



Section 6 – Covered Services and Exclusions

Covered Services

Please visit the CareSource Website at www.caresource.com for information on common services, their coverage status and other information about obtaining services. Please refer to our Website and Section 7 – Referrals and Prior Authorizations of this manual, for more information about referral and prior authorization procedures.

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 Website or calling Provider Services.

This section describes the services and exclusions to benefits that are provided to our CareSource and CareSource Advantage members. CareSource covers all medically necessary Medicare covered services for CareSource Advantage members and Medicaid-covered services for CareSource Medicaid members and CareSource covered services for Children’s Buy-In members. These services are available to our health plan members at no charge.

Determination that services cannot be covered — If a request for authorization is submitted, CareSource will notify the provider and member in writing if a service cannot be covered. The letter will include the reason that the service cannot be covered. Providers and members have the right to appeal the decision. Please see Section 9 – Appeal Procedures of this manual for information on how to file an appeal.

Covered services and exclusions for CareSource and CareSource Advantage members can be found on our Website at www.caresource.com.

Preferred Diabetic Supplier

Great Lakes Medical Supply Inc., (GLMS), is the preferred provider for diabetic meters and diabetic related supplies. GLMS will proactively contact members about refilling monthly supplies and will offer a free new glucometer to members who qualify. Medical supplies are shipped directly to the member's residence and can be ordered by calling **1-800-774-0788**.

Medicaid

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 physician, place the woman in danger of death unless an abortion is performed; or
- 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 physician performing the abortion; or

- 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 physician performing the abortion;.

Before reimbursement for an abortion can be made, the physician 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. The physician'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 billing invoice.

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 physician, place the woman in danger of death unless an abortion is performed; or
- 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; or
- 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; or
- d. The pregnancy was the result of an act of rape and in my professional opinion the recipient was physically unable to comply with the reporting requirement; or
- e. The pregnancy was a result of an act of 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 physician performing the abortion must certify in writing to one of these circumstances by completing the JFS 03197 Abortion Certification form.

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 (JFS 03198 Form), which is located in Section 14 – Forms of this manual, 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.

Hysterectomies — Written consent to the hysterectomy procedure must be obtained from members on the ODJFS Acknowledgement of Hysterectomy Information (JFS 03199 Form), located in the Forms section of this manual. The primary surgeon performing the hysterectomy is responsible for securing the member's consent to the procedure. A copy of the signed/approved Acknowledgement of Hysterectomy Information form must be provided for all hysterectomies, whether performed as a primary or secondary procedure, or for medical procedures directly related to such hysterectomies. The form should include legible signature(s) and be submitted to CareSource with the claim. For instructions on how to complete the ODJFS Acknowledgement of Hysterectomy Information form, please see Section 14 – Forms of this manual, or visit our secure online Provider Portal on our Website, www.caresource.com, to view an instructional tutorial.

Immunizations — Health care providers may administer immunizations obtained through the Vaccines for Children (VFC) program to CareSource members. The vaccines are available free of charge through the Vaccines for Children (VFC) program. **Please bill CareSource for the vaccine with appropriate CPT and ICD-9 vaccination codes and CareSource will reimburse for the administration of the immunization.** Please see Section 5 – Member Support Services and Benefits for more details on immunizations. **CareSource will not reimburse costs for vaccines obtained outside the VFC when provided to children under age 19.**

Wellness exams for adults — All adults are eligible to receive a wellness exam from a PCP at the earliest opportunity upon enrollment with CareSource. A wellness exam may be performed annually and consist 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 over age 50
 - 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 PCP or vision vendor
 - Hearing exams