August 2012

Dear CareSource Provider,

Improving our members’ health and well-being are goals we share. One way CareSource is committing to this is by making it easier for you to work with us. Below are recent “wins” for CareSource Providers and Members.

**New COB Policy** – Great news! CareSource has updated its Coordination of Benefits (COB) policy to benefit our Providers. When CareSource coordinates benefits with the primary carrier, CareSource will pay the patient responsibility (co-payment, co-insurance, deductible) up to the CareSource allowable amount, regardless of the amount that is paid by the primary insurance. The new COB policy is retroactive from January 1, 2012. See your ProviderSource newsletter enclosed for details on how this benefits your practice.

**New Care Management Model for High-Risk Members** – Earlier this year, CareSource rolled out its community-based care management model for our highest-risk Members. This new model includes face-to-face meetings with Members most at-risk, and strengthens our Provider partnerships through enhanced collaboration of care. Enclosed in the ProviderSource newsletter is just one example of how we are helping members through Provider collaboration and personal contact.

**New Medication Therapy Management Program** – Proper medication utilization is a win for patients and Providers. In July, CareSource launched its Medication Therapy Management program for Members. Through the program, local pharmacists offer educational and monitoring services, as needed, to CareSource Members and work collaboratively with physicians and other prescribers to address Members needs’ and improve medication utilization.

Many of these programs and operational improvements are highlighted in the latest edition of our ProviderSource newsletter. We know that great health care begins with you; thank you for your partnership!

Sincerely,

Craig Thiele, MD
Chief Medical Officer

OH-P-594

P.O. Box 8738
Dayton, OH 45401-8738
800-488-0134
caresource.com
High-risk care management in action

*CareSource’s enhanced care management program is in full swing with a community-based model for our highest-risk Members. Below is just one example of how we are helping Members through Provider collaboration and personal contact.*

*Name has been changed to protect privacy.*

No one was happier to go home than Ben*, a CareSource Member who had many health complications. After making a remarkable recovery, he was well enough to be released from the health care facility. Due to the complexity of his illness, Ben had a complicated discharge that needed a full team approach. At the time of his discharge, his CareSource case manager, Sara*, conducted a face-to-face meeting at the health care facility. This personal collaboration with Ben, his family, the facilities case manager and discharge planner was crucial to a smooth transition of care. The group exchanged valuable information, including working together on discharge planning needs and prior authorization of medications Ben needed before going home.

Sara used the CareSource Provider Portal to immediately send needed forms for medications directly to the prescribing physician. She also spoke with the home care agency to facilitate and help coordinate Ben’s care needs for home. CareSource is proud to work through the details of complicated situations like this to help ensure positive outcomes. Through our partnership with Providers, we can give Members like Ben a reason to be hopeful for better health and a brighter future.

“I am so glad you are here to assist with this discharge. I wish more insurance companies would do the same.”

– Ben’s discharge planner
Check Member ID card

CareSource Members are asked to present their CareSource ID card each time services are accessed. CareSource Advantage® (HMO SNP) Members should also present their Medicaid ID card at the time services are accessed. If you are not familiar with the patient, and cannot verify the person as a CareSource Member, please ask to see photo identification. If you suspect fraud, please call 1-800-488-0134.

Please also verify Member eligibility before providing services through our secure Provider Portal or by calling 1-800-488-0134.

How to report suspicions of fraud, waste or abuse

CareSource has a program designed to handle cases of managed care fraud, waste or abuse. Fraud can be committed by Providers or Members.

To report anything that does not seem right:

- **Call:** 1-800-488-0134 (TTY: 1-800-750-0750 or 711) and follow the prompts
- **Email:** fraud@caresource.com
- **Fax:** 1-800-418-0248
- **Write:** Send us a letter or use our confidential “Fraud, Waste and Abuse Reporting Form” on www.caresource.com and mail to:
  - CareSource
  - Attn: Special Investigations Unit
  - P.O. Box 1940
  - Dayton, OH 45401-1940

If you choose to be anonymous, please report as much information about the situation as possible since we will not be able to contact you. Your report will be kept confidential to the extent permitted by law.
Special communication services for patients

CareSource offers sign and language interpreters for Members who are hearing impaired, visually impaired, do not speak English, or have limited English-speaking ability. These services are available at no cost to the Member.

Please note that CareSource requires hospitals, at their own expense, to offer sign and language interpreters for these Members. Non-Hospital Providers should contact Member Services to help these patients receive assistance. Participating Providers are required to identify the need for special services for CareSource patients and offer assistance.

For help with these services, please call 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

Refined DRGs allow more accurate inpatient classification

Ohio Medicaid will be updating its inpatient classification system to All Patient Refined Diagnosis Related Groups (APR-DRGs), version 29. Compared to other DRG systems, the APR-DRGs, developed by 3M™, are more patient-focused and have been expanded to include:

- Reason for admission
- A severity of illness subclass with four levels that take patient age into account
- A risk of mortality subclass with four levels

The APR-DRG system is designed to be:

- Comprehensive and account for all payers, patients and ages, including pediatrics
- A more complete and accurate methodology for classifying patients, providing a basis for a more equitable and fair payment structure for services rendered

CareSource plans to switch to the APR-DRG system to be consistent with Ohio Medicaid. We will keep you updated as we learn more about timelines and implementation.

For more information, visit www.aprdrgassign.com with the following login information:

- User ID: OHHosp
- Password: aprdrg007

CareSource earns high Member ratings in Ohio

Thank you! In the most recent Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, Members rated CareSource very high among Ohio Medicaid health plans. This would not be possible without the care of our Providers.

In the survey, Members also gave high marks to their personal doctor, their ability to get the care they need, and how well their doctors communicate with them. The CAHPS survey is administered annually for the Ohio Department of Job and Family Services to ensure Members of Medicaid managed care plans have timely access to high-quality health care services.
CMS revises non-coverage notices

Effective May 2012, the Centers for Medicare and Medicaid Services (CMS) revised the Notice of Medicare Non-Coverage (NOMNC) and the Detailed Explanation of Non-Coverage (DENC). Now all Medicare consumers, whether enrolled in Original Medicare or in a Medicare Advantage plan, receive the same notices prior to termination of Medicare-covered skilled nursing facility, home health agency, hospice and comprehensive outpatient rehabilitation facility services.

Providers responsible for issuing the NOMNC should be using the updated version. It can be found at www.cms.gov/bni/09_MAEDNotices.asp.

New Coordination of Benefits policy

When CareSource coordinates benefits with the primary carrier, CareSource will pay the patient responsibility (co-payment, co-insurance, deductible) up to the CareSource allowable amount regardless of the amount that is paid by the primary insurance.

The new COB policy is retroactive from January 1, 2012. Providers are highly encouraged to submit claims that were not submitted under the previous COB policy, retroactively as of January 1. This will ensure that the high quality of care that you’re delivering to CareSource Members is captured.

New COB Policy

CareSource will pay the co-pay, co-insurance, deductible after the primary insurance payment up to the CareSource allowable amount.

<table>
<thead>
<tr>
<th>Example:</th>
<th>Carrier</th>
<th>Allowed</th>
<th>Co-pay</th>
<th>Deductible</th>
<th>Co-Insurance</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Insurance</td>
<td>$50</td>
<td>$10</td>
<td>$0</td>
<td>$0</td>
<td>$40</td>
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</tr>
<tr>
<td>CareSource</td>
<td>$35</td>
<td></td>
<td></td>
<td></td>
<td>$10</td>
<td></td>
</tr>
</tbody>
</table>

See Example. Since the co-pay does not exceed the CareSource allowable amount, CareSource will pay $10.
Medication Therapy Management available to CareSource Members

At CareSource, we understand the impact that proper medication utilization can have on your patients. That’s why we have engaged Outcomes® to provide Medication Therapy Management for CareSource Members.

Through the program, local pharmacists offer educational and monitoring services, as needed, to CareSource Members and work collaboratively with physicians and other prescribers to address Members’ needs and improve medication utilization.

You may receive phone calls from local pharmacists regarding the medication you are prescribing your CareSource patients. Member benefits include:
- Safer, more effective medication use
- Selection of the most therapeutic and cost-effective medications
- Improved coordination of care

Disease management program empowers Members

CareSource 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 have a nurse assigned to their case. To refer a CareSource patient to our program who is not already enrolled, call 1-888-882-3614.

Get helpful well-child exam guidelines online

Healthchek is the name for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services in Ohio. CareSource Members should receive these well-child checkups at specific ages from birth through age 20. These comprehensive exams include services, such as immunizations, blood lead level screenings and other services.

Our Providers are essential to the success of this program and the creation of medical homes for children. Please see the CareSource Provider Manual located at www.caresource.com for more details about:
- Healthchek exam frequency
- Proper coding
- Billing procedures

We also offer a checklist on our website that can assist with documentation of the exam components.

www.caresource.com

Making it Easier!
Prenatal and postpartum care time frames

Timing is crucial when it comes to prenatal and postpartum care. CareSource stresses early and ongoing prenatal care for all pregnant Members. Please remember that prenatal care should begin within the first trimester or within 42 days of enrollment in CareSource. A postpartum care visit should take place between 21 and 56 days (3 to 8 weeks) after delivery.

Coordinated Services Program for Ohio Medicaid consumers

In coordination with ODJFS, CareSource is providing a Coordinated Services Program (CSP) for CareSource Members with the goal of increasing appropriate use of medications, emergency room visits and Primary Care Provider (PCP) coordination.

CSP enrollees must get all medications filled at one pharmacy. They are also encouraged to coordinate medical services through their PCP.

CareSource Members may be enrolled if utilization shows a pattern of receiving services at a frequency or in an amount that exceeds medical necessity. Examples might include multiple controlled substances, pharmacies or emergency room visits. Members selected for the program are initially enrolled for 18 months.

Members may also be enrolled through recommendations from medical professionals indicating that Members have demonstrated fraudulent or abusive patterns of medical service utilization. The program is available to all Ohio Medicaid consumers.
Network Notification

Date: June 25, 2012          Number: OH-P-2012-20

To: Ohio Providers

From: CareSource

Subject: New Coordination of Benefits (COB) Policy

Effective Date: Retroactively Effective January 1, 2012

CareSource has updated its COB policy; please share this information with your billing staff.

**New COB Policy:** When CareSource coordinates benefits with the primary carrier, CareSource will pay the patient responsibility (co-payment, co-insurance, deductible) up to the CareSource allowable amount regardless of the amount that is paid by the primary insurance.

The new COB policy is retroactive from January 1, 2012. Please note that all claims should be submitted within CareSource’s 365 day timely filing guidelines.

**Action Requested:** Providers are highly encouraged to submit claims that were not submitted under the previous COB policy, retroactively as of January 1. This will ensure that the high quality of care that you’re delivering to CareSource members is captured.

### Examples of the New COB Policy

<table>
<thead>
<tr>
<th>New COB Policy</th>
<th>Previous COB Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareSource will pay the co-pay, co-insurance, deductible after the primary carrier payment up to the CareSource allowable amount.</td>
<td>If the CareSource allowed amount was greater than or equal to the primary carrier paid amount, then CareSource would have paid $0.</td>
</tr>
</tbody>
</table>

**See Example 1.** Since the co-pay does not exceed the CareSource allowable amount, CareSource will pay $10.

**See Example 2.** Since the CareSource allowed amount was less than the primary paid amount, then we would have paid $0 under the previous policy.
**New COB Policy, Example 1:**

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Allowed</th>
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<th>Deductible</th>
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<td>$10</td>
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<td>$0</td>
<td>$40</td>
</tr>
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<td>CareSource</td>
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<td></td>
<td></td>
<td></td>
<td>$10</td>
</tr>
</tbody>
</table>

**Previous COB Policy, Example 2:**

<table>
<thead>
<tr>
<th>Carrier</th>
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<td>$35</td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

**NOTE:** By paying the CareSource allowable amount, CareSource will not pay more than our normal benefit when other coverage exists or more than the patient’s responsibility after the primary insurance has paid.

If you have COB claims with dates of service between January 1, 2012, through June 25, 2012, and you would like CareSource to reconsider these claims for payment under the new COB policy, please resubmit the claims and the corresponding EOBs.

Visit our Frequently Asked Questions on [www.caresource.com](http://www.caresource.com) for additional details, including timely filing for COB, examples when CareSource will automatically adjust a denied COB claim and more.
Effective June 1, 2012, CareSource will comply with the policy below in accordance with OAC Rule 5101:3-2-21 Policies for Outpatient Hospital Services, (F) Outpatient Surgical Service Claims, (b:ii) Surgical Claim Edits.

Policy
Surgical CPT codes that include the administration of anesthesia in the description of that CPT code will only be reimbursed when an anesthesia CPT code in the range 00100-01999 is also coded on the claim. Select surgical CPT codes will be reimbursed only when they appear on a claim that does not contain other CPT codes in the surgery range. These codes are identified in Appendix C of the OAC Rule (see the “Exception Section” for additional details).

Certain surgical CPT codes will only be reimbursed if a prior authorization number is obtained from CareSource. In addition, certain surgical CPT codes will not be reimbursed because it is not considered a surgery or is incident to another surgery (as defined by Appendix C of the OAC Rule).

Exception
CPT codes 64479, 64480, 64483 and 64484 are not included in the above edit logic due to the nature of the codes being primary and secondary codes.

For questions, please contact your CareSource Provider Relations Representative.

Note: This section has been updated.
Purpose of a Medical Unlikely Edit (MUE)
A Medical Unlikely Edit (MUE) is a unit of service claim edit applied to medical claims against a procedure code for medical services rendered by the same Provider to the same patient on the same day.

Claim edits compare different values on a medical claim to a set of defined criteria to check for irregularities, often in an automated claims processing system. MUEs are designed to limit fraud and/or coding errors by setting a limit the Provider can submit on a claim. Past the MUE limit, clinical documentation is required to support the additional units billed on the claim.

Lab 80000 Series Requirements
Unless already established, CareSource will follow the Centers for Medicare and Medicaid Services/Correct Coding Initiative policy on MUEs for CPT lab codes. For a CPT lab code that does not have any established MUEs, CareSource’s Coding and Medical staff will assign the MUEs for a particular code.

When using a different stain on the same specimen during pathology testing, CareSource will allow more than one unit of the lab (e.g., code 88360 or 88342).

All units billed above the set MUE level will require clinical documentation to support the additional billing.
Network Notification

Date: April 16, 2012
Number: OH-P-2012-13

To: Ohio Providers
From: CareSource

Subject: NDC Code Requirements for Professional Claims

Effective: May 1, 2012

Effective May 1, 2012, CareSource Providers must submit a National Drug Code (NDC) and Units in conjunction with designated HCPCS & CPT code(s) when submitting professional claims and End-Stage Renal Clinic claims for reimbursement. If the NDC is not included on codes that require it, the service line(s) will be denied.

NDC information is not required on hospital claims, but hospitals that are able or are already submitting NDCs are encouraged to continue.

The PPACA (Patient Protection and Affordable Care Act) requires Medicaid to collect rebates for drugs from manufacturers who have rebate agreements administered by CMS. The NDC is essential in identifying the drug manufacturer to facilitate these rebates. The specific code may be included in one of the following groups:

- HCPCS codes in the J series
- HCPCS codes in the Q or S series that represent drugs

ODJFS communicated NDC requirements in the “Provider Information Release #10.11, dated May 16, 2011,” that with the implementation of the Medicaid Information Technology System (MITS), the Office of Ohio Health Plans will require that NDC information be submitted on select medical claims that itemize drugs using the 11-digit format. More information can be found in the Provider Information Release.

For questions, please contact your Provider Relations Representative or call the Provider Services Department at 1-800-488-0134.
Network Notification

Date: June 7, 2012
Number: OH-P-2012-17

To: Ohio Providers
From: CareSource

Subject: Members Taking Nexium, Dexilant, Aciphex

Effective: July 1, 2012

With the transition of the pharmacy benefit back to the Managed Care Plans, some members continued taking non-preferred medication.

Effective July 1, 2012, we are asking members taking a non-preferred Proton Pump Inhibitor (Nexium, Dexilant, Aciphex) to switch to one of the preferred medications (Lansoprazole, Omeprazole, Pantoprazole).

Deadline for Action Required – By July 1, 2012
On July 1, 2012, the prior authorization for one of the following non-preferred medications (Nexium, Dexilant, Aciphex) will expire for your CareSource patient(s). Please change these patients to one of the preferred medications, which do not require prior authorization.

How to Request Prior Authorization
- Online: https://providerportal.caresource.com/OH/
- Phone: 1-800-488-0134
- Fax: 1-866-930-0019
- Clinical Documentation – Supporting documentation must be included with prior authorization requests

Questions?
If you have questions, please call the Provider Services Department at 1-800-488-0134 and follow the prompts in order to place a prior authorization.
Our Care Transitions programs are designed to positively impact health outcomes by:

- Contacting the patients discharged from the hospital to assist with coordination of discharge needs and to ensure a safe home environment
- Helping members with medication adherence
- Assisting with establishing a medical home between patients and providers
- Decreasing inappropriate Emergency Department (ED) utilization and unnecessary admissions/readmissions

**Care Transitions Programs**

**Bridge to Home®**
Bridge to Home focuses on a smooth transition from the hospital or skilled nursing facility to the member’s home by focusing on discharge needs, including follow-up appointments and medication adherence.

**Onsite Care Management**
The Onsite Care Management team collaborates with physicians, pharmacies, local agencies and caregivers to help the member achieve the best possible health outcomes.

**CareSource 24 Nurse Advice Line**
CareSource 24 gives members access to speak with a registered nurse 24/7, even when the doctor’s office is closed.
Emergency Department Diversion
CareSource monitors ED utilization, outreaching to members identified who need a regular source of care for routine medical concerns.

Behavioral Health Seven Day Post Discharge Follow-Up
Behavioral Health nurses outreach to members within seven days of their hospital discharge to coordinate care. Our focus is to improve access and adherence to medication and treatment, link to Community Mental Health Centers, decrease psychiatric readmissions and decrease ED visits.

Behavioral Health Provider Inpatient Notification
A CareSource representative notifies the provider of our member's hospital admission and assists with post discharge follow-up appointments, and helps reinforce medication and treatment adherence for improved care coordination.

Questions or to Refer a Patient
For questions about any CareSource Care Transitions program, or to refer a member, please call 1-866-867-0421.