



February 26, 2010

Greetings,

Improving our members' health and well-being are goals we share. To help us be successful, we're working to make it easier for you to do business with us. We're simplifying interactions and expanding our online tools so that you and your patients can make better health care decisions.

The following are a few specific examples:

- **Earlier this month, we launched our new web-based Provider Toolkit.** The Toolkit is easy to access and offers valuable resources at your fingertips. It offers helpful information about policy updates, manuals, forms, frequently asked questions, assessment tools and more. And, it includes a "Favorites" feature so that each time you visit it automatically remembers the sections you use (see page 2 of the enclosed *ProviderSource* newsletter for more information).
- **In September 2009, we launched our patient-centered medical home pilot, Health Care Home Program, with several primary care practices in Ohio and Michigan.** The pilot promotes a collaborative approach between the member, the primary care provider, and CareSource. It promotes better member access to the care they need, improved engagement between the member and provider, and improved health outcomes. (for more information please see page 6 of the *ProviderSource* newsletter).
- **Results of our late 2009 Provider Satisfaction Survey are in and CareSource appreciates your feedback.** The survey results presented us with areas for operational enhancements in order to strive to provide the highest quality services (for more information refer to page 3 of our *ProviderSource* newsletter).

Please find enclosed the spring edition of our provider communications packet. This mailing includes our *ProviderSource* newsletter, which contains articles I hope you find interesting and beneficial. In addition, we've included information about the Pharmacy Carve Out, CareSource Member Rights and Responsibilities and a handout about Top Claim Denials.

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

Respectfully,

A handwritten signature in black ink that reads "Craig Thiele MD".

Craig Thiele, M.D.  
Chief Medical Officer

OH-P-238



## Network Notification

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**Date:** February 10, 2010

**Number:** OH-P-2010-05

**To:** All Ohio PCP, Specialty Providers

**From:** CareSource

**Subject:** Top Claim Denials

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As part of our ongoing commitment to timely and clearly articulated communication of policy or process changes, the information listed below supplements current policies to include those listed in the CareSource Provider Manual.

As announced in our October 12, 2009 letter (OH-P-204) sent to our Provider Network and our *Code Editing Guidelines on Professional Claims* document included in our Fall 2009 Provider Mailpak, CareSource continues to be committed to industry standard claim adjudication practices. Consistent with these practices, we updated our claims processing edits in November 2009 to help make it easier for you to work with us. Concurrent with this update, we launched enhanced claims functionality on our secure Provider Portal located on our website, caresource.com. The new functionality provides more detailed claim line edit descriptions. All of the edits enhanced or implemented in November 2009 are applied to professional claims submitted on a CMS 1500 form.

Recently, we identified the top five reasons for code editing denials. These include:

- **Not a Primary Diagnosis Code** – This edit identifies ICD-9 diagnosis codes that are not allowed for reporting alone or as a primary diagnosis. Claims submitted with these ICD codes will be denied and must be resubmitted as a corrected claim with a valid Primary Diagnosis Code within timely filing guidelines.

*Example: Two common diagnosis codes seen in this edit are V22.2 (pregnant state, incidental) and V58.69 (Long-term (current) use of other medications). In the ICD-9-CM publication, these codes have a symbol SDx. This symbol identifies V codes that can only be used as a secondary diagnosis.*

- **Invalid Diagnosis** – Diagnosis code is invalid for date of service or does not exist.

*Examples of invalid diagnosis are 075.0 and 311.00. Information regarding coordination and maintenance of ICD-9 diagnosis codes can be found in the introduction of the ICD-9-CM publication.*

- **Unbundled Code (CCI Edit)** -- This edit compares CPT codes reported for the same date of service to find procedures that should not be submitted together. Unbundling is the act of billing CPT codes which are components of other CPT codes. Unbundling can either be incidental (procedures which are not essential to complete the procedure) or mutually exclusive (related procedures). Depending on the particular code combination, CareSource may deny one or more of the related codes. There are three unbundling edits used by CareSource including (U) = Unbundling, (I) = Incidental, and (E) Exclusive.

*Example includes 69210 (Removal impacted cerumen) has a relationship with 69200 (Removal foreign body from external auditory canal; without general anesthesia). Also, Procedure codes 11721 (debridement of the nail) and 11056 (pairing or cutting of benign lesion) have a relationship.*

- **Daily Frequency Exceeded** -- This edit is based on CPT and HCPCS code descriptions, along with CMS and industry standards, that define maximum billable units per procedure. If a claim line contains units that exceed these limits, CareSource will only allow the appropriate unit values associated with that code.

*Examples include: 10040 (acne surgery) which has a daily max of 1; 92065 (orthoptic treatment) which has a daily max of 1, and 33916 (surgery on a great vessel) which has a daily max of 1.*

- **Non-Specific Diagnosis Codes** – When selecting diagnosis codes, select the code that provides the most detail.

Two common diagnosis codes seen in this edit are 250 (diabetes mellitus) and 493 (asthma). In the ICD-9-CM book, these codes have a symbol  $\sqrt{4}^{\text{th}}$ . There are also codes that have the symbol  $\sqrt{5}^{\text{th}}$ . These symbols indicate that the code requires a fourth or fifth digit.

If you have any questions about the information in this Network Notification, please contact Provider Services at 1-800-488-0134.



## Pharmacy Carve-Out Reminder

Effective February 1, 2010, prescription drug coverage for members of Medicaid Managed Care Plans (MCPs) transferred to the Medicaid fee-for-service (FFS) program. This change was required due to the State of Ohio's decision to carve out the Medicaid pharmacy benefit from all MCPs coverage of services. This change was only for retail prescription drugs and those administered in the patient's home, including drugs administered through a home health agency.

To facilitate the carve-out of the pharmacy benefit, CareSource will no longer require prior authorization for home health infusion and injection nursing visits (99601, 99602, 99506). **CareSource will also waive prior authorization requirements for home skilled nursing, physical therapy, speech therapy, occupational therapy and social work visits.**

Effective for dates of service beginning February 1, CareSource will allow up to two skilled nursing visits (2 hours total) per day. More than two skilled nursing visits (2 hours or more) per day will require prior authorization. All limits to these services defined by Ohio Administrative Code 5101:3-12-01 apply. Any medical supplies used during these visits should be billed to CareSource with the appropriate code.

Please refer to our *Updates/Announcements* page (on the Provider Materials section of [www.caresource.com](http://www.caresource.com)): *Subject: Pharmacy Benefit changes as mandated by ODJFS (OH-P-2009-01)* for more information and to faxed notification: *Prior Authorization Waived for all Skilled Home Visits – effective 2-1-2010 (OH-P-2010-01)*.

CareSource will conduct ongoing audits of home health services to ensure medically appropriate utilization. CareSource may contact you to provide documentation for these audits.

If you are a prescribing CareSource provider for Medicaid members you are now required to contact the FFS vendor, ACS, for medication prior authorizations. For questions about the FFS prior authorization and prior authorization requests, providers should contact ACS at 1-877-518-1546. For questions or problems processing claims, pharmacies should contact ACS at 1-877-518-1545.

Also, some medical supplies are now covered under the pharmacy FFS program, including diabetes supplies, spacers, peak flow meters and condoms. As such, these supplies can no longer be billed under the Durable Medical benefit.

For more information, please visit the Ohio Department of Job and Family Services website at [www.jfs.ohio.gov](http://www.jfs.ohio.gov).

## Member Rights and Responsibilities

CareSource wants to inform its providers about the rights and responsibilities of CareSource members.

### CareSource members have the right to:

- To receive all services that CareSource must provide.
- To be treated with respect and with regard for their dignity and privacy.
- To be sure that their medical record information will be kept private.
- To be given information about their health. This information may also be available to someone who they have legally okayed to have the information or who they have said should be reached in an emergency when it is not in the best interest of their health to give it to them.
- To be able to take part in decisions about their health care unless it is not in their best interest.
- To get information on any medical care treatment, given in a way that they can follow.
- To be sure that others cannot hear or see them when they 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, and get, a copy of their 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 them given out unless CareSource has to by law.
- To be able to say no to treatment or therapy. If they say no, the doctor or CareSource must talk to them about what could happen and they must put a note in their medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing.
- To be able to get all CareSource written member information from CareSource:
  - at no cost to them;
  - in the prevalent non-English languages of members in CareSource's service area;
  - in other ways, 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 providers if they do not speak English or need help in understanding information.
- To be able to get help with sign language if they are hearing impaired.
- To be told if the health care provider 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). They can also contact member services for more information

- To file any complaint about not following their advance directive with the Ohio Department of Health.
- To change their primary care provider (PCP) to another PCP on CareSource's panel at least monthly. CareSource must send them something in writing that says who the new PCP is by the date of the change.
- To be free to carry out their rights and know that CareSource, CareSource's providers or ODJFS will not hold this against them.
- To know that CareSource must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives them care whenever possible and appropriate.
- If they are a female, to be able to go to a woman's health provider on CareSource's panel for covered woman's health services.
- To be able to get a second opinion from a qualified provider on CareSource's panel. If a qualified provider is not able to see them, CareSource must set up a visit with a provider not on our panel.
- To get information about CareSource from us.
- 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.

Note: Providers can also find the complete CareSource Member Rights and Responsibilities on our website, [www.caresource.com](http://www.caresource.com).