency program and their education and training are consistent with their intended scope of practice.

Physicians who are pursuing certification must be certified within the time frame specified by their respective board. Failure to become certified may result in termination as a participating health partner.

Physicians whose boards require periodic recertification will be expected, but not required, to be recertified, although failed attempts at recertification may be reason for termination. At the time of recredentialing, if board certification status has expired, a letter will be sent to the physician to request explanation. If the response indicates quality concerns as a reason, the Vice President, Senior Medical Director or designated Medical Director will contact the physician and investigate directly.

To be credentialed as a subspecialist and listed in the directory under that subspecialty, physicians must:

a. Complete an approved fellowship training program in the respective subspecialty, and

b. Be board certified by a board recognized by the American Board of Medical Specialties (ABMS). If no subspecialty board exists or the board is not a member of ABMS, then subspecialty recognition will be determined based on education, training and experience requirements of the fellowship training program and/or other suitable board certification recognition.

Delegation of Credentialing/Recredentialing

CareSource will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is NCQA-accredited for these functions, utilizes an NCQA-accredited credentials verification organization (CVO) and/or successfully passes a pre-delegation audit demonstrating compliance with NCQA, federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing health partner file review

Delegates must be in good standing with Medicaid and the Centers for Medicare and Medicaid Services (CMS). Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

CareSource may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited CVO. Health partners will be notified of this and must adhere to the requests from the chosen CVO.

Appeals of Credentialing/Recredentialing Decisions

CareSource may decide that an applying or participating health partner 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 health partner will be notified in writing. Appeal opportunities are available to a participating health partner if he/she has been affected by an adverse determination. To submit an appeal request, the following steps apply:

Step 1 – Submit to the Vice President/Senior Medical Director an appeal request in writing, along with any other supporting documentation.

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

All appeal requests must be received by CareSource within 30 calendar days of the date the health partner 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 health partner will be notified in writing of the committee's decision.

Step 2 – If the committee maintains the original decision, an appeal may be made consistent with provisions of the CareSource Fair Hearing Plan. Any appeal request must be submitted in writing and received by CareSource within 30 calendar days of the date the health partner is notified of the first appeal decision.

Appeals may be sent to:

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

Applying health partners do not have appeal rights. However, they may submit additional documents for reconsideration by the credentialing committee to the address above.

If you would like to review the CareSource Fair Hearing Plan, please see our website at **CareSource.com**. Search "Fair Hearing."

Health Partner Disputes

Health partner 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

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

CareSource
Attn: Health Partnerships
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 health partner 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 health partner that is subject to a suspension or termination may dispute the action and request a hearing through the CareSource Fair Hearing Plan.

Reconsideration and Appeals of Credentialing/Recredentialing Decisions

CareSource may decide that an applying or participating health partner 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 health partner will be notified in writing. 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: Vice President/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 health partner 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 health partner will be notified in writing of the committee's decision.

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 health partner is notified of the reconsideration decision.

Appeals may be sent to:

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

Applying health partners may submit additional documents for reconsideration by the credentialing committee to the address above. An application rejection due to the health partner'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 see our website at **CareSource.com**. Search "Fair Hearing."

CHAPTER 6: FRAUD, WASTE AND ABUSE

Health care fraud, waste and abuse hurts everyone, including members, health partners, taxpayers and CareSource. As a result, CareSource has a comprehensive fraud, waste and abuse program in our Special Investigations Unit. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

Definition of Terms

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

Waste 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).

Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight. (Inspector General)

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

Improper Payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts. (Improper Payments Elimination and Recovery Act [IPERA]).

Examples of Member Fraud, Waste and/or Abuse:

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

Examples of Health Partner Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower Medicaid/ Medicare reimbursement rates
- Billing for services not provided
- Requiring members to pay for CareSource covered services
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Purchasing drugs from outside the United States
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking member IDs, resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using member/enrollee lists for the purpose of submitting fraudulent claims
- Billing drugs billed for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark violations
- Retaining overpayments made in error by CareSource
- Preventing members from accessing eligible or covered services resulting in under utilization of services offered

Examples of Pharmacy Fraud, Waste and/or Abuse:

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

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

Examples of Employee Fraud, Waste and/or Abuse:

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

Examples of Vendor Fraud, Waste and/or Abuse:

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

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

Corrective actions can include, but are not limited to:

- Member and/or health partner education
- Written corrective action plan
- Health partner termination with or without cause
- Health partner summary suspension
- Recovery of overpaid funds
- Member disenrollment

- Reporting to one or more applicable state and federal agencies
- Contract termination
- Employee disciplinary actions
- Legal action

Refer to your provider agreement for specific information on each type of health partner termination/suspension. Refer also to the CareSource Fair Hearing Plan for information on the appeal process. The CareSource Fair Hearing Plan is available at **CareSource.com**. Search "Fair Hearing Plan."

Reporting Fraud, Waste and Abuse

You can report your suspicions of fraud, waste or abuse to the CareSource Special Investigations Unit. Contact information for reporting fraud, waste and abuse is located at **CareSource.com**, in the "Communicating with CareSource" section of this Health Partner Manual and at the end of this section.

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.

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

a. Knowingly* presents, or causes to be presented, a false or fraudulent claim for payment or approval

b. Knowingly* makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim

c. Conspires to commit a violation of any other section of the False Claims Act

d. 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

e. 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

f. 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

g. 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.

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

The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, CareSource is required to comply with certain provisions of the DRA. One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Acts and other state laws regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste and abuse when handling CareSource business.

The time 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.

Ohio Law

While Ohio has not passed its own false claims statute, there may nevertheless be liability under various Ohio laws regarding false or fraudulent claims with respect to Medicaid program expenditures, including:

- Medicaid Fraud, Ohio Revised Code Sec. 2913.40
- Medicaid Eligibility Fraud, Ohio Revised Code Sec. 2913.401
- Falsification, Ohio Revised Code Sec. 2921.13
- Offenses by Medicaid health partners, Ohio Revised Code Sec. 5164.35

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

Protection for Reporters of Fraud, Waste or Abuse

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 Special Investigations Unit using one of the reporting methods outlined at the end of this section.

Incentives for Whistleblowers

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

Prohibited Affiliations

CareSource is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities and non-procurement activities (42 C.F.R. § 438.610). Relationships must be terminated with any trustee, officer, employee, health partner or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that your corporate entity, those with more than 5 percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us immediately utilizing the contact information in the "How to Report Fraud, Waste or Abuse" reporting section.

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 health partners are subject, and in accordance with accepted practices.

Disclosure of Ownership, Debarment and Criminal Convictions

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

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 using the contact information in the "How to Report Fraud, Waste and Abuse" section.

If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request.

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

How to Report Fraud, Waste or Abuse

It is CareSource's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act or any state Medicaid fraud laws. If you have knowledge or information that any such activity may be or has taken place, please contact our Special Investigations Unit. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting anonymously:

- **Call**: **1-800-488-0134** and tell Katie, our interactive voice response system, that you are calling to report fraud.
- **Write**: CareSource
  Attn: Special Investigations Unit
  P.O. Box 1940
  Dayton, OH 45401-1940

Options for reporting that are not anonymous:

- **Fax**: 800-418-0248
- **Email***: fraud@caresource.com

You may use the Fraud, Waste and Abuse Reporting Form located at **CareSource.com**.

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

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

A Roadmap to Avoid Medicare and Medicaid Fraud and Abuse

The Office of the Inspector General (OIG) has created free materials for health partners to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse.

The OIG roadmap for new physicians and other training materials are available at **https://oig.hhs.gov/compliance/physician-education/index.asp.**

CMS also released a roadmap for physicians on avoiding Medicare fraud, waste and abuse as well as provider compliance. This resource is located at **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FandA_Physicians_FactSheet_905645.pdf.**

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

CHAPTER 7: KEY CONTRACT PROVISIONS

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

Participating health partners are responsible for:

- 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.
    - **60-day notice is required** if you plan to close your practice to new patients. If we are not notified within this time period, you will be required to continue accepting CareSource members for a 60 calendar day period following notification.
- **For 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 primary care provider (PCP) or a back-up health partner 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 health partner 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 must be filed within 365 days of the date of service or discharge.
- Health partners should keep all demographic and practice information up to date. Email updates to ProviderMaintenance@caresource.com.

Our agreement also indicates that CareSource is responsible for:

- Paying 90 percent of clean claims within 30 days of receipt.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the "Health Partner Appeals" section of this manual.
- Offering a 24-hour nurse advice line for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance which involves subtracting the primary payment from the lessor of the primary carrier allowable or the Medicaid allowable. If the member's primary insurer pays a health partner 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 health partners to follow standard practice procedures even though they may not be spelled out in our provider agreement.

Examples:

- Participating health partners, 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 health partners 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 in the "Member Support Services and Benefits" section of this manual.

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

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a health partner to your practice helps us keep our records current and are critical for claims processing.

Timeline of Provider Changes:

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
Providers intent to terminate	90 calendar days

Why is it important to give changes to CareSource?

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.

How to Submit Changes to CareSource:

- **Email**: ProviderMaintenance@caresource.com
- **Fax**: 937-396-3076
- **Mail**: CareSource
  Attn: Provider Maintenance
  P.O. Box 8738
  Dayton, OH 45401-8738

Americans with Disabilities Act Standards:

Additionally, health partners will remain compliant with Americans with Disabilities Act (ADA) standards, including but not limited to:

a. Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities

b. Accessibility along public transportation routes and/or provide enough parking

c. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities

d. Providing secure access for staff-only areas

CHAPTER 8: MEMBER ENROLLMENT AND ELIGIBILITY

Note: Enrollment and member eligibility is distinctly different for Medicaid and Medicare members. Therefore, the first part of this section is for Medicaid health partners; policies and procedures for Medicare enrollment and eligibility are located at the end of this section.

Medicaid Member Enrollment

Medicaid eligibility is determined by a consumer's county Department of Job and Family Services county case worker.

The Ohio Department of Medicaid (ODM) provides eligibility information to CareSource on a monthly basis. ODM also notifies CareSource of some eligibility changes throughout the month. New members are effective on the first of the month except for babies born to existing members.

Medicaid 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.

Health partners may use our secure Provider Portal on our website to check member eligibility, or call our Health Partner Services department.

Provider Portal: https://providerportal.caresource.com/OH/
Click on "Member Eligibility" on the left, which is the first tab.

Health Partner Services Department: 1-800-488-0134
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.

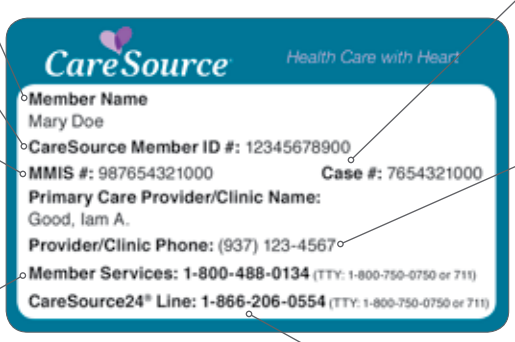
The Ohio Medicaid Member ID card contains the following :

Member's Name

CareSource Member's ID – use this number on claims.

MMIS # – the member's State Medicaid ID number; please do not use this to bill CareSource.

Member Services phone number and TTY for the hearing impaired.



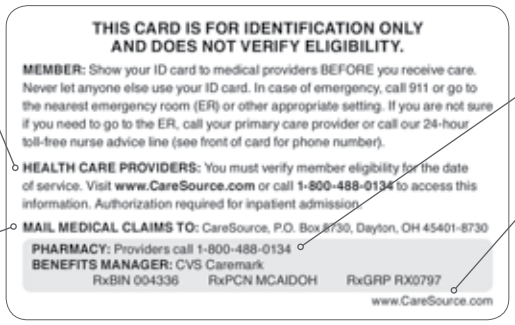
Case # – This number may be valid for multiple household members. It is not the member's ID number.

Primary Care Physician/ Clinic Name – Members choose a participating health partner to be their primary care provider (PCP). IF a choice is not made, a PCP is assigned.

CareSource 24 Line

Health Partner Services – The toll-free phone number for health partners who have questions or wish to verify eligibility over the phone.

Send Paper Claims to



(Back of Ohio Medicaid Member ID card)

Pharmacy Information

Website – Our website contains plan information, as well as special functionality: verify eligibility, check claims or prior authorization status, submit a prior authorization, check COB and more.

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.

Medicaid Member Eligibility Verification

Except for emergency services, health partners 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 Health Partner Services at **1-800-488-0134** and tell Katie, our interactive voice response system, you want to verify member eligibility. She will direct you 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, primary care providers (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 (please review the "Member Support Services and Benefits" section of this manual). 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.

Newborn Enrollment for Medicaid Members

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 section of our website at **CareSource.com** and select "Provider Portal" from the menu options. Once you enter the mother's case number, you should be able to view all eligible members of the household.

Member Disenrollment

Members may disenroll from CareSource for a number of 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. Review the "Member Support Services and Benefits" section for more information. 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 health partners 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, health partners are asked to notify our Care Management department for assistance.

CareSource requires that a health partner'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, health partners may initiate the dismissal by following the guidelines below.

- The health partner's 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:
  - **Mail**: CareSource
    Attn: SORT
    P.O. Box 1947
    Dayton, OH 45401-1947
  - **Fax**: 937-396-3095

For PCPs Only: The letter must contain specific language stating that:

- The member must contact the CareSource 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.

Automatic Renewal of Membership

If CareSource members lose Medicaid eligibility, but become eligible again within 60 days, they are automatically re-enrolled in CareSource and assigned to the same PCP if possible.

Member Enrollment and Health Partner Marketing

It is common for health care health partners to inform their patients about their affiliation with managed care plans. **Advocating enrollment in a specific health plan, however, is not permitted.** As a Medicaid health plan and a health insuring corporation licensed by the Ohio Department of Insurance (ODI), CareSource is responsible for upholding these laws. Through your contract with CareSource, you and your practice are required to comply with these regulations, as well.

Our licensed marketing representatives are available to visit your office and speak with patients about their option to join CareSource. They can also share ODM-approved materials for distribution at your office. In addition, they can help you with any questions regarding acceptable written educational materials and marketing materials.

Correspondence to any Medicaid participant that refers to your participation with CareSource must be approved in advance. Please contact your Health Partnership Representative, and if necessary we will submit your materials to ODM for approval on your behalf.

Medicare Only

Medicare Member Enrollment And Eligibility

Medicare Eligibility Verification

To verify member eligibility, please use one of the following methods:

- **Provider Portal**: Log on to **CareSource.com** and select Provider Portal from the menu options. You can check CareSource member eligibility up to 24 months after the date of service on our Provider Portal. You can search by date of service plus any one of the following: member name and date of birth, Medicare number or CareSource member ID number.
- **Phone**: Call Health Partner Services at **1-800-488-0134** and tell Katie, our interactive voice response system, you want to verify member eligibility. She will direct you 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.

PCPs can obtain a monthly list of eligible members who have chosen them or were assigned to them from the CareSource Provider Portal. This list does not prove eligibility for benefits or guarantee coverage. Please use one of the above methods to verify member eligibility. Log on to our Provider Portal to view or print your list.

Health partners should always verify member eligibility before rendering services except in an emergency. This helps prevent unpaid claims.

CHAPTER 9: MEMBER SUPPORT SERVICES AND BENEFITS

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

Medicaid New Member Identification Cards and Kits

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

Medicaid New Member Kit Contains:

- A Member Handbook, which explains plan services and benefits and how to access them.
- 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.

Note: Ohio Medicaid 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 health partners and facilities participating with CareSource. A current list of health partners can be found at any time at **CareSource.com** under our Find a Doctor/Provider tool.

CareSource24, Nurse Advice Line

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

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

CareSource24 nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the primary care provider (PCP) by explaining the importance of their role in coordinating the member's care.

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

Care Management/Outreach

CareSource provides the services of care management medical and behavioral health nurses, social 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.

Medicaid Only

Direct Access for Medicaid

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

Care Management Services

CareSource's Care Management program is a fully integrated health management program that strives for improved clinical outcomes, enhanced member satisfaction and optimal resource utilization. We promote integration of physical and behavioral health to manage the member across the continuum of care with a holistic approach.

More importantly, our program is designed to support the care and treatment you provide and recommend to your patient. We stress the importance of establishment of the medical home, identification of barriers, and keeping appointments, and we can assist in arranging transportation to the health partner's office. This one-on-one personal interaction with outreach specialists and professional care managers helps provide a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional needed community resources.

CareSource encourages you to take an active role in your patient's care management program through the Patient Profile feature on the Provider Portal. This profile provides member-specific information on pharmacy and emergency department (ED) utilization, scheduled or planned services. This information provides you with critical information necessary to make informed decisions pertaining to your patient. In addition, we invite and encourage you to direct and provide input into patient assessment activity and participate in the development and monitoring of a care plan individualized to the needs of your patient. We believe communication, coordination and collaboration are integral to ensure the best care for these patients.

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

- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Depression
- Members with special health care needs
- Members with serious and persistent mental illness (SPMI)

Care Management for High-Risk Members

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

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

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

Medicaid Only

CareSource Disease Management Program

CareSource Medicaid members with chronic conditions, including asthma and diabetes, will be automatically enrolled into CareSource's enhanced disease management program.

Members enrolled in the program will receive free information to help them better manage their asthma or diabetes. Information sent to members will include care options for them to discuss with their health partner.

Members identified as high risk will have a nurse assigned to their case to help educate, coordinate and provide resources and tools to help the member reach their health care goals.

How to Refer Medicaid Members to Disease Management

If you have a CareSource patient with asthma or diabetes who you believe would benefit from this program and is not already enrolled, call **1-888-882-3614**.

Emergency Department Diversion Program

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 for our members.

We instruct members to call their 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 also 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. Please see the "Primary Care Providers" section of this manual for more information.

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.

Medicaid Only

Perinatal and Neonatal Care Management

CareSource's perinatal and neonatal care management program utilizes 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 health partners 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 health partners.

We encourage our prenatal care health partners to notify our Care Management department at **1-800-993-6902** when a member with a high-risk pregnancy has been identified. Care Management is notified of medically complex infants at the time of admittance to the neonatal intensive care unit.

Babies First Program

Babies First is a free program offered to pregnant members and parents or guardians of babies less than 18 months of age. Through this program, members can earn up to $150 on a MyCareSource Rewards® card. The program focuses on encouraging pregnant members to visit their doctor for prenatal care early in their pregnancies, and then as often as their doctor recommends. Additionally, the program encourages well-baby visits as recommended, to help ensure mom and baby will be as healthy as possible.

The MyCareSource Rewards card is a restricted spend card, accepted at several local merchants. The card can be used to purchase healthy items and baby toys, but cannot be used to purchase unhealthy items such as tobacco, alcohol or candy.

For more information, members can visit **CareSource.com/OHbabiesfirst** or call Member Services at **1-800-488-0134**.

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** for additional information about vision services.

Interpreter Services – Non-Hospital Health Partners

CareSource offers sign and language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking ability. We can also provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services are available at no cost to the member or health partner. As a health partner, 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 Health Partner 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.

Interpreter Services – Hospital Health Partners

CareSource requires hospitals, at their own expense, to offer sign and language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking ability. We can provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services should be available at no cost to the member. You are also required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. If you do not have access to interpreter services, contact our Health Partner 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.

Medicaid Only

Medicaid Healthchek Program

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 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

PCPs receive a list of eligible CareSource members at the beginning of each month who have chosen or been assigned to the PCP as of that date. The list also includes indicators for patients who 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 Only

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 of the needed data. Please use the Healthchek form at http://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM03518.pdf.

Healthchek Codes

In order 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.

Electronic Claims

Completion of CRC02 and CRC03 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.

Medicaid Only

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.”

Healthchek Exam Referrals

If the PCP is unable to provide all of 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 health partner within CareSource’s health partner 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).

Medicaid Only

Vaccines for Children Program

The federal Vaccines for Children (VFC) program makes designated vaccines available at no cost to VFC participating health care health partners 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 health partners 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 health partners at no cost.

Health partners 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)

Immunization Schedule

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 October 1, 2015, CareSource requires health partners to use ICD-10-CM Codes and CPT Codes on claims. Please refer to the Code Tables located on the CMS website at www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html.

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

Statewide Web-Based Immunization Registry

CareSource encourages all participating health partners to take advantage of the statewide web-based immunization registry called IMPACT SIIS, found at https://odhgateway.odh.ohio.gov/impact/.

The registry consolidates immunizations from multiple health partners 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.

Medicaid Transportation

Transportation can be provided for member medical appointments, Women, Infants and Children (WIC) appointments and Medicaid redetermination appointments with the County Department of Job and Family Services. The transportation benefit is limited to 15 round-trip visits (30 one-way trips) annually per member for Medicaid. 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 selecting the option for transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

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.

Medicaid Only

Medicaid Member Rights and Responsibilities

As a CareSource health partner, you are required to respect the rights of our members.

CareSource members are informed of their rights and responsibilities via their Member Handbook. The list of our members' rights and responsibilities are listed below.

All members are encouraged to take an active and participatory role in their own health and the health of their family. Member rights, as stated in the member handbook, are as follows:

- To receive information about CareSource, our services, our practitioners and health partners and member rights and responsibilities.
- To receive all services that CareSource must provide, and receive them in a timely manner.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To get information on any appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure that others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease or revenge as specified in federal regulations.
- To ask for and get a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless CareSource has to by law.
- To be able to say no to treatment or therapy. If the member says no, the doctor or Managed Care Plan (MCP) must talk to the member about what could happen, and put a note in the member's medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing about the organization or the care we provide.

Medicaid Only

- To be able to get all MCP written member information from the MCP:
  - At no cost to you
  - In the prevalent non-English languages of members in the MCP's service area
  - To help with the special needs of members who may have trouble reading the information for any reason
- To be able to get help free of charge from CareSource and its health partners if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the health partner is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will).
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your PCP to another PCP in CareSource's network at least monthly. CareSource must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that the MCP, the MCP's health partners or the Ohio Department of Medicaid (ODM) will not hold this against you.
- To know that the MCP must follow all federal and state laws, and other laws about privacy that apply.
- To choose the health partner that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a women's health partner in CareSource's network for covered women's health services.
- To be able to get a second opinion from a qualified health partner in CareSource's network. If a qualified health partner is not able to see you, CareSource must set up a visit with a health partner not in our network.
- To make recommendations regarding CareSource's member rights and responsibilities policy.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Medicaid Only

Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601
312-886-2359
312-353-5693 – TTY

Bureau of Civil Rights
Ohio Department of Job and Family Services
30 E. Broad St., 37th Floor
Columbus, Ohio 43215
1-866-227-6353
1-866-221-6700 – TTY
Fax: 614-752-6381

CareSource may not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services in the receipt of health services.

Members of CareSource Are Also Informed of the Following Responsibilities:

- Use only approved health partners.
- Keep scheduled health partner appointments, be on time, and if you have to cancel, call 24 hours in advance.
- Follow the advice and instructions for care you have agreed upon with your health partners.
- Always carry your ID card and do not let anyone else use your ID card.
- Always present your ID card when receiving services.
- Notify your county caseworker and CareSource of a change in your phone number or address.
- Contact your PCP after going to an urgent care center or after getting medical care outside of CareSource's covered counties or service area.
- Let us know if you have other health insurance coverage.
- Provide the information that CareSource and your health partners need in order to provide care for you.
- Understand as much as possible about your health issues and take part in reaching goals that you and your health partner agree upon.

Medicaid Only

HIPAA Notice of Privacy Practices – Members are notified of CareSource's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CareSource's 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. CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, Protected Health Information (PHI) of members.

As a health partner, please remember to follow the same HIPAA regulations as a covered entity and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Medicaid Member Grievance and Appeals Procedures

Members have the right to file a grievance or appeal and request a State Hearing or Independent External Quality Review. As a CareSource health partner, we may contact you to obtain additional documentation when a member has filed a grievance or appeal or has requested a State Hearing or Independent External Quality Review. State and federal agencies require CareSource to comply with all requirements, which include aggressive resolution time frames.

Members are encouraged to call or write to CareSource to let us know of any complaints regarding CareSource or the health care services they receive. Members or health partners, 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 health partners can contact CareSource at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) to learn more about these procedures.

Member Grievances – Any time a member informs us that they are dissatisfied with CareSource, or one of our health partners, it is a grievance. CareSource investigates all grievances. If the grievance is about a health partner, CareSource calls the health partner'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 15 calendar days.

Medicaid Only

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 90 calendar days. CareSource will respond to the appeal in writing within 15 calendar days of when it was received.

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.

Health partners may submit a verbal request to the Grievance and Appeals department by calling **1-800-488-0134**.

CareSource will make a determination within one (1) 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 health partner 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 health partner will be notified in writing of the determination to process as a standard appeal within two (2) calendar days of receipt of the appeal, including information that the member can appeal the decision. In the event that 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.

Medicaid Only

State Hearings – CareSource members can request a state hearing through ODM if CareSource makes a decision to deny, reduce, suspend or stop care for a member. CareSource members can also request a state hearing if they receive a bill from a health partner as a result of CareSource's denial of payment. CareSource members are not 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 mailing date on the form. 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. Health partners 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 health partner 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. At any time during this process, members may contact ODM or the Ohio Department of Insurance (ODI).

Independent External Review – In addition to a state hearing, CareSource members may ask for an independent external review if CareSource decides not to approve medical care, based on medical necessity that has been requested for them. These reviews are conducted by a certified medical review organization instead of CareSource. Members must exhaust CareSource's appeal process first and request the independent external review within 45 calendar days of the date CareSource notifies them of the appeal denial.

To Request an External Review, Members Can Write to Us At:

CareSource
Attn: Independent Review – QI Department
P.O. Box 1947
Dayton, OH 45401-1947

Or requests can be made by calling Member Services toll-free at **1-800-488-0134** (TTY: 1-800-750-0750 or 711). For urgent cases, determinations are made within 72 hours of asking for the review. If the case is not urgent, determinations are made within 30 calendar days.

CHAPTER 10: PHARMACY

Medicaid Only

MEDICAID

CareSource covers all medically necessary Medicaid-covered prescription drugs and medical supplies. This applies to everyone who gets health care through an Ohio Medicaid managed care plan.

Details of Managed Care Plans Administering Prescription Drug Coverage:

- **Copayment requirements** – Members will not be required to pay a copayment for prescription drugs. Some medical supplies are now covered under the managed care plan, including diabetes supplies, spacers, peak flow meters and condoms.
- **Other medical supplies and durable medical equipment** – To support member access and convenience, other medical supplies, such as wound care supplies and enteral feeds, can continue to be filled by the CareSource pharmacy benefit manager (PBM) through the retail pharmacy as previously done for a limited period of time until a durable medical equipment (DME) health partner can be contacted.
- **Medications administered in the health partner setting** – Medications that are administered in a health partner setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center will be billed to the managed care plan. Prior authorization requirements now exist for many injectables.
- **Transition period** – A 30 day transition period applies for members moving from fee-for-service to Managed Care Plans. After the 30 day transition period has ended, prior authorization may be applicable depending on the member's medication. Please check our website for medications that require prior authorization.

Formulary

CareSource uses evidence-based guidelines to ensure health care services and medications meet the standards of excellent medical practice and are the lowest cost alternative for the member.

CareSource uses a Preferred Drug List (PDL) or formulary. Some drugs require prior authorizations. The online Formulary contains information about prior authorizations, quantity limits and step therapy protocols and therapeutic interchanges for most drug classes.

Step Therapy and Quantity Limits

Certain medications on the PDL are covered if utilization criteria are met. Step therapy is one such utilization technique that requires using a formulary medication before the non-formulary medication would be approved for use.

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

Generic Substitution

Generic substitution occurs when a pharmacy dispenses a generic version rather than a prescribed brand-name product. In the online formulary, **boldface type** indicates generic availability. However, not all strengths or dosage forms of the generic name in boldface type may be generically available. In most instances, a brand-name drug for which a generic product becomes available will become non-formulary, with the generic product covered in its place, upon release of the generic product onto the market.

However, the formulary document is subject to state-specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

Generic drugs are usually priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness, and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drugs.
- Manufactured in the same strength and dosage form as the brand-name drugs.

When a generic drug is substituted for a brand-name drug, you can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic interchange).

A list of preferred drugs is available at **CareSource.com**. This site also includes other information about the Ohio Medicaid pharmacy program.

Medicaid Pharmacy Prior Authorization

CareSource will process prior authorizations requests in accordance with Ohio Medicaid regulations. Prior authorization requires that a drug be preapproved in order for it to be covered under a health benefit.

The prior authorization staff will adhere to the Ohio Administrative Code and determine medical necessity for formulary exception requests that will be reviewed based on drug-specific prior authorization criteria or standard non-formulary prescription request criteria.

Health partners can submit prior authorization requests by phone or fax. Health partners will be required to submit pertinent medical or drug history, prior treatment history and any other necessary supporting clinical information with the request.

Medicaid Pharmacy Questions

Online (preferred): **CareSource.com**
Fax (preferred): 866-930-0019
Phone: 1-800-488-0134

Medication Therapy Management Program

CareSource offers a Medication Therapy Management (MTM) program for all CareSource 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 patient's medications.

CareSource Specialty Pharmacy Program

All specialty medications are provided by CVS Caremark Specialty pharmacy to improve medication compliance, side effect management and disease state management. CVS Caremark Specialty Pharmacy provides specialty medications directly to the member or the prescribing physician and coordinates nursing care if required. Please visit our website at **CareSource.com** to see more details about the specialty pharmacy program.

Network Pharmacy

Our Pharmacy Directory gives you a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website at **CareSource.com** for a complete list of network pharmacies.

Medicaid Questions

For questions pertaining to prior authorization requests, please contact us at **1-800-488-0134** or fax 866-930-0019.

Tell Us the Medical Reasons for Exceptions

Typically, our PDL includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

CareSource has an exception process that allows the member or the member's representative to make a request for an exception. Reasons for exceptions may include intolerance or allergies to drugs, or inadequate or inappropriate response to drugs listed on the PDL. The member or member's representative must initiate the request by calling Member Services. CareSource then reaches out to the health partner to obtain the appropriate documentation.

CareSource will provide a decision no later than 72 hours after the request is received, or within 24 hours if the member is suffering from a serious health condition. Health partners may be asked to provide written clinical documentation as to why a member needs an exception. In determining whether an exception will be given, CareSource will consider whether the requested drug is clinically appropriate.

Approval and Denial of Drug Exceptions

If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as you continue to prescribe the drug for your patient and that drug continues to be safe and effective for treating the condition.

If we deny your request for an exception, you can ask for a review of our decision by making an appeal. Please review the "Appeals" section for details on how to submit appeals.

Appeals

An appeal is defined as a special kind of complaint a member may make if he or she disagrees with a decision to deny a request for health care services and/or prescription drugs or payment for services and/or prescription drugs they already received. A member may also make a complaint if he or she disagrees with a decision to stop services that they are receiving. For example, a member may ask for an appeal if our plan doesn't pay for a drug, item or service they think they should be able to receive.

Our members' health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first. Please contact us for grievances, organization determinations, coverage determinations and appeals questions at **1-800-488-0134**. We will work with you to try to find a satisfactory solution to your problem.

CHAPTER 11: PRIMARY CARE PROVIDERS

Primary Care Provider Concept

All CareSource members choose or are assigned to 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 health plan's Provider Directory. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling our Member Services department at **1-800-488-0134**.

PCP Roles and Responsibilities

According to the Ohio Administrative Code (OAC) 5610-26-03.1(B), PCP care coordination responsibilities include at a minimum, the following:

1. Assisting with coordination of the member's overall care, as appropriate for the member.
2. Serving as the ongoing source of primary and preventive care.
3. Recommending referrals to specialists, as required.
4. Triaging members as described in paragraph OAC 5610-26-03.1(A)(2) of the rule.
5. Participating in the development of care management care treatment plans and notifying CareSource of members who may benefit from care management. Please see the "Member Support Services and Benefits" section on how to refer members for care management.

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

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

PCPs Are Responsible For:

- Treating CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plan and the Ohio Department of Medicaid (ODM) as outlined in this manual.
- 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.

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

Medicaid Only

PCPs Providing Prenatal and Postpartum Care

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

Prenatal and Postpartum Care Documentation

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

- Evidence of prenatal teaching – This includes education on infant feeding; Women, Infants, and Children (WIC); birth control, prenatal risk factors, dietary and nutrition information and childbirth procedures.
- Components of the postpartum checkup – This includes documenting the pelvic exam, blood pressure, weight, breast exam and abdominal exam.

Medicaid Only

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 the “Member Support Services and Benefits” section.

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.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during well-child/EPSDT exams as needed. CareSource endorses the same recommended childhood immunization schedule that is recommended by the Center for Disease Control and approved by the Advisory Committee on Immunization Practices, 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 can be found at www.aap.org.

Medicaid Only

CareSource Clinical Practice Registry and Member Profile

CareSource Clinical Practice Registry

Quick and easy to access on our secure Provider Portal, the CareSource Clinical Practice Registry helps PCPs 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 at https://providerportal.caresource.com/OH/.

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.

Member Profile Benefits

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

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

CHAPTER 12: PROVIDER APPEALS PROCEDURES

Appeals of Claims Denials or Adverse Decisions

If you do not agree with the decision of a processed claim, you will have 365 days from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied. If the appeal is denied, health partners will be notified in writing. If the appeal is approved, payment will show on the health partner's Explanation of Payment (EOP).

Please note: If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim; you do not need to file an appeal. Health partners have 365 days from the date of service or discharge to submit a corrected claim.

How to Submit Appeals

Claims Appeals:

Health partners can submit claims through our secure Provider Portal, or in writing:

Provider Portal: https://providerportal.caresource.com/OH/
Under the Provider Portal, click on the "Claims Appeals" tab on the left.

Fax: 937-531-2398

Writing: CareSource
Attn: Health Partner Appeals
P.O. Box 2008
Dayton, OH 45401-2008

Use the Health Partner Claim Appeal Request Form located on our website. Please include:

- The member's name and CareSource member ID number
- The health partner's name and ID number
- The code(s) and reason why the determination should be reconsidered
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or Electronic Data Information (EDI) for reconsideration
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination

If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file an appeal.

CareSource Medicaid Health Partner Appeals

Health Partner or Health Partner Appealing on Behalf of a Member

Standard Medical Necessity Appeals of Non-Certification Determinations

An appeal is defined as a formal request by a member or health partner, including facilities or other health care entities on behalf of a member or health partner for a review of a determination or action.

Timeline for Clinical Appeals

Clinical appeals can be submitted by the member or health partner after receiving a letter from CareSource denying coverage. Appeals can be filed by a:

- **Health partner** – within 180 days from the date of denial, date of discharge or date of service
- **Health partner on behalf of a member with written authorization from the member** – within 90 days of receipt
- **Member** – within 90 days of receipt

Additional Details about Clinical Appeals

Timing for Medical Necessity Appeals

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days from the date of denial, date of discharge or date of service.

Appeals Filed on Behalf of the Member

Medical necessity appeals filed by members or health partners on behalf of a member must be submitted to CareSource within 90 days and will be resolved within 15 calendar days of receipt or as expeditiously as the member's condition warrants. Appeals on behalf of the member must include written authorization to appeal on their behalf for the specific service that is being appealed. All other medical necessity appeals will be resolved within 30 calendar days of receipt.

Expedited Appeals

An expedited appeal should be considered if the health partner feels that the patient's life or health is at risk if a decision about care is not made in a timely manner.

Requests may be a verbal request and should be submitted to the Grievance and Appeals department by calling **1-800-488-0134**.

CareSource will make a determination within one (1) 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 health partner 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 health partner will be notified in writing of the determination to process as a standard appeal within two (2) calendar days of receipt of the appeal, including information that the member can appeal the decision. In the event that 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.

Notification of Resolution

CareSource will verbally notify the health partner or facility of the appeals resolution if the member is in an inpatient setting and will send written notification to both the health partner and member on the same business day of the decision.

Extending an Appeal

A member can verbally request that CareSource extend the time frame to resolve a standard or expedited appeal up to 14 calendar days. CareSource may request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days. CareSource must submit documentation that the extension is in the member's best interest to the Ohio Department of Medicaid (ODM) for prior approval. If ODM approves the extension, CareSource must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

Dissatisfaction of Medical Necessity Appeals – One Level of Appeal

If you are dissatisfied with any medical necessity decision made by CareSource, we offer one level of appeal as mandated by ODM. Members have the right to a state hearing as a first or second level of appeal (See "State Hearings" in the "Member Support Services and Benefits" section of this manual for more information).

You may use the Health Partner Appeal Request Form on **CareSource.com** to submit your appeal, but this form is not required.

Appeal requests should include:

- The member's name, CareSource member ID number and date of birth
- The health partner's name and CareSource provider billing number
- The place, date and type of service that had a non-certification determination for clinical appeals
- The reason why the determination should be reconsidered
- Any additional available medical information to support your reasons for reversing the determination

The Appeals department may request additional information from you to document medical necessity.

All appeal requests and associated information are reviewed by clinicians previously uninvolved with the case. You will be notified in writing of the outcome of your appeal request.

Medical necessity appeals of non-certification determinations must be submitted to CareSource within 180 calendar days from the date of denial, date of discharge or date of service.

How to Submit Appeals

Appeals may be submitted by fax or in writing:

Provider Portal: https://providerportal.caresource.com/OH/

Fax: 937-531-2398

Writing: CareSource
Attn: Health Partner Appeals – Clinical
P.O. Box 2008
Dayton, OH 45401-2008

CHAPTER 13: QUALITY IMPROVEMENT PROGRAM

CareSource is committed to providing care that is safe, effective, member-centered, timely, efficient and equitable. The scope of the CareSource Quality Improvement (QI) program is comprehensive and includes both clinical and non-clinical services. CareSource monitors and evaluates quality of care, safety and service delivered to our members, with emphasis on accessibility to care, availability of services and physical and behavioral health care delivered by network practitioners and health partners. CareSource also monitors member services through practitioners, health partners, hospital, utilization management, care management and pharmacy programs. Member satisfaction and health outcomes are monitored through routine health plan reporting, annual Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores, assessment of health partner and member satisfaction and review of accessibility and availability standards, utilization trends and quality improvement activities. Performance is assessed against goals and objectives that are in keeping with industry standards. Annually, CareSource completes an evaluation of our QI program.

Program Scope

CareSource supports an active, ongoing and comprehensive Quality Improvement program. The scope of the Quality Improvement program includes:

- Advocate for members across settings
- Meet member access and availability needs for physical and behavioral health care
- Determine interventions for HEDIS overall rate improvement that increase preventive care rates and facilitate support of members' acute and chronic health conditions and complex needs
- Determine interventions for CAHPS rate improvement that enrich member and health partner experience and satisfaction
- Demonstrate enhanced care coordination and continuity across settings
- Meet members' cultural and linguistic needs
- Monitor important aspects of care to ensure the safety of members across health care settings
- Determine practitioner adherence to clinical practice guidelines
- Support member self-management efforts
- Partner collaboratively with network partners, practitioners, regulatory agencies and community agencies
- Ensure regulatory and accrediting agency compliance

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

Primary Care Physicians (PCPs)

Patients with…	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	No later than the end of the following working day after the patient's initial contact with the PCP site
Regular and routine care needs	Not to exceed 6 weeks

Non-PCP Specialists

Patients with…	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care needs	Not to exceed 12 weeks

Non-PCP Specialists

Patients with…	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 14 calendar 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 health partner is unable to see the member within the appropriate time frame, CareSource will facilitate an appointment with a participating health partner or a nonparticipating health partner, 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 health partners as well as between medical health partners and behavioral health partners.

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

How to Submit Changes to CareSource:

Email: ProviderMaintenance@caresource.com

Fax: 937-396-3076

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

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.

Quality Measures

CareSource uses HEDIS measures to measure the quality of care delivered to 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 pressing areas of care. Potential quality measures are:

- Wellness and prevention
  - Preventive screenings (e.g. breast cancer, cervical cancer, chlamydia)
  - Well-child care
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure
- Behavioral health
  - Follow-up after hospitalization for mental illness
  - Antidepressant medication management
  - Follow-up for children prescribed attention-deficit/hyperactivity disorder medication
- Safety
  - Use of imaging studies for low back pain

CareSource uses CAHPS surveys, to capture member perspectives on health care quality. CAHPS is a program overseen by the United Stated Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ). Potential CAHPS measures include:

- Customer service
- Getting care quickly
- Getting needed care
- How well doctors communicate
- Ratings of all health care, health plan, personal doctor or specialist

Preventive Guidelines and Clinical Practice Guidelines

CareSource approves and adopts nationally accepted standards and guidelines and promotes them to practitioners and members to help inform and guide clinical care provided to members. Guidelines are reviewed at least every two years, or more often as appropriate, and updated as necessary. They may be found on **CareSource.com.** The use of these guidelines allows CareSource to measure the impact of the guidelines on outcomes of care. Review and approval of the guidelines are completed by the CareSource Clinical Advisory Committee every two years or more often as appropriate. The guidelines are then presented to the CareSource Quality Enterprise Committee. Topics for guidelines are identified through analysis of members. Guidelines may include, but are not be limited to:

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

Guidelines are promoted to health partners through newsletters, **CareSource.com**, direct mailings, the CareSource Health Partner Manual and through focused meetings with CareSource Health Partnership representatives. Information about clinical practice guidelines and 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 Health Partner Services at **1-800-488-0134**.

Medicaid Health Partner Performance and Profiling

As a function of medical management oversight responsibilities, CareSource monitors over utilization and under utilization of medical services. Health partner profiling is done periodically to measure utilization of common inpatient and outpatient services as preventive services, HEDIS clinical performance measures and pharmacy utilization. Summary reports for these measures are available to individual health partners upon request and routine periodic reporting is being developed.

If a health partner is found to be performing below minimum care standards for participation with CareSource, this information is shared with the health partner so practitioners can make positive changes in practice patterns. We work with the health partner to develop an action plan for improvement. Further action may include onsite assessment, auditing medical care at specific intervals, disseminating comparative data or standards of care, meeting with physicians, probation, reporting deficiencies to appropriate authorities, or termination of participation with CareSource. CareSource also works with participating health partners, if necessary, to develop corrective action plans for those who do not meet the standards.

External Quality Reviews

Through our contract with the Ohio Department of Medicaid (ODM), we are required to participate in periodic medical record reviews. ODM retains an External Quality Review Organization (EQRO) to conduct medical record reviews for CareSource members. You may periodically receive requests for medical record copies from an EQRO or from CareSource for these purposes. Your contract with CareSource requires that health care health partners furnish patient medical records to us for this purpose. EQRO reviews are a permitted disclosure of a member's personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). As we have in the past, we hope to continue sharing the results of these studies and working in partnership to achieve the best health care possible for our members.

Tips for complete medical record documentation – CareSource realizes that supplying medical records for review requires your staff's valuable time, and we appreciate your cooperation with our requests and associated timelines. We offer the following suggestions to ensure complete and accurate documentation of patient services:

- Use legible handwriting.
- Consider dictated notes, which can improve comprehension of medical records with less chance of misinterpretation.
- Include the patient's name on the front and back of every page of the medical record.
- Initial and date lab results in the medical record to indicate that they have been reviewed by a physician.
- Record all patient visit dates and sign all chart entries.
- Consider using preprinted forms to document all aspects of comprehensive services, such as Healthchek exams.

We appreciate your attention to detail in chart documentation.

CHAPTER 14: REFERRALS AND PRIOR AUTHORIZATIONS

This section describes the referral and prior authorization processes and requirements for services provided to CareSource members. Please visit our Provider Portal at **CareSource.com** for the most current information on prior authorization (PA) and referral requirements.

Referrals

If you have questions about referrals and prior authorizations, please call our Medical Management department at **1-800-488-0134**.

Medicaid Only

Medicaid Services That Do Not Require a Referral

Some health care services provided by specialists do not require a referral from a Primary Care Provider (PCP). Members may schedule self-referred services from participating health partners themselves. PCPs do not need to arrange or approve these services for members as long as any applicable benefit 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 health partner)
- Podiatric care
- Psychiatric care at Community Mental Health Centers only
- Psychological care (from private practitioners or at Community Mental Health Centers)
- Care at public health clinics
- Care at Federally Qualified Health Centers and Rural Health Clinics
- Most radiology services (must be ordered by a participating health partner)
- Routine eye exams (at participating vision centers, within benefit limits)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours
- Services for children with medical handicaps

Medicaid Only

Medicaid Members May Go to Nonparticipating Health Partners For:

- Emergency care
- Care at Community Mental Health Centers
- Family planning services provided at qualified family planning health partners (e.g., Planned Parenthood)
- Care at Federally Qualified Health Centers and Rural Health Clinics
- Care at Ohio Department of Mental Health and Addiction Services facilities that are Medicaid health partners

Medicaid Referral Procedures

A referral is required for specialty services not listed above and for plan members to be evaluated or treated by most specialists. Any treating doctor 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 prior authorization for any services rendered to CareSource patients. You can request a prior authorization by calling our Medical Management department at **1-800-488-0134**, and select the option to request a prior authorization. Or you can submit a request online at **CareSource.com** and select the Provider Portal option from the menu.

If you have difficulty finding a specialist for your CareSource member, please refer to the Find a Doctor/Provider tool on **CareSource.com**.

Steps to Make a Referral

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.

Medicaid Only

Standing referrals – A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral.

Members who meet the definition of Children with Special Health Care Needs may access specialty care health partners directly through the use of a standing referral.

Members are instructed to obtain the standing referral from their PCP. Children with Special Health Care Needs are patients 6 months and older, and younger than 21, who have asthma, HIV/AIDS, teen pregnancy, a letter of approval from the Bureau of Children with Medical Handicaps, or are receiving Supplemental Security Income (SSI) for a chronic medical condition.

Referrals to Out-of-Plan Health Partners – A member may be referred to out-of-plan health partners if the member needs medical care that can only be received from a doctor or other health partner who is not participating with our health plan. Treating health partners must get prior authorization from our health plan before sending a member to an out-of-plan health partner.

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. However, health partners 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 health partner for a second opinion:

- The health partner must be a participating health partner. If not, prior authorization must be obtained to send the patient to a nonparticipating health partner.
- The health partner must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The health partner must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the health partner giving the second opinion.

Prior Authorization Procedures

Prior authorizations for health care services can be obtained by contacting the Medical Management department online, by email, phone, fax or mail:

Online: CareSource.com and select the Provider Portal option from the menu

Email: mmauth@caresource.com

Fax: 888-752-0012.
For fax requests, use the prior authorization form on **CareSource.com**.

Mail: Send prior authorization requests to:
CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Phone: Call 1-800-488-0134 and Katie, our interactive voice response system, will direct you to submit authorization requests, depending on your need.

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource member ID number
- Health partner name and NPI
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan health partner, if applicable
- Clinical information to support the medical necessity for the service

If the request is for inpatient admission (whether it is elective, urgent or emergency), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

If inpatient surgery is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, any appropriate clinical and anticipated discharge needs.

If the request is for outpatient surgery, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs.

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received.

When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Health partners must verify eligibility on the date the service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the health partner.

CareSource will notify you of prior authorization determinations by a letter mailed to the health partner's address on file.

For standard prior authorization decisions, CareSource provides notice to the health partner and member as expeditiously as the member's health condition requires, but no later than 14 calendar days following receipt of the request for service.

Urgent prior authorization decisions are made within 72 hours of receipt of request for service. Please specify if you believe the request is urgent.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Medicaid Only

Medicaid Services That Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. They include, but are not limited to the following services:

- All inpatient care
- All abortions
- Some home care services
- Nursing facility services
- Hospice care
- Organ transplants
- Cosmetic procedures and plastic surgery
- Orthodontia treatment and other dental services
- For ambulette transportation – please call our transportation vendor for service
- Ambulance transportation – except for emergent or facility-to-facility transfers
- Some durable medical equipment, including:
  - All powered or customized wheelchairs
  - Manual wheelchair rentals over three months
- All miscellaneous codes (example E1399)
- Hearing aids
- Contact lenses
- Food supplemental/nutritional supplements > 30 cans per month
- Pain management

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

- MRI/MRAs
- CT/CTA scans
- PET scans

There will be two ways ordering health partners can obtain prior authorization from NIA for an imaging procedure:

- **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. Eastern Standard Time (EST)

Authorization requests are approved at intake in most cases. If an approval cannot be issued during the initial intake, more information may be required.

Note: Imaging procedures performed during an inpatient admission, hospital observation stay or emergency room visit are not included in this program.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Synagis Prior Authorization

CareSource's medical policy for administration of Synagis follows the American Academy of Pediatrics (AAP) guidelines for respiratory syncytial virus (RSV). 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.

In addition, any health partner who is not a participating health partner with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource member.

CareSource does not require prior authorization for unlisted procedure CPT codes. However, it requires a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code.

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. Denials will be reconsidered through the appeal process with pertinent clinical records.

Medicare Only

Medicare Services That Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. They include, but are not limited to the following services:

- All inpatient care
- All abortions
- All home care services
- Nursing facility services
- Hospice care
- Organ transplants
- Durable medical equipment over $750 billed charges
- Prosthetic devices over $750 billed charges
- Cosmetic procedures and plastic surgery
- Non-formulary drug requests
- Some part B and part D drugs
- Ambulance and ambulette transportation – except for emergent or facility-to-facility transfers
- Emergency medical response system
- Physical therapy visits greater than 20 per calendar year
- Outpatient diagnostic/therapeutic radiology services
- Occupational therapy visits greater than 20 per calendar year
- Speech therapy visits greater than 15 per calendar year
- Chiropractic visits greater than 12 per calendar year
- Mental health/psychiatry visits greater than 10 per calendar year
- Podiatry office visits greater than 8 per calendar year
- Substance abuse services greater than 12 per calendar year

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

- MRI/MRAs
- CT/CTA scans
- PET scans

There will be two ways ordering health partners can obtain prior authorization from NIA for an imaging procedure:

- **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. Eastern Standard Time (EST)

Authorization requests are approved at intake in most cases. If an approval cannot be issued during the initial intake, more information may be required.

Note: Imaging procedures performed during an inpatient admission, hospital observation stay or emergency room visit are not included in this program.

Please note that our prior authorization requirements are subject to change. Please refer to the Evidence of Coverage at **CareSource.com** for the most current information on services that require prior authorization and the prior authorization process.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Utilization Management (UM)

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The Medical Management department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the CareSource care management team are made, if needed. CareSource makes it's UM criteria available in writing by mail, fax or email and via the web.

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

Fax: 888-752-0012

Email: mmauth@caresource.com

On an annual basis, CareSource completes an assessment of satisfaction with the UM process and identifies any areas for improvement opportunities.

Access to Staff

Health partners may call our toll free number at **1-800-488-0134** to contact Medical Management staff with any UM questions.

- Staff members are available from 8 a.m. to 5 p.m. during normal business hours for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

Criteria – CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. This criteria is designed to assist health partners 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 criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health care health partners 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 under utilization.

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 Medical Management department. Physicians may call to discuss an adverse decision with CareSource's physician reviewer by calling the Medical Management department at **1-800-488-0134**, ext. 2830, within five business days of the determination.

Health Partner Appeals Procedure

If you are dissatisfied with a determination made by our Medical Management department regarding a member's health care services or benefits, you may appeal the decision. Please see the "Appeal Procedures" section in this manual for information on how to file a clinical appeal.

Retrospective Review

A retrospective review is a request for an initial review for authorization of care, service or benefit for which an authorization is required, but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. Upon written request, CareSource shall permit retrospective review where a prior authorization was required but not obtained (Retro Authorization). To qualify, the service must meet all of the following:

- The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original prior authorized service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria will need to be met to qualify for a retro authorization review.

Claims not meeting the necessary criteria will be denied.

A request for retrospective review can be made by calling **1-800-488-0134** and allowing Katie, our interactive voice response system, to direct you to the Medical Management department, or by faxing the request to 888-527-0016. Clinical information supporting the request for services must accompany the request.

Post Stabilization Services

Please call **1-800-488-0134** for any questions related to post-stabilization services. The definition of "Post-Stabilization Care Services" is 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. Prior Authorization 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 health partner. To request prior authorization for observation services as a nonparticipating health partner or to request authorization for an inpatient admission please call **1-800-488-0134**. When calling, tell Katie, our interactive voice response system, that you are requesting post stabilization. During regular business hours, your call will be answered by our Medical 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.

Medicaid Only

Surgical Procedure Forms

CareSource accepts the same certification and consent forms for abortion, hysterectomy and sterilization procedures that the Ohio Department of Medicaid (ODM) accepts. The most current copies of the abortion certification, hysterectomy and sterilization consent forms can be obtained online at www.medicaid.ohio.gov/resources/publications/medicaidforms.aspx.

CHAPTER 15: AMERICANS WITH DISABILITIES ACT (ADA)

The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, health partners 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, health partners' diagnostic equipment must accommodate individuals with disabilities.

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

Please see the following pages for information about the ADA. More information on this subject may be obtained at www.cdihp.org.

Q. Which health partners are covered under the ADA?

A. Private hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists and health clinics are among the health partners covered by the Title III of the ADA. Title III applies to all private health partners, regardless of size. It applies to health partners of both physical and mental health care. If a professional office is located in a private home, the portion of the home used for public purposes is covered by the ADA.

Hospitals and other health care facilities that are operated by state or local governments are covered by Title II of the ADA. Health partners that offer training sessions, health education, or conferences to the general public must make these events accessible to individuals with disabilities.

Policies and Procedures

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

Q. What kinds of modifications to policies or procedures might be required?

A. Modifying standard policies, practices or procedures can be an inexpensive but effective way to provide access to health care services. This may mean taking extra time to explain a procedure to a patient who is blind or ensuring that a patient with a mobility impairment has access to an accessible exam room.

Effective Communication, Auxiliary Aids and Services

Health partners must find appropriate ways to communicate effectively with persons who have disabilities affecting their ability to communicate. Various auxiliary aids and services such as interpreters, written notes, readers, large print or Braille text can be used depending on the circumstance and the individual.

Q. Why are auxiliary aids and services so important in the medical setting?

A. Auxiliary aids and services are often needed to provide safe and effective medical treatment. Without these aids and services, medical staff runs the risk of not understanding the patient's symptoms, misdiagnosing the patient's medical problem and prescribing inappropriate treatment. Similarly, patients may not understand medical instructions or warnings that may have a serious impact on their health.

Q. How does a health partner determine which auxiliary aid or service is best for a patient?

A. The health partner can choose among various alternatives consulting with the person and carefully considering his or her expressed communication needs in order to achieve an effective result.

Q. Can a patient be charged for part or all of the costs of receiving an auxiliary aid or service?

A. No. A health partner cannot charge a patient for the costs of auxiliary aids and services, either directly or through the patient's insurance carrier.

Q. In what medical situations should a health partner obtain a sign language interpreter?

A. If a patient or responsible family member usually communicates in Sign Language, an interpreter should be present in all situations in which the information exchanged is lengthy or complex (for example, discussing a patient's medical history, conducting psychotherapy, communicating before or after major medical procedures and providing complex instructions regarding medication).

If the information to be communicated is simple and straightforward, such as prescribing an X-ray or a blood test, the physician may be able to communicate with the patient by using pen and paper.

Existing Facilities/Barrier Removal

Q. When must private medical facilities eliminate architectural and communication barriers that are structural in nature from existing facilities?

A. When the removal of those barriers is readily achievable, meaning easy to accomplish, without much difficulty or expense. Like undue burden, readily achievable is determined on a case-by-case basis in light of the resources available to an individual health partner.

Q. How does one remove "communication barriers that are structural in nature"?

A. For instance, install permanent signs, flashing alarm systems, visual doorbells and other notification devices, volume control telephones, assistive listening systems and raised character and Braille elevator controls.

Complaints

Q. What if a patient thinks that a health partner is not in compliance with the ADA?

A. If a health partner cannot satisfactorily work out a patient's concerns various means of dispute resolution, including arbitration, mediation, or negotiation, are available. Patients also have the right to file an independent lawsuit in federal court and to file a formal complaint with the U.S. Department of Justice.

Excerpted from and based on, "ADA Q and As" by Deborah Leuchovius, ADA Specialist, PACER (Parent Advocacy Coalition for Educational Rights) 8161 Normandale Blvd., Bloomington, MN 55437.

CHAPTER 16: CARESOURCE MYCARE OHIO (MEDICARE-MEDICAID PLAN)

What is MyCare Ohio?

MyCare Ohio is the state of Ohio's dual demonstration. MyCare Ohio is a system of managed care plans selected to coordinate the physical, behavioral and long-term care services for individuals over the age of 18 who are dually eligible for both Medicaid and Medicare. This includes people with disabilities, older adults and individuals who receive behavioral health services.

The MyCare Ohio program coordinates Medicare and Medicaid benefits for Medicare-Medicaid enrollees. The goal of MyCare Ohio program is to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees, including long-term services and supports.

MyCare Ohio stresses a team approach to health care. **Every enrollee gets a care manager assigned to help coordinate care.** The care team includes the individual, the individual's family and/or caregiver, the CareSource care manager, the waiver service coordinator (if appropriate) the primary care provider, specialists and other health partners as appropriate to support and coordinate the member's care.

CareSource MyCare Ohio is serving people in these 12 Ohio counties:

Columbiana	Lorain	Stark
Cuyahoga	Mahoning	Summit
Geauga	Medina	Trumbull
Lake	Portage	Wayne

Purpose of This CareSource Mycare Ohio Section

The information provided within this section of the Health Partner Manual is to address information specific to the CareSource MyCare Ohio plan. This information should be used in tandem with the information provided elsewhere throughout this manual. Please refer to other areas of this manual for information about traditional Medicaid.

Health partners of personal care, long-term support, home modifications, home caregivers and other similar services apart from physicians, physician assistants, hospitals and similar health care services will find this section particularly important for information about submitting claims for payment, appeals, certification, referrals and prior authorization for services.

Opting Out of CareSource MyCare Medicare Coverage

MyCare Ohio allows for individuals to opt out of Medicare coverage from the plan managing their MyCare benefits. Individuals will have the option to have CareSource provide their Medicare benefits or to opt out of the Medicare portion of the program and stay with their current Medicare Advantage plan or traditional Medicare.

Health partners need to confirm the MyCare Ohio member's option for Medicare coverage. If a member chooses a different plan for their Medicare benefits, CareSource will only manage Medicaid benefits and will only reimburse claims for Medicaid services. Claims for Medicare must be submitted to the plan managing their Medicare benefits.

Therefore, it is important to verify member eligibility prior to each service rendered. Health partners may use our secure Provider Portal on our website to check member eligibility, or call our Health Partner Services department.

Provider Portal: https://providerportal.caresource.com/OH/
Click on "Member Eligibility" on the left, which is the first tab.

Health Partner Services Department: 1-800-488-0134

Quick Reference Information

Note: the information below is available from **CareSource.com**.

Important Phone Numbers:		
Health Partner Services:	1-800-488-0134	Monday to Friday 8 a.m. to 6 p.m.
Prior Authorizations:	1-800-488-0134	Monday to Friday 8 a.m. to 6 p.m.
Claims Inquiries:	1-800-488-0134	Monday to Friday 8 a.m. to 6 p.m.
Member Services:	1-855-475-3163	Monday to Friday 8 a.m. to 6 p.m. 24/7/365
CareSource 24, 24-Hour Nurse Advice Line:	1-866-206-7861	
TTY for the Hearing Impaired:	1-800-750-0750 or 711	Monday to Friday 8 a.m. to 6 p.m.
Important Fax Numbers:		
Care Management Referral:	877-946-2273	
Credentialing:	866-573-0018	
Fraud, Waste and Abuse:	800-418-0248	
Medical Prior Authorization:	888-752-0012	
Health Partner Appeals:	937-531-2398	
Health Partner Maintenance (e.g., office changes, adding/ deleting a health partner):	937-396-3076	

Addresses:	
General Correspondence:	CareSource P.O. Box 8738 Dayton, OH, 45401-8738
Medical Prior Authorizations:	CareSource P.O. Box 1307 Dayton, OH 45401-1307
Health Partner Appeals:	CareSource Attn: Health Partner Appeals P.O. Box 2008 Dayton, OH 45401-2008
Member Appeals and Grievances:	CareSource Attn: Member Appeals P.O. Box 1947 Dayton, OH 45401
Claims:	CareSource P.O. Box 8730 Dayton, OH 45401
Fraud, Waste and Abuse:	CareSource Attn: Special Investigations Department P.O. Box 1940 Dayton, OH 45401-1940
Health Partner Demographic Changes:	CareSource Attn: Health Partner Maintenance P.O. Box 8738 Dayton, OH 45401-8738

Web Services

Website: CareSource.com
Provider Portal: https://providerportal.caresource.com
CareSource Payer ID: 31114

Clearinghouse	Phone	Website
Alveo	800-327-1213	www.alveohealth.com
Availity	800-282-4548	www.availity.com
Change Healthcare	800-845-6592	www.changehealthcare.com
Consolidated Pro Systems (CPS)	888-255-7293	www.changehealthcare.com
Dyserv	614-294-6078	www.dyserv.com
Manacon	937-746-6685	NA
Practice Insight	832-476-9030	www.practiceinsight.com
Quadax	440-777-6305	www.quadax.com
RelayHealth	800-527-8133	www.relayhealth.com
ZirMed	877-494-7633	www.zirmed.com

In order to receive electronic funds transfer (EFT) payment from CareSource, you must enroll with InstaMed. Call InstaMed at 1-215-789-3682.

Radiology

CareSource works with NIA Magellan Imaging Services for radiology and imaging services. Authorizations can be ordered through www.radmd.com.

Services That Require Prior Authorization:

- All abortions
- All home care services
- All inpatient care
- All intensive outpatient program services
- All partial hospital program services
- Assertive community treatment
- Ambulance transportation – except for emergent or facility-to-facility transfers
- Chiropractic visits greater than 12 per calendar year
- Community psychiatric supportive treatment
- Cosmetic procedures and plastic surgery
- Day treatment
- Durable medical equipment over $750 billed charges
    - All powered or customized wheelchairs
    - Manual wheelchair rentals over three months
    - All miscellaneous codes (ex: E1399)
- Hospice care
- Mental health visits greater than 10 per calendar year
- Non-emergent diagnostic imaging procedures:
    - CT/CTA scans
    - MRI/MRAs
    - PET scans
- Non-formulary drug requests
- Nursing facility services
- Occupational therapy visits greater than 20 per calendar year
- Organ transplants
- Pain management services
- Physical therapy visits greater than 20 per calendar year
- Podiatry office visits greater than 8 per calendar year
- Orthotics/prosthetic devices over $750 billed charges
- Some dental services
- Some Part B and Part D drugs
- Speech therapy visits greater than 15 per calendar year
- Substance abuse services greater than 12 per calendar year

Any health partner who is not a participating health partner with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource member.

Note: All waiver services require prior authorization.

Waiver health partners can view their authorizations on the Provider Portal under Service Plans. Waiver health partners may submit claims for waiver services via the Claims link on the Service Plan.

CareSource Member ID Card

All new CareSource MyCare Ohio members receive a membership ID card, which replaces the state Medicaid card. If the member has selected CareSource to provide both their Medicare and Medicaid benefits, they will have a single ID card replacing both their state Medicaid and their Medicare Card. These members will require only one card for both plans.

However, if a member does not select CareSource to provide their Medicare benefits, they will continue to use the card for their selected Medicare plan.

Health partners need to confirm the MyCare Ohio member's option for Medicare coverage. If a member chooses a different plan for their Medicare benefits, CareSource will only manage Medicaid benefits and will only reimburse claims for Medicaid services. Claims for Medicare must be submitted to the plan managing their Medicare benefits.

Therefore, it is important to verify member eligibility prior to each service rendered. Health partners may use our secure Provider Portal on our website to check member eligibility, or call our Health Partner Services department.

Provider Portal: https://providerportal.caresource.com/OH/
Click on "Member Eligibility" on the left, which is the first tab.

Health Partner Services Department: 1-800-488-0134

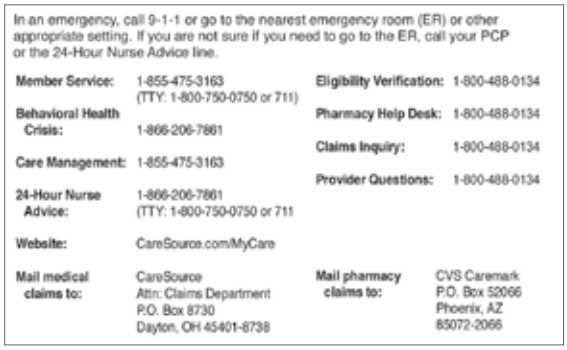
Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification.

CareSource MyCare Ohio Medicare-Medicaid Member ID Card


MyCareOhio
Connecting Medicare + Medicaid
CareSource

Member Name: Cardholder Name
Member ID #: Cardholder ID#
Health Plan (80840)
MMIS Number: Medicaid Recipient ID#
PCP Name: PCP Name
PCP Phone: PCP Phone
HB452_OHMMC-0056

MedicareRx
Prescription Drug Coverage
RxBin: 004336
RxPCN: MEDDADV
RxGRP: Rx5045


In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

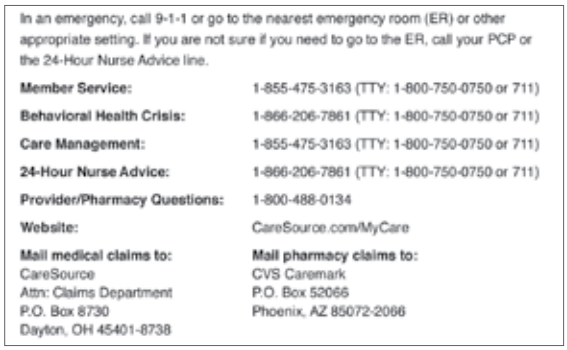
Member Service:	1-855-475-3163 (TTY: 1-800-750-0750 or 711)	**Eligibility Verification:**	1-800-488-0134
Behavioral Health Crisis:	1-866-206-7861	**Pharmacy Help Desk:**	1-800-488-0134
Care Management:	1-855-475-3163	**Claims Inquiry:**	1-800-488-0134
24-Hour Nurse Advice:	1-866-206-7861 (TTY: 1-800-750-0750 or 711	**Provider Questions:**	1-800-488-0134
Website:	CareSource.com/MyCare		
Mail medical claims to:	CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401-8738	**Mail pharmacy claims to:**	CVS Caremark P.O. Box 52066 Phoenix, AZ 85072-2066

CareSource MyCare Ohio Medicaid-Only Member ID Card


MyCareOhio
Connecting Medicare + Medicaid
CareSource

Member Name: Cardholder Name
Member ID #: Cardholder ID#
MMIS Number: Medicaid Recipient ID#
PCP Name: PCP Name
PCP Phone: PCP Phone
HB452_OHMMC-0136

RxBin: 004336
RxPCN: ADV
RxGRP: RX3292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How to Submit Claims for Reimbursement/Claims Appeals

All claims for reimbursement or appeals for claim denials should be submitted electronically through our secure Provider Portal on our website. The Portal can be accessed at **CareSource.com/MyCare**. Click on "Providers" and the link for "Provider Portal."

Instructions for submitting claims and/or appeals for denial of claims can be found at the Provider Portal.

To access the Provider Portal: **https://providerportal.caresource.com/OH/**

How to Submit Appeals

Submit clinical appeals by fax or in writing:

Fax: 937-531-2398
8 a.m. to 6 p.m. Monday through Friday, Eastern Standard Time (EST).

Writing: CareSource
Attn: Health Partner Appeals – Clinical
P.O. Box 2008
Dayton, OH 45401-2008

Certifications and Health Partner Sanctions

Health Partner Network

Credentialing Process for Network Facilities/Services

It is the policy of CareSource to ensure the quality and qualifications of professionally licensed practitioners and organizational health partners through a credentialing and recredentialing process which complies with regulatory and accreditation standards. Please see the "Credentialing" section of this manual for full details and explanations located at **CareSource.com**.

The ultimate goal of the credentialing program is to ensure the highest quality of care for our members. CareSource embraces the Institute of Medicine's definition as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Prohibited Affiliations

Revocation of licensure will result in immediate termination of the contract between the health partner and CareSource. The Health Partnership team will assist in obtaining the health partner's attestation that there are no health partner employees who have been debarred, suspended or have been criminally convicted and that the health partner will notify CareSource of any changes in ownership. The Credentialing department will monitor the health partner attestations upon recredentialing. Should an adverse determination be made against a health partner either during the time of recredentialing, or between credentialing cycles, for quality of care and/or service, the health partner is given the determination in writing and provided with the appeal process. Depending on the reason for the determination, CareSource notifies the appropriate authorities.

Any health partners found to be noncompliant with CareSource credentialing requirements will be given the opportunity to provide explanation for the noncompliant area. The information will then be presented to the Credentialing Committee for review and determination of network status. Action may be taken based on the data collected. Examples of action taken include continuation in the program, required participation in continuing education, required supervision, a clear plan for improvement with the practitioner, evidence of changes in the scope of practice, or termination of the practitioner from the program.

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 health partners are subject, and in accordance with accepted practices.

Health Partners: Home and Community-Based Services Waiver Programs

The Ohio Department of Aging (ODA) is responsible for the certification of health partners who provide services for Medicaid waiver programs administered through the Community Long-Term Care Division. In addition to holding a Medicaid Provider Agreement, providers of services must meet Ohio Administrative Code 173-39-02 Conditions of participation.

Health partner sanctions are specifically addressed in the Ohio Administrative Code 173-39-05, Disciplinary Actions.

OAC Waiver Rules

Health partners are obligated to abide by the regulations and policies of the state. They must read and understand all Ohio Administrative Code (OAC) rules that pertain to their health partner type and the services they deliver.

The following OAC chapters can be used as reference for health partners.

- State plan home health and private duty nursing services
  - Chapter 5101:3-12, Ohio Home Care Program
- Waiver health partners and services
  - Chapter 5101: 3-45, Administered Waiver Service health partners
  - Chapter 5101:3-46, Ohio Home Care Waiver
  - Chapter 5101:3-50, Transitions Carve-out Waiver

There are multiple additional state websites that will be helpful to health partners. They include the following:

- Ohio Department of Job and Family Services (ODJFS) main website: http://jfs.ohio.gov
- ODJFS consumer website: http://medicaid.ohio.gov/
- ODJFS provider website: http://medicaid.ohio.gov/providers.aspx
- MITS (Medicaid Information Technology System) website: http://medicaid.ohio.gov/PROVIDERS/MITS/MITSInformationReleases.aspx
- MITS eTutorial website: http://medicaid.ohio.gov/PROVIDERS/Training/MITSOnlineTutorialsforProviders.aspx
- eManuals: http://emanuals.odjfs.state.oh.us/emanuals

Health partners need to be aware the pursuant to section 173.391 of the Revised Code, ODA (or ODA's designee) may take disciplinary action against a health partner for good cause, including misfeasance, malfeasance, nonfeasance, confirmed abuse or neglect, financial irresponsibility or any conduct ODA determines in injurious or poses a threat, to the health, safety, or welfare of the consumers of the health partner's services.

Health partners are encouraged to review and be familiar with Chapter 173-39-05, "Disciplinary Actions" for the definitions including and not limited to Level-one disciplinary action, Level-two disciplinary action, Level-three disciplinary action and appeals.

Fraud, Waste and Abuse

How to Report Fraud, Waste or Abuse

It is CareSource's policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act or any state Medicaid fraud laws. If you have knowledge or information that any such activity may be or has taken place, please contact our Special Investigations Unit (SIU). Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting anonymously:

- Call: **1-800-488-0134** and tell Katie, our interactive voice response system, that you are calling to report fraud
- Write: CareSource
  Attn: Special Investigations Unit
  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 at **CareSource.com**.

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

To assure all enrollees receive safe, reliable care, CareSource utilizes an Incident Management reporting system. This system allows CareSource to identify and report enrollee issues referred as "Incidents." Examples of an Incident include issues such as enrollee falls, thefts, complaints of or dissatisfaction with their health partner, complaints of abuse or neglect and even enrollee's death.

Some incidents require CareSource to investigate the issue and report it to CMS and the state within 24 hours. At times, local law enforcement may be called to be involved. All incidents are monitored for trends.

Allegations of possible health partner Fraud, Waste and Abuse are also investigated and reported by CareSource's SIU. Appropriate actions are taken by SIU and reported to the appropriate authorities.

For more information about Fraud, Waste or Abuse, please see refer to the "Fraud, Waste and Abuse" chapter of this manual.

Referrals and Prior Authorizations
This section describes the referral and prior authorization processes and requirements for services provided to CareSource members. Please visit our Provider Portal at **CareSource.com** for the most current information on prior authorization and referral requirements.

Access to Staff

- Staff members are available from 8 a.m. to 5 p.m. during normal business hours for inbound calls regarding utilization management (UM) issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

Referrals

If you have questions about referrals and prior authorizations, please call our Medical Management department at **1-800-488-0134**.

Medicare Referral Procedures

Medicare members are not required to obtain referrals from their PCP prior to obtaining services from specialists. However, PCPs are asked to assist members in obtaining specialty services.

If you have difficulty finding a specialist for your member, please use the Find a Doctor/ Provider tool located at **CareSource.com**.

Please note that members may go to nonparticipating health partners for:

- Emergency care
- Out of area dialysis care
- Out of area urgently needed care

Services Rendered by Out-of-Plan Health Partners – A member may be sent to out-of-plan health partners if the member needs medical care that can only be received from a doctor or other health partner who is not participating with our health plan. PCPs must get prior authorization from our health plan before sending a member to an out-of-plan health partner. You can request prior authorization by calling our Medical Management department at **1-800-488-0134** and selecting the prompt to request prior authorization.

Second Opinions – A second opinion is not required for surgery or other medical services. However, health partners, or members may request a second opinion at no cost to the member other than applicable copayments, coinsurance and deductibles. The following criteria should be used when selecting a health partner for a second opinion:

- The health partner must be a participating health partner. If not, prior authorization must be obtained to send the patient to a nonparticipating health partner (see the "Prior Authorization" section).
- The health partner must not be affiliated with the member's primary care provider (PCP) or the specialist practice group from which the first opinion was obtained.
- The health partner must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the health partner giving the second opinion.

Medicaid Services That Do Not Require a Referral

Some health care services provided by specialists do not require a referral from a PCP. Members may schedule self-referred services from participating health partners themselves. PCPs do not need to arrange or approve these services for members as long as any applicable benefit 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 health partner)
- Podiatric care
- Psychiatric care at Community Mental Health Centers only
- Psychological care (from private practitioners or at Community Mental Health Centers)
- Care at public health clinics
- Care at Federally Qualified Health Centers and Rural Health Clinics
- Most radiology services (must be ordered by a participating health partner)
- Routine eye exams (at participating vision centers, within benefit limits)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours

Medicaid Members May Go to Nonparticipating Health Partners For:

- Emergency care
- Care at Community Mental Health Centers
- Family planning services provided at Qualified Family Planning health partners (e.g., Planned Parenthood)
- Care at Federally Qualified Health Centers and Rural Health Clinics
- Care at Ohio Department of Mental Health and Addiction Services (MHA) facilities that are Medicaid health partners

Medicaid Referral Procedures – A referral is required for specialty services not listed above and for plan members to be evaluated or treated by most specialists. Any treating doctor 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 prior authorization for any services rendered to CareSource patients. You can request a prior authorization by calling our Medical Management department at **1-800-488-0134** and selecting the option to request a prior authorization. Or you can submit a request online at **CareSource.com** and select the Provider Portal option from the menu.

If you have difficulty finding a specialist for your CareSource member, please call our Health Partner Services department at **1-800-488-0134**.

Medicaid Steps to Make a Referral

- **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 of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral.

- **Referrals to out-of-plan health partners** – A member may be referred to out-of-plan health partners if the member needs medical care that can only be received from a doctor or other health partner who is not participating with our health plan. Treating health partners must get prior authorization from our health plan before sending a member to an out-of-plan health partner.
- **Referrals for second opinions** – A second opinion is not required for surgery or other medical services. However, health partners 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 health partner for a second opinion:

- The health partner must be a participating health partner. If not, prior authorization must be obtained to send the patient to a nonparticipating health partner.
- The health partner must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The health partner must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the health partner giving the second opinion.

Services That Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. They include, but are not limited to the following services:

Medical Services That Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. They include, but are not limited to the following services:

- All inpatient care
- All abortions
- All home care services
- Nursing facility services
- Hospice care
- Organ transplants
- Durable medical equipment over $750 billed charges
- Prosthetic and Orthotic devices over $750 billed charges
- Cosmetic procedures and plastic surgery
- Partial hospitalization
- Hearing aids
- Ambulance transportation – except for emergent or facility-to-facility transfers

- Ambulette transportation
- Physical therapy visits exceeding 20 per calendar year
- Occupational therapy visits exceeding 20 per calendar year
- Speech therapy visits exceeding 15 per calendar year
- Chiropractic visits exceeding 12 per calendar year
- Mental health/psychiatry visits exceeding 10 per calendar year
  - Assertive Community Treatment (ACT)
  - Community Psychiatric Supportive Treatment (CPST)
- Podiatry office visits exceeding 8 per calendar year
- Substance abuse services exceeding 12 per calendar year
- Outpatient diagnostic/therapeutic radiology services:
  - CT, CTA
  - MRI, MRA
  - PET Scans

Some dental services require prior authorization; please reference our dental handbook online at **CareSource.com**.

In addition, any health partner who is not a participating health partner with CareSource must obtain prior authorization for all non-emergency services provided. Examples include tobacco cessation counseling for pregnant women, freestanding birth center services, outpatient hospital services, ambulatory surgical center services and specialists.

CareSource does not require prior authorization for unlisted procedure CPT codes. However, it requires a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code. Claims submitted without clinical records for unlisted procedure CPT codes will be denied. Denials will be reconsidered through the appeal process with pertinent clinical records.

Please note that our prior authorization requirements are subject to change. Please refer to **CareSource.com** for the most current information on services that require prior authorization and the prior authorization process.

Early Periodic Screening, Diagnosis and Treatment

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally-mandated program of comprehensive preventive health services available to Medicaid-eligible persons from birth through 20 years of age. EPSDT is designed to maintain health by providing early intervention to discover and treat health problems. The scope of services provided to an individual depends on the individual's age, gender, family medical history, ethnic background, or findings of the EPSDT screening or other covered medical services. When an EPSDT screening visit indicates the need for further evaluation, diagnosis and/or treatment, and the service requires prior authorization, health partners can request prior authorization to exceed coverage or benefit limits for members under the age of 21. All requests will be reviewed for medical necessity.

Prior Authorization Procedures

Prior authorizations for health care services can be obtained by contacting the Medical Management department online, by email, phone, fax or mail:

Online: CareSource.com on the Provider Portal

Email: mmauth@caresource.com

Fax: 888-752-0012.
For fax requests, use the prior authorization form on **CareSource.com**.

Mail: Send prior authorization requests to:
CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Phone: 1-800-488-0134 and allow Katie, our interactive voice response system, to help you navigate to authorization requests, depending on your need.

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource member ID number
- Health partner name and National Provider Identifier (NPI)
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan health partner, if applicable
- Clinical information to support the medical necessity for the service

If the request is for inpatient admission (whether it is elective, urgent or emergency), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

If inpatient surgery is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, any appropriate clinical and anticipated discharge needs.

If the request is for outpatient surgery, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs.

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Authorizations are not a guarantee of payment. Health partners must verify eligibility on the date the service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the health partner. CareSource will notify you of prior authorization determinations by a letter mailed to the health partner's address on file.

For standard prior authorization decisions, CareSource provides notice to the health partner and member as expeditiously as the member's health condition requires, but no later than 14 calendar days following receipt of the request for service.

Urgent prior authorization decisions are made within 72 hours of receipt of request for service. Please specify if you believe the request is urgent.

Utilization Management

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The Medical Management department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the CareSource care management team are made, if needed. CareSource makes it's UM criteria available in writing by mail, fax or email and via the web.

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

Fax: 888-752-0012

Email: mmauth@caresource.com

On an annual basis, CareSource completes an assessment of satisfaction with the UM process and identifies any areas for improvement opportunities.

Criteria – CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. This criterion is designed to assist health partners 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 criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health care health partners 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 under utilization.

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 Medical Management department. Physicians may call to discuss an adverse decision with CareSource's physician reviewer by calling the Medical Management department at **1-800-488-0134**, ext. 2830, within five business days of the determination.

Health Partner Appeals Procedure

If you are dissatisfied with a determination made by our Medical Management department regarding a member's health care services or benefits, you may appeal the decision. Please see the "Appeal Procedures" section in this manual for information on how to file a clinical appeal.

Retrospective Review

A retrospective review is a request for an initial review for authorization of care, service or benefit for which an authorization is required, but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. Upon written request, CareSource shall permit retrospective review where a prior authorization was required but not obtained (Retro Authorization). To qualify, the service must meet all of the following:

- The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original prior authorized service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria will need to be met to qualify for a retro authorization review.

Claims not meeting the necessary criteria will be denied.

A request for retrospective review can be made by calling **1-800-488-0134** and allowing Katie, our interactive voice response system, to direct you to the Medical Management department, or by faxing the request to **888-527-0016**. Clinical information supporting the request for services must accompany the request.

Post Stabilization Services
Please call **1-800-488-0134** for any questions related to post-stabilization services.

The definition of “Post-Stabilization Care Services” is 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. Prior Authorization 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 health partner. To request prior authorization for observation services as a nonparticipating health partner or to request authorization for an inpatient admission please call **1-800-488-0134**. When calling, tell Katie, our interactive voice response system, you are requesting post stabilization. During regular business hours, your call will be answered by our Medical 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.

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July 2017

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