Spring 2014

ProviderSource

A newsletter for CareSource Providers

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CareSource™
Health Care with Heart

Quality remains a top priority

Since day one, CareSource has remained focused on quality improvement. We continually assess the quality of care and service offered to our members and implement programs to improve internal functioning, delivery of health care services and health outcomes. This is the essence of our Quality Improvement (QI) program.

Our QI program is evolving and responsive to member and provider needs, incorporating standards established by the medical community through practitioner input as well as regulators and accrediting bodies. Activities are focused on:

- Improving the coordination and continuity of member care and the health status of our members, including those with complex health needs
- Evaluating the access, availability, and over- and under-utilization of health care services
- Ensuring the quality of member care and services
- Identifying and implementing appropriate safety and error-avoidance initiatives in collaboration with providers
- Overseeing member and provider satisfaction measurement and improvement activities
- Evaluating the effectiveness of QI activities in producing measurable improvement in member care and service

We use a variety of innovative programs, education initiatives, data analysis, monitoring systems and improvement projects to achieve our goals. Examples include online provider tools, clinical guidelines and other resources. More details about our QI program are on our website at **CareSource.com**. Click on "Providers" then "Ohio." Under "Ohio Providers," click on "Member Care," then "Quality Improvement."

Quality improvement would not be possible without close collaboration with health care providers. Thank you for your partnership.

Coding Corner
USING MODIFIER 25

Modifier 25 is used to indicate a separately identifiable evaluation and management service by the same physician on the same day as a minor procedure or service. Please keep in mind the following parameters for usage:

- This modifier is *not* used to report E/M services that resulted in a decision to perform major surgery (see modifier 57).
- Modifier 25 should be used only when a significant, separately identifiable E/M visit is rendered on the same day as a minor surgical procedure.
- To determine if the E/M visit is separately identifiable and it is appropriate to use modifier 25, the documentation must show that the patient's condition required a significant, separately identifiable E/M service on the day a minor procedure or service was performed above and beyond the other service provided.
- Payment for preoperative and postoperative visits is included in the payment for the procedure. For minor procedures, when the decision to perform the minor procedure is typically made immediately before the service (for example, whether sutures are needed to close a wound, whether to remove a mole or wart, etc.), the E/M visit is considered to be a routine preoperative service and should not be billed in addition to the minor procedure. (The policy applies only to minor surgeries and endoscopies for which a global period of 0-10 day applies.)

Example:

An established patient visits her internist to follow up for hypertension. The patient also complains of new knee pain. The physician completes a problem-focused history and exam, evaluates the patient's hypertension, determines the blood pressure is higher than it should be, and adjusts medications. During the encounter, the physician also evaluates the knee and determines the patient would benefit from arthrocentesis. The physician gives the patient an injection and schedules a follow-up visit for one month. The correct codes to use for this visit are: **99212-25** and **20610**.

Clinical documentation

Please remember that signed clinical documentation is required when using the following modifiers.

Modifier 25	**Only when billed with a minor procedure code**
Modifier 57	**Always required**
Modifier 59	**Always required**

Thank you for your attention to coding guidelines. We appreciate your help with timely and accurate claims processing and payment.

New CMS-1500 claim form

The CMS-1500 claim form has been revised with changes including those to more adequately support the use of the ICD-10 diagnosis code set.

The revised CMS-1500 form (version 02/12) will replace version 08/05. The new form will give providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes, which is important as the Oct. 1, 2014 transition approaches.

To assist our providers, CareSource will accept both forms until April 1, 2014. **After April 1, CareSource will only accept the new CMS-1500 claim form.** Check with your service vendor to determine when they will switch to the new CMS-1500 claim form.

For more information about ICD-10, visit the ICD-10 Resource Center on our website at **CareSource.com**. Additional resources are also available on the Centers for Medicare & Medicaid Services (CMS) website at **www.cms.gov/ICD10**.

Identifying suspected fraud, waste or abuse

The CareSource Special Investigations Unit (SIU) is a group dedicated to proactively preventing, detecting, investigating, correcting and reporting health care fraud, waste and abuse. As part of this effort, SIU monitors medical and pharmacy data looking for outliers. Examples of the things SIU looks for include, but are not limited to:

- Billing for unnecessary medical services, durable medical equipment or drugs
- Medical records that do not support the services billed
- Unbundling and upcoding of services to obtain higher reimbursement
- Billing social activities as psychotherapy
- Scheduling more frequent return visits than necessary
- Providers billing for services or drugs outside of their scope of medical practice
- High volumes of narcotic activity for providers and members

All reported allegations are taken seriously and handled from referral to investigation closure. A full investigation may include data analysis, medical record review, interviews, on-site visits, desk audits or contact with law enforcement and other agencies.

Help us in the fight against health care fraud, waste and abuse. Visit **CareSource.com/providers/ohio/ohio-providers/claims-information/report-fraud/** for more information and details about how to report suspected fraud, waste or abuse.

CareSource Just4Me™: It's not Medicaid

CareSource Just4Me is not a Medicaid health plan. It is a brand new health insurance option available on the Marketplace. It provides comprehensive benefits in 30 counties throughout Ohio in an effort to meet the health care needs of many individuals who do not have health insurance.

CareSource Just4Me differs from CareSource Medicaid in a variety of ways:

1. Reimbursements are based on Medicare rates and schedules.
2. Copays, coinsurance and deductibles are associated with most CareSource Just4Me plans and should be collected at the time of service. Member responsibility can be found inside the purple box on the CareSource Just4Me member ID cards.
3. Marketplace eligibility can change so do not rely on ID cards alone. Always verify eligibility at every visit.
4. Member ID cards include all plan members. Please ensure to include the appropriate member suffix when submitting claims.
5. All services must be performed in-network to be eligible for reimbursement.

If you are interested in becoming a CareSource Just4Me provider or have questions about member eligibility, benefits or copays, please visit **CareSource.com/Just4Me** and click "Providers," or call our Provider Services Department at **1-800-488-0134**.

Prior authorization and clinical appeal decision timeframes

Have you submitted a prior authorization request to CareSource that has not been approved? If so, you may file a clinical appeal. However, if you have *new information* that was not included in your first request, you may want to consider filing a new prior authorization request that includes the new information.

The turnaround time for a clinical appeal is 15-30 days, depending on the member's coverage. See the chart below for more details about clinical appeal timeframes. Remember, providers may submit appeals to CareSource by fax at 937-531-2398.

Health Plan	Timeframe for a CareSource Decision on Provider Clinical Appeals	Additional Information
CareSource (Ohio Medicaid)	30 days for provider appeals	
CareSource Advantage® (HMO SNP – Medicare Advantage Special Needs Plan)	15 days for providers filing on behalf of members	Non-participating providers must submit a completed Waiver of Liability form for post-service appeals before the appeal can be processed.
CareSource Just4Me™ (Health Insurance Marketplace Plan)	Please refer to the CareSource Just4Me Provider Manual for timeframes related to your specific appeal type.	Providers must have the member's signed consent to file an appeal.

The timelines do not apply if we do not receive sufficient information to determine whether or not the health care services are covered services.

Care management program empowers members

CareSource's care management program is a fully integrated health management program designed to support the care and treatment you provide to your patients. We offer a full spectrum of services for a broad range of conditions.

Members diagnosed with asthma or diabetes are automatically enrolled in our enhanced disease management program. Our program offers resources and tools to help members reach their health care goals. Outreach includes:

- Quarterly, diagnosis-specific educational mailings
- Monthly phone messages on disease-specific topics

Members identified with complex conditions are referred to a high risk case management nurse to assess, coordinate, and monitor their care. To refer a CareSource patient who is not already enrolled in the case management program, call **1-800-993-6902**.

Online care plans

Individualized care plans for CareSource members enrolled in case management can be found on our Provider Portal. Here, you will find goals and interventions that our case management nurse and your patient have identified as opportunities for improved health outcomes. The case management nurse will notify you when your patients are enrolled in case management and will encourage you to review and provide input into the online care plan to help meet these patients' individual needs.

Access is fast and simple

To register for our secure Provider Portal, just follow these steps:

1. Visit the Provider Portal at **https://providerportal.caresource.com**.
2. Click on "register here" and complete the 3-step registration process. (Note: You will need your Tax ID number.) Click "Continue."
3. Create a username and password to use each time you access the Portal.

If you need assistance, please call our Provider Services Department at **1-800-488-0134**.

BMI: Weighing your patients' health risks

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

BMI should be calculated at least annually and documented in the patient's medical record. BMIs for children 3-17 years of age should be documented as a BMI percentile or plotted on an age-growth chart. All children 3-17 years of age should receive counseling for nutrition and physical activity. If needed, schedule a follow-up appointment dedicated to discussing weight concerns. Providers should use the appropriate CPT, HCPCS, or ICD-9 codes.

A helpful resource

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

SBIRT services now covered

Screening, Brief Intervention and Referral to Treatment (SBIRT) services are covered by Medicare and Ohio Medicaid. SBIRT services support integrated behavioral health initiatives for patients with non-dependent substance use. These early intervention services can help prevent substance use disorders and the more intense treatment required for them.

SBIRT consists of three major components:		
S	**BI**	**RT**
Screening	**Brief Intervention**	**Referral to Treatment**
Assessing a patient for risky substance use behavior using standardized screening tools	Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice	Providing a referral to brief therapy or additional treatment for patients in need of additional services

The following codes may be used to bill for medically reasonable and necessary SBIRT services when provided in a physician's office or outpatient hospital by licensed or certified practitioners qualified to perform them and working within their State Scope of Practice Act.

HCPCS Code	Descriptor
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention, 15-30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention, greater than 30 minutes

For more information, please refer to the SBIRT network notification on our website at **CareSource.com** or visit **www.integration.samhsa.gov/clinicial-practice/sbirt**.

Clinical guidelines provide treatment protocols

CareSource adopts evidence-based clinical practice guidelines from federal and medical professional organizations for a variety of conditions. We endorse the use of these treatment protocols by providers for the management of conditions such as:

- Asthma
- Diabetes
- Attention Deficit Hyperactivity Disorder (ADHD) –
  A new guideline has been added recently to this set
- Depression

These guidelines help ensure proper diabetes screenings, including Hemoglobin A1C, LDL-C, dilated retinal eye exam, blood pressure monitoring and treatment, and screening for nephropathy; medication management for asthma and ADHD; and appropriate follow-up care after inpatient admissions for members with depression.

How to access the entire set of clinical and preventive guidelines

1. Visit our website at **CareSource.com**.
2. Click on "Providers" then "Ohio."
3. Under "Ohio Providers," click on "Member Care" then "Clinical Guidelines."

If you don't have access to our website, please call Provider Services at **1-800-488-0134** to have the guidelines mailed to you.

Specialty pharmacy program provides added value to members

U.S. spending on specialty prescription drugs is projected to increase 67 percent by the end of 2015. CareSource partners with CVS Caremark Specialty Pharmacy to provide and help manage the growth and complexity of specialty medications.

These drugs are for patients with rare and chronic diseases such as cancer, HIV/AIDS, rheumatoid arthritis, multiple sclerosis and hepatitis C. CVS Caremark Specialty Pharmacy provides specialty medications directly to the member or the prescribing physician and coordinates nursing care, if required.

Advantages of our program

- 24-hour access to pharmacists and nurses to help reduces ER visits and hospitalizations
- Multiple checks and balances to ensure patient safety
- Disease- and drug-specific patient care management services to improve member health outcomes
- A reliable refill schedule to help improve medication adherence

To access the list of specialty medications provided, please visit **www.cvscaremarkspecialtyrx.com/sites/default/files/pdf/SpecialtyDrugs.pdf**.

Search our drug formulary online

CareSource offers the convenience and efficiency of an online formulary search tool. It can help you save time by quickly looking up medications to make sure they are covered by CareSource. You can also check for prior authorization requirements, generic alternatives to brand-name drugs, or any restrictions or limits that may apply.

You can search for drugs alphabetically, by brand or generic name, or by therapeutic class. To access the tool, please follow these easy steps:

1. Visit our website at **CareSource.com**.
2. Click on "Providers" and choose "Ohio."
3. Under "Ohio Providers," choose "Member Care" then click on "Pharmacy."
4. Choose "CareSource Medicaid Pharmacy Information." Click on "Online Drug Formulary" to begin your search. Please remember that there is a separate formulary search tool for CareSource Advantage® (HMO SNP), our Medicare Advantage special needs plan (SNP). It is administered by our pharmacy benefit manager. To access it, choose "CareSource Medicare CareSource Advantage® (HMO SNP) Pharmacy Information" instead. Then scroll down and click on "Formulary Drug Search Tool."

Our website also includes:

- Pharmacy forms, policies and procedures for requesting prior authorization or exceptions
- More information about our pharmacy benefit and CVS Caremark, our pharmacy benefit manager

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NCQA ACCREDITATION COMMENDABLE

URAC ACCREDITED HEALTH PLAN (for Medicaid) HEALTH CALL CENTER

OH-P-856 I March 2014

ProviderSource is a publication of CareSource, a non-profit, public-sector managed health care plan serving all regions of Ohio.

HOW TO REACH US

Provider Services:
1-800-488-0134 (TTY: 1-800-750-0750 OR 711)

CareSource24®, 24-Hour Nurse Advice Line: 1-866-206-0554

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