Provider Manual

CareSource®
MyCare Ohio

(HMO D-SNP)

CareSource®

This content has been reviewed; however, changes and/or revisions occur frequently. The provider should check the Provider Manual and Updates & Announcements pages on **CareSource.com** for the most up-to-date information.

Dear CareSource Provider,

Thank you for your participation. CareSource values our relationships with our providers, and we are actively working to make it easier for you to deliver quality care to our members.

CareSource has provided managed health care services since 1989. Since our first Medicaid managed care pilot in collaboration with community leaders and health care providers like yourself, we have continued to drive innovation and transformation of CareSource® MyCare Ohio (HMO D-SNP). CareSource has a strong history of serving under-resourced populations with health and life services, maintaining a unique understanding of our members' needs.

This manual is a resource for working with our plan. It communicates policies and information about our programs. This manual also outlines key information such as claims submission, reimbursement processes, authorizations, member benefits and more to make it more efficient for you to do business with us. This manual is available on **CareSource.com** > Providers > Tools & Resources > Provider Manual. You may also request a hard copy of the manual by calling Provider Services at **1-800-488-0134**. Our hours of operation are Monday through Friday, 8 a.m. to 8 p.m. Eastern Time (ET).

CareSource communicates updates to our provider network regularly via network notifications available on the Updates & Announcements page at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements and on our secure Provider Portal at **CareSource.com** > Login > Provider.

To support our providers, we have dedicated Provider Services teams specialized with each plan to help assist with questions and concerns. Additionally, an external team of Provider Relations Account Managers is available to provide onsite training and work with our providers in their communities.

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

Sincerely,

CareSource®

TABLE OF CONTENTS

SECTION I - INTRODUCTION

Welcome

Welcome, and thank you for participating with CareSource.

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 (PAs) 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 focuses on helping people of all circumstances transform their lives through quality health care and other services.

Our goal is to create an integrated medical home for our members. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy. As a CareSource MyCare Ohio Plan (MCOP), we improve the health of our members by utilizing a contracted network of high-quality participating providers. 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, ensuring members have timely access to health care services and receive all appropriate preventive services.

CareSource also distributes the member rights and responsibilities statements to the following groups. Member's rights and responsibilities can also be found on **CareSource.com**:

- New members, upon enrollment
- Existing members, when requested
- New providers, when they join the network
- Existing providers, when requested

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 providers.

Vision and Mission

Our vision is: Transforming lives through innovative health and life services.

Our mission is: Making 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

- Provider relations
- Provider services
- Member eligibility/enrollment information
- Claims processing
- Decision-support informatics
- Quality improvement
- Regulatory/compliance
- Special investigations for fraud, waste and abuse
- Member services, including a member call center with CareSource as well as with our benefit managers:
  - Dental: Delta Dental
  - Vision: EyeMed
  - Pharmacy: Express Scripts, Inc

In addition to the functions above, our care management programs include the following:

- Low, medium and complex case management – a "no wrong door" referral intake
- Telephonic case management
- Disease management
- Preventive health and wellness assistance with focused health needs/risk assessment
- Emergency department diversion – high emergency department utilization focus (targeted at members with frequent utilization)24-Hour Nurse Advice Line
- Maternal and child health

- Comprehensive prenatal, postpartum and family planning services
- Outreach programs in partnership with community agencies to target members at greatest risk for preterm birth or complications

- Behavioral health (BH) and substance use disorder (SUD) management
- Collaboration with pharmacy and medication therapy management (MTM)

The CareSource Foundation

CareSource gets actively involved in the communities that we serve, from employees serving on hundreds of nonprofit boards to investing dollars back. We listen, we learn and we are driven to action. As a result, we launched the CareSource Foundation in 2006 to add another component to our professional services: community response. Focus areas of the CareSource Foundation are closely aligned with the greatest needs of our member demographics. Areas of emphasis include children's health, special populations such as seniors and individuals with disabilities, the uninsured and life issues such as hunger, domestic violence, SUD and homelessness.

The CareSource Foundation has awarded grants totaling over $32 million. Grants focus on issues of the uninsured, critical trends in children's health and special populations. Several large signature grants were made specifically to address issues of access to coverage in the new health care reform landscape and elevating children from the cycle of poverty through the power of education.

The CareSource Foundation believes in people, organizations and initiatives that actively work to improve the physical health and well-being of individuals residing in the CareSource service areas. We believe that passion, knowledge and vision generate positive, long-lasting change and that meaningful collaboration creates strong partnerships with grantees.

Compliance and Ethics

At CareSource, we serve a variety of audiences – members, providers, 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 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 providers, consultants and vendors.

General Compliance and Ethics Expectations of Providers

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

For questions about provider expectations, please call Provider Services at **1-800-488-0134**.

If you suspect potential violations, misconduct or non-compliant conduct which impacts CareSource or our members, please leverage one of the following methods to communicate the issue to CareSource:

- Ethics and Compliance Hotline: **1-844-784-9583** or caresource.ethicspoint.com
- Compliance Officer: **937-487-5110** or

CorporateComplianceOfficer@caresource.com Any issues submitted to the

Ethics and Compliance Hotline may be submitted anonymously.

The CareSource Corporate Compliance Plan is posted for your reference on **CareSource.com** > About Us > Legal > Corporate Compliance. Please let us know if you have questions regarding the CareSource Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

Accreditation

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our Ohio Medicaid, Marketplace and CareSource MyCare Ohio plans. 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.

SECTION II – BASIC PLAN INFORMATION

CareSource communicates with our provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSource.com** and network notifications. Please reach out to our Provider Services department with any questions.

Call Center Information

Provider Services	
Provider Services Number	**1-800-488-0134**
Hours of Operation	8 a.m. to 8 p.m. ET Monday through Friday
Provider Portal	providerportal.caresource.com/OH

Member Services	
Member Services Number	**1-855-475-3163 (TTY: 1-833-711-4711 or 711)**
Hours of Operation	8 a.m. to 8 p.m., Monday through Friday
24-Hour Nurse Advice Line	**1-866-206-0554**
Hours of Operation	24 hours a day, 7 days a week, 365 days a year
Behavioral Health Crisis Line	**1-866-206-7861**

Holiday Hours

Representatives are available by telephone Monday through Friday, except on observed holidays. Please visit **CareSource.com** > Providers > Contact Us for the holiday schedule or contact Provider Services for more information.

Phone

Our interactive voice response (IVR) system 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.

Our Call Center staff is readily available to assist you with your inquiries and ensure you receive the information you need promptly.

Additionally, our dedicated Provider Relations team is here to provide specialized support and resources tailored to your needs.

Department	Number
Provider Services	1-800-488-0134
Prior Authorizations	1-800-488-0134
Claim Inquiries	1-800-488-0134
Member Services	1-855-475-3163 (TTY: 1-833-722-4711 or 711)
24-Hour Nurse Advice Line	1-866-206-7861
Fraud, Waste and Abuse Hotline	1-844-415-1272
TTY for the Hearing Impaired	1-800-750-0750 or 711
Medicare Part D Drug Coverage Determination	1-800-935-6103
Medicaid Covered Drug Prior Authorization	1-800-935-6103

Medicare Part B Drug Coverage	1-866-264-7934

Mail

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

Member Appeals & Grievances

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

Provider Claim Disputes & Appeals

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

Claims

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

Fraud, Waste and Abuse

CareSource
Attn: Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

Medicare Pharmacy Appeals

Express Scripts
P.O. Box 6588
St. Louis, MO 63166-6588
c/o Medicare Clinical Appeals

Medicare Pharmacy Grievances

Medicare Pharmacy Grievances
CareSource
P.O. Box 1947
Dayton, OH 45401-1947

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

Provider Representative Information

Our goal is to build collaborative and mutually supportive relationships with our network. CareSource's Provider Representatives are dedicated to helping your practice.

You can find your assigned Provider Representative by visiting **CareSource.com** > Providers > Provider Overview > Contact Us.

SECTION III – PROVIDER RESOURCES

CareSource strives to make it easy for you to work with us. This section compiles resources you need for contacting CareSource, finding key information and monitoring updates.

Provider Services

Provider Services	
Provider Services Number	**1-800-488-0134**
Hours of Operation	Monday through Friday, 8 a.m. to 8 p.m. ET
Provider Portal	providerportal.caresource.com/OH

Holiday Hours

Representatives are available by telephone Monday through Friday, except on observed holidays. Please visit **CareSource.com** > Providers > Contact Us for the holiday schedule or contact Provider Services for more information.

Website

Accessing our website, **CareSource.com**, is quick and easy. On the Provider section of the site, you will find:

- Commonly used forms
- Frequently asked questions
- Clinical and preventive guidelines

- CareSource preventive services member rewards information
- And much more!

Provider Portal

Our secure online Provider Portal allows you instant access at any time to valuable information. You can access the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal. 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 to deliver better health outcomes for our members.

Provider Portal Benefits

- Easy access to a secure online (encrypted) tool with 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 Tools

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

- **Payment history** – Search for payments by check number or claim number.
- **Claims features**
  - Claims submission – Submit or upload claims, including corrected claims.
  - Claims status – Search for status of claims and claim disputes.
  - Claims attachments – Submit documentation needed for claims processing.
  - Rejected claims – Find claims that may have been rejected so that you can resubmit them.
  - Claim disputes – Submit and review status of claim disputes and appeals.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Eligibility termination dates** – View the member's eligibility spans from the Member Information panel.
- **Care management referrals** – Submit automated care management forms on our portal for efficiency in enrolling members.
- **Benefit limits** – Track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy and speech therapy, and more.

- **Care treatment plans** – Providers can view care treatment plans.
- **Clinical Practice Registry (CPR)** – Filter patient data to identify opportunities for preventive health screenings.
- **Recovery letters** – View and download letters.
- **Review documents and letters** – View submitted claim documents in addition to dispute and appeal letters.
- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **File grievance** – File a grievance and check grievance status.
- **Service plan** – Waiver providers can review, print, respond to and acknowledge approved services.
- **Redetermination Date** – View the date the member must prove their eligibility to ODM.

Provider Portal Registration

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

1. Visit **CareSource.com** > Login > Ohio and click on Provider Portal.
2. Click on the "Register for an account" link and complete the three-step registration process. You will need your Tax ID number and your CareSource Provider Number, located in your welcome letter.
3. Click the "Continue" button.
4. 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 Provider Services at **1-800-488-0134**.

Routine Dental Providers

Please use the **Providers > Dental Provider Login >** menu option of the Provider Portal to access Delta Dental's capabilities specifically for routine dental services.

Routine Vision Providers

Please visit **CareSource.com** > Providers > Education > Patient Care > Vision to access the EyeMed provider website.

Forms

Providers may access CareSource MyCare Ohio forms by visiting the Forms Library > Medicaid Addendum

- ODM 03199: Acknowledgment of Hysterectomy Information
- HHS 687: Consent for Sterilization
    - HHS 687-1: Consent for Sterilization (Spanish)
- ODM 03197: Abortion Certification Form
- SUD Residential Admission Form
- Out-of-Network Provider Application
- CareSource MyCare Ohio Provider Agreement

Providers may access plan forms at **CareSource.com** > Providers > Tools & Resources > Forms. Select forms are highlighted below and linked for your convenience:

- Provider Consent Form
- Standardized Appeal/Dispute Form
- Provider Specific Appeal Forms
    - Provider Standard Appeal Request Form
    - Consent for Provider to File an Appeal on Patient/Member's Behalf

SUD Residential Admission form

Out of Network Provider Application

Provider Agreement

Prior Authorization

Provider Policies

CareSource maintains medical, pharmacy, reimbursement and administrative policies on our website. Approved policies may be found at **CareSource.com** > Providers > Tools & Resources > Provider Policies. Policies are regularly reviewed, updated, withdrawn or added; and therefore subject to change. CareSource provides notice to providers regarding a change in policy at least 30 calendar days prior to implementation.

Provider Trainings

CareSource is committed to promoting quality care for our members and facilitating effective collaboration with our providers. To support these goals, we require our providers to

complete annual training sessions and participate in additional training opportunities that enhance your ability to deliver care and conduct business with us.

Key Training Requirements

1. **Annual Trainings:** All providers must complete annual training sessions that cover essential topics related to quality care and operational procedures.
2. **ODM Provider Training:** CareSource mandates that providers attend training sessions delivered by the Ohio Department of Medicaid (ODM) as required by ODM regulators.
3. **Model of Care Training:**
    - The Centers for Medicare & Medicaid Services (CMS) requires all CareSource MyCare Ohio plans to provide initial and annual Model of Care (MOC) training.
    - This training is mandatory for all network providers to see dual-eligible members, as well as for out-of-network providers who routinely see dual-eligible members. Providers must attest to completing the annual MOC training.

Accessing Training and Materials

We know your time is valuable and that you are working with multiple insurance plans. To help improve access and understanding, we have developed a provider-facing Learning Management System. We are excited to introduce HealthPlanResources.com. This new, easy-to-use tool houses all provider training for CareSource and tracks completion of training. All training on our platform is developed in-house and is specific to our organization.

- **Single Sign-On Access:** If you are registered with our Provider Portal, you can access HealthPlanResources.com directly by selecting it from the left menu bar.
- **First-Time Access:** If you do not have portal access, visit HealthPlanResources.com and use your NPI* along with the generic password **ProvidersR#1** to create your account.
- **Office Managers/Administrators:** If you manage a group of providers, you can complete training and manage accounts for all providers under your Tax Identification Number (TIN).

*Note: If you do not have an NPI number, you can create a new account on HealthPlanResources.com using a unique email address as your username. Ensure that you use the same email and password for future access through single sign-on.

Questions?
For further information about our Provider Education Program or inquiries regarding HealthPlanResources.com please visit **CareSource.com** and navigate to Providers > Education > Training & Events.

Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway at CareSource. Newsletters are found on our website at **CareSource.com** > Providers > Tools & Resources > Newsletters & Communications.

Network Notifications

Network notifications are published for CareSource providers to regularly communicate updates to policies and procedures. Network notifications are found on our website at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements.

Listserv Subscriptions

CareSource subscribes to the appropriate distribution lists for notification of all Ohio Administrative Code (OAC) rule clearances and final rules published with medical assistance letters, Medicaid handbook transmittal letters and other transmittal letters affecting managed care program requirements. We encourage our network to subscribe and monitor updates.

Email distribution lists include:

- RuleWatch Ohio at rulewatchohio.gov
- ODM Rule Notification at Medicaid.ohio.gov/wps/portal/gov/Medicaid/stakeholders-and-partners/legal-and-contracts/

To find news and updates directly from ODM, providers may sign up on the subscription form at Medicaid.ohio.gov/home/govdelivery-subscribe.

Claims Payment Systemic Errors (CPSE) Report

A CPSE is defined as the MCOP's claim's adjudication incorrectly underpaying, overpaying, or denying claims that impact five or more providers. A report containing all active CPSEs is updated monthly and can be found on the **CareSource.com** and the Provider Portal. CareSource tracks and communicates statuses of claims payment systemic errors on our monthly CPSE report. Providers may use the report to view updates on status, target dates for reprocessing and resolutions. You can access the CPSE report on **CareSource.com** > Provider > Updates & Announcements.

Clinical Practice Registry and Member Profile

Quick and easy to access on our secure Provider Portal, the CareSource Clinical Practice Registry helps primary care providers (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

- Asthma
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening
- Diabetes (e.g., cholesterol, eye exam, hematology, kidney)
- Emergency room visits

The CareSource Clinical Practice Registry is located on our secure Provider Portal.

Member Profile

With its comprehensive view of patient medical and pharmacy data, our Member Profile can help you improve health outcomes for your CareSource MyCare Ohio patients. The Member Profile can also help you determine an accurate diagnosis more efficiently, reduce unnecessary diagnostic tests and minimize emergency room visits.

Key Benefits of the Member Profile

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

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

Preventive Guidelines and Clinical Practice Guidelines

CareSource approves and adopts evidence-based nationally recognized standards and guidelines and promotes them to providers to help inform and guide clinical care provided to members. Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management tools. Guidelines are reviewed at least every two years or more often as appropriate and updated as necessary. They may be found at **CareSource.com** > Providers > Education > Patient Care > Health Care Links.

The use of these guidelines allows CareSource to measure their impact on member health outcomes. Review and approval of the guidelines are completed by the Market CareSource Provider Advisory Committee (PAC). The CareSource Enterprise PAC approves the guidelines and Quality Enterprise Committee (QEC) is notified of guideline approval. Topics

for guidelines are identified through analysis of member population demographics and national or state priorities. Guidelines may include, but are not limited to:

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

Guidelines are promoted to providers through one or more of the following:

- Newsletters
- Our website
- Direct mailings
- This manual
- Focused meetings with CareSource
- Provider Engagement Specialists

Information regarding clinical practice guidelines and other health information is 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 Provider Services at
1-800-488-0134.

Provider Advisory Council / Provider Engagement Committee

The purpose of the Provider Advisory Council / Provider Engagement Committee is to provide a quarterly forum amongst market-specific practicing health care providers and CareSource staff to discuss policy, programs and quality initiatives. The council is comprised of practicing market-specific providers who participate with CareSource and is representative of the major specialties that serve members. The objectives of the Provider Advisory Council / Provider Engagement Committee include:

- Foster discussion among practicing health care providers
- Discuss CareSource new and revised medical policies, clinical best practice guidelines and clinical operations decisions
- Provide a forum for practicing physicians and advance practice providers (APPs) to provide perspective regarding new programs and changes to existing programs, which helps assure clinical operations remain relevant to practicing clinicians
- Provide peer review and advice regarding CareSource provider quality of care concerns
- Review and acceptance of clinical practice guidelines (medical and behavioral health) at a minimum every two years or more often as necessary
- Address ad hoc emergent quality of care (health, safety and welfare) issues

The Ohio Market Medical Director/Chairperson appoints council members. CareSource will include ODM CareSource MyCare Ohio as a participant in its Provider Advisory Council / Provider Engagement Committee meetings in addition to reporting on its activities to ODM on a semi-annual basis.

SECTION IV – PROVIDER RESPONSIBILITIES

This section outlines key responsibilities for providers in the CareSource MY network.

Appointment 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 providers.

CareSource expects participating providers to offer hours of operation no less than the hours of operation offered to commercial members or comparable to ODM fee-for-service (FFS), if the provider serves only Medicaid members.

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency medical condition.	24 hours, 7 days/week
Urgent Care (includes medical, behavioral health and dental services)	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to: sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache. Acute illness or substance dependence that impacts the ability to function but does not present imminent danger.	24 hours, 7 days/week
Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours

Behavioral Health Routine Care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
American Society of Addiction Medicine (ASAM) Residential/Inpatient Services — 3: 3.1, 3.5, 3.7	Initial screening, assessment, and referral to treatment	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services — 4	Services needed to treat and stabilize a member's behavioral health condition	24 hours, 7 days/week
Primary Care Appointment	Care provided to prevent illness or injury; examples include but are not limited to routine physical examinations, immunizations, mammograms, and pap smears.	Within 30 business days
Non-Urgent Sick Primary Care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 calendar days
Prenatal Care — First or Second Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing	First appointment within 7 calendar days; follow-up appointments no more than 14 calendar days after request
Prenatal Care — Third Trimester or High-Risk Pregnancy		Within 3 calendar days
Specialty Care Appointment	Care provided for a non-emergent/ non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

*A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. It is expected that if a provider is unable to see the member within the appropriate time frame, CareSource will facilitate an appointment with a participating provider or a nonparticipating provider, 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 care providers as well as between physical care providers and

behavioral health providers.

Advanced written notice of status changes, such as a change in address, phone or addition or removal of a provider 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.

Americans with Disabilities Act

Providers are required to comply with Americans with Disabilities Act (ADA) standards, including but not limited to:

- Providing waiting room and exam room furniture that meet the needs of all enrollees, including those with physical and non-physical disabilities
- Accessibility along public transportation routes and/or providing enough parking
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities
- Providing secure access for staff-only areas

The 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, providers 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, providers' diagnostic equipment must accommodate individuals with disabilities.

CareSource network providers, in accordance with 42 CFR 438.206(c)(3), must provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities. CareSource and its network providers 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.

For more information about the ADA, go to ada.gov/.

After-Hours Care

Telephone Arrangements

PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services. They must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.

- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments needed by a member.
- Identify and reschedule broken and no-show appointments.
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals or those people with cognitive impairments).
- Schedule continuous availability and accessibility of professional, allied and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other method and then transferred to a member's medical record.
- During after-hours calls, a provider must have the arrangements for the following:
    - Office phone is answered after hours by an answering machine service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call.
    - Office phone is answered after hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the provider has directed to return the call.
    - Office phone is transferred after hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner.

Culturally Competent Care

Consistent with federal mandate 42 CFR 438.206 (2), Access and Cultural Considerations, CareSource participates in efforts to promote the delivery of services in a culturally competent manner to all members. Participating providers must also meet the requirements of this mandate and any applicable state and federal laws or regulations pertaining to provision of services and care.

We expect providers to follow all state and federal civil rights laws. We do not discriminate, exclude or treat people differently based on race, color, national origin, disability, age, religion, sex (which includes pregnancy, gender, gender identity, sexual preference and sexual orientation), or based on marital, health or public assistance status. All people should have a fair and just chance to be as healthy as they can be. CareSource will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the U.S. Department of Health and Human Services (HHS).

Commitment to Optimal Health

CareSource has a long-standing commitment to equitable health outcomes – also known as health equity. Health equity is achieved when every person has an equal opportunity to be healthy, regardless of their social position or circumstances (Centers for Disease Control). To achieve optimal health, individuals and families need access to health-related social needs (HRSN), such as safe housing and neighborhoods, economic stability, quality education, health care, support for healthy behaviors and social and community cohesion.

Success addressing differences in health outcomes is also dependent upon organizations, providers and caregivers being culturally competent. Culturally competent organizations incorporate and recognize the importance of one's culture at all levels. Cross-cultural relations are assessed, dynamics resulting from cultural differences are recognized and attended to, cultural knowledge is expanded and services are adapted to meet culturally unique needs. A culturally competent system also includes a mindfulness of how different patient populations' health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes intersect and influence one another.

CareSource recognizes that many of our members experience demographic differences in health outcomes. We continuously work to develop programs to address cultural and linguistic needs, provide education about cultural humility to our workforce and solicit feedback from providers about what is most needed. As Ohio's population grows and becomes more diverse, understanding what the changing needs of those that we serve are is of the utmost importance. We strive to continuously evolve.

CareSource considers equitable and culturally competent care a core value of our organization. According to the United States Department of Health and Human Services Office of Minority Health, the lack of culturally and linguistically appropriate services is one of the most modifiable factors in improving health care.

CLAS Standards: National Culturally & Linguistically Appropriate Services

CareSource adheres to the National Culturally & Linguistically Appropriate Standards (CLAS), which serve as a blueprint for health care providers and organizations to implement culturally and linguistically appropriate services. CLAS consists of 15 standards that encompass the following topic areas:

- Principal Standard: provision of effective, equitable, understandable and respectful quality care and services that are response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.
- Governance, Leadership and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement & Accountability

Network providers must ensure that:

- Members understand that they have access to free medical interpreter services in their native language, including Sign Language. No cost TDD/TTY services are available to facilitate communication with hearing impaired members.
- Health care is provided with consideration of the members' cultural background, encompassing race/ ethnicity, language and health beliefs. Cultural considerations may impact/influence member health decisions related to preventable disease or illness.
- The provider office staff makes reasonable attempts to collect race-and language-specific member data. Staff is available to answer questions and explain race/ethnicity categories to a member, to assure accurate identification of race/ethnicity for all family members.
- Treatment plans are developed based on evidence-based clinical practice guidelines with consideration of the member's race, country of origin, native language, social norms, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.
-

Provider Network Management System

Cultural competency information as well as languages spoken by office location will be collected in ODM's Provider Network Management (PNM) system and will be utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the MyCare Ohio Plans on a weekly basis for them to align their directories with the information contained in the PNM.

Electronic Health Records

CareSource encourages, supports and facilitates provider adoption and the effective utilization of electronic health records (EHR), including for population health and quality improvement. For network providers who have not yet adopted EHR, while CareSource will not endorse a specific system, CareSource will help
to educate providers on the opportunities for better integration, potential interoperability and quality gap closure stemming from EHR use. CareSource will also work with providers to align real-time sources to use EHR information within our organization and across care management entities within CareSource, providers and the State of Ohio's OhioRISE.

Providers who are interested in these opportunities should contact the CareSource provider relations team in order to assess and coordinate engagement opportunities for EHR. You can find your assigned Provider Representative by visiting **CareSouce.com** > Providers > Provider Overview > Contact Us.

Fraud, Waste & Abuse Reporting

Health care fraud, waste and abuse hurts everyone, including members, providers, taxpayers and CareSource. As a result, CareSource has a comprehensive fraud, waste and abuse program in our Program Integrity department. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

The Program Integrity department routinely monitors for potential billing discrepancies or potential fraud, waste and abuse. When found, an investigation is initiated and if warranted, corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Contract termination
- Employee disciplinary actions
- Reporting to one or more applicable state and federal agencies
- Legal actions

Definition of Terms

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

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 or other recipients). 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.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider/member has not knowingly and/or intentionally misrepresented facts to obtain payment.

Improper Payments are 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. Anyone who identifies an improper payment should report it to CareSource using one of the reporting methods below.

Examples of Fraud, Waste and Abuse

Note: The lists below are not all-inclusive.

Member Fraud, Waste and/or Abuse

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions, i.e., changing prescription forms to get more than the amount of medication prescribed by their physician
- Non-disclosure of other health insurance coverage
- Obtaining unnecessary equipment and supplies
- Identity theft/sharing ID cards, i.e., member receiving services under someone else's ID, sharing your ID with others, or submitting prescriptions under another person's ID
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Provider Fraud, Waste and/or Abuse

- Prescribing drugs, equipment or services that are not medically necessary
- Billing for services not provided
- 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
- Scheduling more frequent return visits than are needed

- Billing for services outside of your medical qualifications
- Using patient lists for the purpose of submitting fraudulent claims
- Drugs billed for inpatients as if they were outpatients
- Payments stemming from kickbacks or Stark Law violations
- Not reporting overpayments or overbilling
- Preventing members from accessing covered services resulting in underutilization of services offered

Pharmacy Fraud, Waste and/or Abuse

- Prescription drugs not dispensed as written
- 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 or illegal drugs
- Billing prescriptions not filled or picked up

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

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

Vendor Fraud, Waste and/or Abuse

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

Your provider agreement provides specific information on each type of termination/suspension. The Fair Hearing Plan, available at CareSource.com/documents/fhp, provides information on an appeal process for specific provider terminations.

Network providers, in accordance with 42 CFR 438.608, are required to report and return to CareSource any overpayment within sixty (60) calendar days of identification and notify

CareSource in writing of the reason for the overpayment.

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.

The False Claims Act addresses those who:

- Knowingly* presents, or cause to be presented, a false or fraudulent claim for payment or approval
- Knowingly* makes, use or cause to be made or used, a false record or statement material to a false or fraudulent claim
- Conspire to commit a violation of any other section of the False Claims Act
- Have possession, custody or control of property or money used, or to be used, by the government and knowingly deliver, or cause to be delivered, less than all of that money or property
- Are 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 or make or deliver the receipt without completely knowing that the information on the receipt is true
- Knowingly* buy, 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
- Knowingly* make, use, or cause 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 conceal or
knowingly and improperly avoid or decrease 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.*

A violation of the federal Anti-Kickback Statute constitutes a false and fraudulent claim under the federal False Claims Act.

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

The 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

Protection for Reporters of Fraud, Waste or Abuse

In addition, 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 Program Integrity department.

Additional information on the False Claims Act and our fraud, waste and abuse policies can be found on **CareSource.com** > Providers > Education > Fraud, Waste & Abuse.

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, providers 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. §1395(a) and §1903(s).
- 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.
- 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.

Prohibited Affiliations

CareSource is prohibited from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities, this includes ineligibility to participate in federal programs by the

U.S. Department of Health and Human Services (HHS) or another federal agency under 2 CFR 180.970 and exclusion by HHS's Office of the Inspector General or by the General Services Administration under 2 CFR 376.

Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation. If you become aware that your corporate entity, those with more than five percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us immediately by emailing providermaintenance@caresource.com.

Disclosure of Ownership, Debarment and Criminal Convictions

Before CareSource enters or renews an agreement with your practice or corporate entity, you must disclose any debarment, proposed for debarment, suspension or declared ineligible status related to federal programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity. You must also notify CareSource of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration.

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 emailing Provider Maintenance at providermaintenance@caresource.com.

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 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. Federal and state law and CareSource policy prohibit any retaliation or retribution against persons who report suspected violations. If you have knowledge or information that any such activity may be or has taken place, please contact our Program Integrity department. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for Reporting Anonymously:

Call 1-844-415-1272. Our Fraud, Waste and Abuse hotline is available 24 hours a day.

Write:

CareSource
Attn: Program Integrity
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 on **CareSource.com** > Providers > Tools & Resources > Forms.

You may also report fraud, waste or abuse directly to the state of Ohio by using one of the methods below:

- Ohio Attorney General's Office, Medicaid Fraud Control Unit (MFCU)
  By phone: 1-800-282-0515
  Online: ohioattorneygeneral.gov/About-AG/Service-Divisions/Health-Care-Fraud/Report-Medicaid-Fraud
- The Ohio Auditor of State (AOS)
  By phone: 1-866-FRAUD-OH
  Email: fraudohio@ohioauditor.gov

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.

Physician Education Materials

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse. This brochure can be found on the Office of Inspector General's website at oig.hhs.gov/compliance/physician-education/index.asp.

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

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. As a reminder, providers should also continue to reference the requirements contained within the provider agreement. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Provider Responsibilities

- 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.
    - Minimum of 60-day notice is required if you plan to close your practice to new patients. If we are not notified within this period, you will be required to continue accepting CareSource MyCare Ohio members for a 60-calendar day period following notification.
- For PCPs only: Providing 24-hour availability to your CareSource MyCare Ohio patients by telephone. Whether through an answering machine or a taped message used after-hours, patients should be given the means to contact their PCP or a back-up provider 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 provider and only recommends emergency room use for after hours.
- Submission of claims or corrected claims should be within 365 days of the date of service or discharge.
- Appeals involving medical necessity determinations must be received within 60 calendar days from the date of the denial. Claim disputes must be submitted no later than 12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely dispute submission, whichever is later.
- Keeping all demographic and practice information up to date. Information updates submitted through Provider Network Management (PNM). (See OAC 5160-26-05.1)
- Notify CareSource of change in member demographic circumstances. Information updates should be submitted on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.
- Referring members to providers in the CareSource network.

CareSource Responsibilities

- Prompt Pay Requirements and Penalties:

  In accordance with 42 CFR 447.46 and this Agreement, except if the MCOP and its network provider has established an alternative payment schedule mutually agreed upon and described in the provider contract, the MCOP must:

  1. Claims from independent (non-agency) providers for MyCare Ohio Home- and Community-Based Services (HCBS) Waivers services and private duty nursing (PDN):
     - Pay or deny 90% of all submitted clean claims within 14 calendar days of the date of receipt of the claim;
     - Pay or deny 99% of clean claims within 30 calendar days of the date of receipt of the claim; and

- Pay or deny 100% of all claims within 60 calendar days of receipt of the claim.

2. All other claim types (excluding claims from independent providers):
    - Pay or deny 90% of all submitted clean claims within 21 calendar days of the date of receipt of the claim;
    - Pay or deny 99% of clean claims within 60 calendar days of the date of receipt of the claim; and
    - Pay or deny 100% of all claims within 90 calendar days of receipt of the claim.

- 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 provider 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 providers to follow standard practice procedures even though they may not be spelled out in our provider agreement.

Examples:

- Participating providers, 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 providers 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 below for more information.

Member Rights & Responsibilities

As a CareSource provider, you are required to respect the rights of our members. CareSource members are informed of their rights and responsibilities via their Member Handbook. The 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 and responsibilities, as stated in the Member Handbook, are as follows:

- To receive information about CareSource, our services, our practitioners and providers and member rights and responsibilities.

- To receive all services that our plan must provide.
- 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 discuss 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 or behavioral health care treatment, given in a way that you can follow.
- To be sure 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 we have to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or our plan must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See your member handbook information.
- To be able to get all CareSource MyCare Ohio written member information from our plan:
    - At no cost to you.
    - In the prevalent non-English languages of members in CareSource MyCare Ohio'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 our plan and its providers 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 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).
- To file any complaint about not following your advance directive with the Ohio Department of Medicaid (ODM).
- To be free to carry out your rights and know that CareSource, CareSource's providers or ODM will not hold this against you.
- To know that we must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider in our network for Medicaid-covered woman's health services.
- To be able to get a second opinion for Medicaid-covered services from a qualified provider in our network. If a qualified provider is not able to see you, we must set up a visit with a provider not in our network.
- If CareSource is unable to provide a necessary and covered service in our network, we will cover these services out of network for as long as we are unable to provide the service in network. If you are approved to go out of network, this is your right as a member and will be provided at no cost to you.
- To get information about CareSource from us.
- To make recommendations regarding CareSource MyCare Ohio's member rights and responsibility policy.
- To make recommendations regarding a change in CareSource staff.
- To contact the Unite 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 with any complaint of discrimination based on race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

Members of CareSource are also informed of the following responsibilities:

- Have an in-network PCP.
- Use only approved PCPs.
- Keep scheduled doctor (specialist) appointments, be on time, and if you have to cancel, call 24 hours in advance.
- Follow the plans and instructions for care you have agreed upon with your doctors and other health care providers.

- Always carry your CareSource MyCare Ohio member ID card and present it when receiving services.
- Never let anyone else use your CareSource MyCare Ohio member ID card.
- 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 CareSource and your county caseworker know if any member of your family has other health insurance coverage.
- Provide the information that CareSource and your health care providers need in order to provide care for you.
- Understand as much as possible about your health conditions and take part in reaching goals that you and your PCP agree upon.
- Let us know if you suspect health care fraud or abuse.

Notification of Practice Changes

Participating providers must provide CareSource with adequate notice of practice changes. 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.

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
Provider's intent to terminate	90 calendar days

To update your demographic information in Express Scripts (ESI), please follow the directions below.

1. Log onto ESI's provider website.
2. Select "Begin a New Process."
3. Select "Report a Change in My Pharmacy."

Provider Directory Information Attestation

State and Federal regulations require health plans to validate and update published information regarding their contracted provider network every 90 days. This validation ensures we have the most accurate information for claims payment and provider directories. This information is critical to process your claims. In addition, it reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare. **Providers are required to attest to directory information every 90 days.**

Accurate provider directory information ensures we can connect the right patients to the right provider.

What happens if I do not attest to my information?

CMS require health plans to verify the accuracy of provider directory information every 90 days. Not attesting to your information and/or providing updated information when applicable can result in claims payment issues and inaccurate provider data in our online and printed directories. With the No Surprises Act in effect as of January 1, 2022, providers who do not attest quarterly risk being suppressed in impacted provider directories.

Changes in Member Demographic Circumstances

Notify CareSource of change in member demographic circumstances. Information updates can be submitted on the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

Provider Maintenance

The Ohio Medicaid provider network management (PNM) system serves as the system of record for provider data for ODM and the MCOPs. As a result, data in the PNM system is used in claims payment, the MCOP's provider directory, and ODM provider directory. To ensure provider information remains current it is important for providers to keep their information up to date in the PNM system. Please remember, as an ODM provider and in accordance with your provider agreement, providers are responsible to notify ODM of changes within 30 days (see OAC 5160-1-17.2 (F).

Updating the PNM system: When there is a change in a provider's information, please log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update. Self- service functions include but are not limited to: location changes, specialty changes, and key demographic (e.g., name, NPI, etc.) changes. Once information is accepted into the PNM system, accepted information is sent to the MCOPs daily for use in their individual directories. The provider must update their information in the PNM system first before the MCOPs are able to make changes to their directory. The MCOPs are required to direct providers back to the PNM system if there are changes.

Not all changes happen automatically. Some self-service updates/changes require ODM staff review and approval before they are saved to the provider's record. Providers should validate if a change has been accepted/updated in the PNM before expecting it to show up for the MCOP. For a list of updates that are automatic versus manual, please see the **Updating a Provider File Quick Reference Guide.**

HIPAA and Protected Health Information (PHI)

In the day-to-day business of patient treatment, payment and health care operations, CareSource and its providers 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 PII to be appropriately protected wherever it is stored, processed and transferred while conducting normal business. As a provider, you should be taking measures to secure your sensitive provider 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 it when no longer needed.
- 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.

HIPAA Notice of Privacy Practices

Members are notified of CareSource's privacy practices as required by the 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 and how they may file a complaint with the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) related to their privacy. CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, PHI of members.

As a provider, please remember:

- Follow the HIPAA regulations as required for all covered entities.
- Only make reasonable and appropriate uses and disclosures of PHI for treatment, payment and health care operations.
- Disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the HIPAA regulation 45 CFR

164. For example, providers may disclose patient information to CareSource for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others.

Thank you for your assistance in providing requested information to CareSource in a timely manner.

Sensitive Health Diagnoses

When a patient has a sensitive health diagnosis (e.g., treatment for drug/alcohol use, genetic testing, HIV/ AIDS, mental health or sexually transmitted diseases), you should verify if the patient has granted consent to share health information.

Log in to the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal and search for the CareSource patient using the Member Eligibility option. A message displays if the patient has not consented to sharing sensitive health information. If the patient has not consented, you may not have access to all the patient's health information on the Provider Portal.

Please encourage your CareSource patients who have not consented to complete a Member Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located on **CareSource.com** > Members > Tools & Resources > Forms. The Member Consent/HIPAA Authorization Form can also be used to designate a person who can speak on the patient's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the patient specifies.

Member Consent

When you check eligibility on the Provider Portal, you can also determine if a member has granted consent to share their health information with their past, current and future treating providers. A message displays on the Member Eligibility page if the member has not consented to sharing their health information.

Please encourage CareSource members who have not consented to complete our Member Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located at **CareSource.com** > Providers > Forms.

The Member Consent/HIPAA Authorization Form can also be used to designate a person to speak on the member's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the member specifies.

Prenatal and Postpartum Care

Documentation

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

- **Evidence of prenatal teaching** – This includes education on infant feeding; Women, Infants

and Children (WIC); birth control; prenatal risk factors; dietary/nutrition information and childbirth procedures.

- **Components of the postpartum checkup** – This includes documenting the pelvic exam, blood pressure, weight, breast exam and abdominal exam.

Prenatal Risk Assessment Forms

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

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 our website. 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.

Primary Care Providers

Primary Care Provider Concept

The Centers for Medicare & Medicaid Services (CMS) requires FIDE-SNP plans to provide initial and annual Model of Care (MOC) training to all network providers contracted to see

dual-eligible members routinely. Providers are required by CMS to attest to completing the annual model of care training. To view and attest that you have completed the training and receive credit, please log on to the Provider Portal, which will prompt you to review and attest to completing the model of care training.

All CareSource MyCare Ohio members may choose 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 online Provider Directory available at **CareSource.com** > Members > Tools & Resources > Find a Doctor. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling Member Services.

Primary Care Provider Roles and Responsibilities

PCPs are responsible for:

- Treating CareSource MyCare Ohio 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, seven 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 plans outlined in this manual.
- Providing 30 days of emergency coverage to any CareSource MyCare Ohio patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by CareSource MyCare Ohio patients dismissed from the practice.
- Ensuring demographic and practice information is up to date for directory and member use.

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

Immunization Schedule

Immunizations are an important part of preventive care and should be administered as needed. CareSource endorses the immunization schedule recommended by the Centers for Disease Control and Prevention and approved by the Advisory Committee on Immunization Practices. The schedule is updated annually, and the most current updates can be found at cdc.gov/vaccines.

Sign and Language Interpretation Assistance

CareSource offers on-site sign and language interpreters as well as over-the-phone (OPI) and video remote interpreting (VRI) when appropriate, for medical appointments outside of the surgical, hospital or emergency room setting*. These services are available to CareSource MyCare Ohio members who are hearing impaired, do not speak English or have limited English-speaking proficiency. These services are available at no cost to the member or provider. As a provider, you are required to identify the need for interpreter services for your CareSource MyCare Ohio patients and offer assistance to them appropriately.

To arrange services, please contact our Provider 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.

*CareSource requires hospitals, emergency rooms and skilled nursing facilities, at their own expense, to offer sign and other language interpreters for members who are deaf or hard of hearing, do not speak English or have limited English-speaking proficiency. This includes providers that perform in-office surgeries. These services should be available at no cost to the member.

Quality Improvement

CareSource is committed to providing evidence-based care in a safe, member-centered, timely, efficient and equitable manner. The scope of the CareSource Quality Improvement (QI) program is comprehensive and inclusive of both clinical and non-clinical services, as well as health, safety, and/or welfare concerns. CareSource uses a population health lens to monitor and evaluate the quality of the care and service delivered to our members emphasizing:

- Equitable delivery of service
- Accessibility and availability to medical, behavioral health and other care
- Quality of care and member safety
- Internal evaluation of program areas, including Utilization Management, Care Management and Pharmacy

Population Health Management and Quality Improvement Program

CareSource administers our CareSource MyCare Ohio business in an efficient and effective manner and assures an organizational focus on Population Health Management (PHM) and continuous QI and learning. CareSource has an integrated comprehensive Population Health Management (PHM) model that utilizes quality improvement (QI) science techniques designed to maintain and improve physical and psychosocial well-being and address health disparities through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.

Population Health Strategy
CareSource's population health program encompasses the covered services and programs listed in this manual (including, but not limited to prenatal postpartum, behavioral health, care coordination, utilization management, quality improvement, HealthChek, annual physicals/well visits, immunizations, and health equity).

An annual PHM strategy is designed to directly impact the health of our member populations through programmatic design, implementation, evaluation, and continuous improvement. It is comprehensive and includes data collection and monitoring; assessing population level and individual member health risks and health-related social needs; creating wellness, prevention, case management and care transitions programs to address identified risks and needs, using stratification to identify and connect members to the appropriate programs, and using predictive analytics to identify which members, communities or populations are emerging as high-risk.

Program Scope:

- Improve the health outcomes of identified communities and groups
- Utilize data to analyze community and population level health and health-related social needs and set measurable goals for improvement
- Utilize initial and continuous assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted health improvement activities
- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes and slow the progression of disease or disability
- Coordinate care across the continuum of medical, behavioral health, oral health and preventive screenings
- Deploy strategies to drive improvements in health specifically for populations proactively identified as experiencing health disparities
- Partner with appropriate community-based providers to support individual members, families, and caregivers in managing care
- Utilize a person-centered and family-centered approach for care planning
- Continually evaluate and improve on the strategic plan on an ongoing basis through meaningful quality measurement

Member and provider satisfaction and health outcomes are monitored through:

- Quality improvement activities
- Routine health plan reporting
- Annual HEDIS®—measures the quality of our health plan
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member Experience Survey scores
- Member feedback captured via surveys, inclusion in advisory councils and workgroups
- Review of accessibility and availability standards
- Utilization trends
- Other performance and experience measures, such as HCBS performance measures

CareSource assesses its performance against goals and objectives that are in keeping with industry standards. We complete an annual evaluation of our QI program and Population Health Strategy.

Program Scope

CareSource supports an active, ongoing and comprehensive quality improvement program across the enterprise. To maintain a robust QI program, our scope includes:

- Advocate for members across settings, including review and resolution of quality-of-care issues
- Meet member access and availability needs for physical and behavioral health care and LTSS needs
- Determine interventions for HEDIS overall rate improvement and other performance metrics to improve preventive care scores and facilitate support of members' acute and chronic health conditions and other complex health, safety or welfare needs
- CareSource uses the annual member CAHPS survey to capture member perspectives on health care quality and establishes interventions based on results to enrich member and provider experiences
- Demonstrate enhanced care coordination and continuity across settings
- Meet members' cultural and linguistic needs, encompassing the health-related social needs (HRSN)
- Ensure CareSource is effectively serving members with complex health needs
- Assess member population characteristics and needs
- Assess geographic availability and accessibility of primary care providers and specialists
- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings

- Determine practitioner adherence to clinical practice guidelines
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies
- Ensure regulatory and accrediting agency compliance, including, but not limited to:
    - All federal requirements as outlined in and in compliance with 42 CFR §438.330, 42 CFR 422.152, Centers for Medicare and Medicaid Services (CMS), Ohio Department of Medicaid (ODM), ODM Quality Strategy, National Committee for Quality Assurance (NCQA) and in alignment with the plan's Model of Care (MOC)
    - Compliance audit and performance measurement
    - Compliance with NCQA accreditation standards

Quality Strategy

CareSource seeks to advance a culture of quality and safety that begins with our senior leadership and is cultivated throughout the organization. CareSource utilizes the Institute of Healthcare Improvement (IHI) framework developed to optimize health system performance, as well as the Institute for Healthcare Improvement Quadruple Aim for Populations.

The Institution for Healthcare Improvement Quintuple Aim Framework

CareSource aligns with the IHI framework to:

- Improve the member experience of care (including clinical quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care
- Improve provider satisfaction (professional wellness)
- Advance health equity

In addition, CareSource uses Six Sigma tools, when indicated, to focus on improving member experience, member safety and enduring our processes consistently deliver the desired results.

Quality Measures

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. CareSource uses HEDIS measures to monitor the quality of care delivered to our 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 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 significant areas of care. Potential quality measures:

- Healthy Adult & Women's Health

    - Preventive screenings (breast cancer, colorectal cancer)
- Chronic Conditions
    - Diabetes care, such as glycemic status (A1c) index, blood pressure control for members with diabetes and kidney health evaluations for members with diabetes
    - Controlling high blood pressure
- Behavioral Health
    - Follow up after hospitalization for mental illness
- Care Coordination
    - Follow up after hospitalization
- Long-Term Care

Patient Safety Program

CareSource recognizes that patient safety is the cornerstone of high-quality health care, contributing to the overall health and welfare of our members. Our CareSource Patient Safety program evaluates patient safety trends with the goal of reducing avoidable harm. Our patient safety program is developed in the context of our population health management approach and includes regulatory/accreditation, policies and procedures, training and implementation, continuous monitoring and program evaluation and improvement. Safety events are monitored through retrospective review of quality-of-care concerns and real-time reporting of claims data. Data analysis of our provider and health system network ensures situational risks can be identified in a timely manner, reviewed and mitigated by a proactive corrective action, or performance improvement steps.

Preventive Guidelines and Clinical Practice Guidelines

CareSource approves and adopts evidence-based nationally accepted standards and guidelines and promotes them to practitioners and members to help inform and guide clinical care provided to members. Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management topics. Guidelines are reviewed at least every two years or more as often as appropriate, and updated as necessary. They may be found at **CareSource.com** > Providers > Education > Patient Care > Health Care Links. The use of these guidelines allows CareSource to measure its impact on member health outcomes. Review and approval of the guidelines are completed by the CareSource Provider Advisory Committee (PAC) and Enterprise PAC. The Quality Enterprise Committee (QEC) is notified of guideline approval. Guidelines may include, but are not limited to:

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

Guidelines may be promoted to practitioners and providers through newsletters, our website, direct mailings, provider manual, and through focused meetings with CareSource Provider Engagement Specialists. Information regarding clinical practice

guidelines and other health information may be 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 Provider

Services. HEDIS is a registered trademark of the NCQA.

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 providers are subject, and in accordance with accepted practices.

Quality-of-Care Reviews

CareSource ensures the provision of safe and quality care to members by investigating and mitigating potential quality of care concerns, that include:

- Inappropriate treatment
- Delay of care
- Compromising member health, safety or welfare
- Having the potential to limit functional abilities on a permanent or long-term basis

In order to properly assess quality of care concerns CareSource Enterprise Quality Improvement initiates contact with providers to request medical records using established processes and timelines. As per our policies and provider contracts, we are authorized to ask for protected health information for health care operations, which includes quality issue reviews. Medical record requests are forwarded to providers via mail, e-mail or fax and may be returned to CareSource via these same mechanisms as detailed in the medical record request document.

All providers are expected to return medical record requests related to quality-of-care concerns within 14 days from initial receipt of the request, unless otherwise defined by program guidelines or state or federal law requirements. In the event that a state, federal or regulatory agency, or if the health and safety of a member requires that medical records must be submitted under a shorter time frame, providers are expected to comply with the shorter turnaround time. Providers and facilities that utilize third party health information management vendors are responsible for providing medical records to CareSource or facilitating delivery of medical records to CareSource by the identified contractor. We are legally bound to interact with providers only and CareSource is not subject to any fees charged by health information management companies for medical record retrieval or submission.

Your health partner representative may contact you if medical records are not received within the 14-day timeframe to ensure you received the request. In addition, our market Chief Medical Officer may also be in contact to facilitate and ensure receipt of the required

medical records to complete the quality-of-care reviews. Providers or facilities who repeatedly fail to return requested medical records are reported to the Credentialing Committee and may face other directed intervention or penalties up to and including contract termination.

SECTION V – PROVIDER ENROLLMENT, CREDENTIALING AND CONTRACTING

Provider Enrollment (Administered by the Ohio Department of Medicaid)

Overview

Enrollment, credentialing and contracting are distinct yet interconnected processes. Enrollment with ODM is the initial step where providers formally join the Medicaid program. Enrollment occurs through ODM PNM system. If required, credentialing follows, requiring providers to verify their qualifications and expertise through documented evidence, ensuring they meet the necessary standards and possess the required skills. Credentialing is done through ODM. Finally, contracting involves establishing a formal agreement that outlines the specific responsibilities and expectations of both parties, ensuring clarity and mutual understanding in the professional relationship. Contracting is done through MCOP. These steps collectively ensure that providers are appropriately integrated and recognized within the CareSource network.

There are many resources available on the ODM website about the requirements to become a participating provider. Please visit medicaid.ohio.gov/resources-for-providers/enrollment-and-support for several useful documents that answer relevant questions.

Provider Enrollment (ODM Functions)

In accordance with the Code of Federal Regulations, 42 CFR 438.608, provider enrollment with the state Medicaid agency is required to be reimbursed by the state's contracted MCOP. MCOPs are not allowed to contract with providers who are not enrolled with ODM. ODM does not have reciprocity agreements with other state Medicaid agencies or Centers for Medicare and Medicaid Services (CMS). Enrollment with ODM is necessary even if you are enrolled with Medicaid in another state or Medicare. The enrollment process can be completed online by visiting: **ODM Enrollment Process.** If you do not want to become a fully enrolled provider with ODM, but want to serve Ohio Medicaid beneficiaries, please complete the **MCP Single Case Agreement** in the provider network management (PNM) system or use the **ODM 10295 single case agreement form.** If you use online enrollment in PNM, and you want your provider enrollment span to only be 120 days, you must call ODM and ask that your enrollment be truncated. The ODM 10295 form provides a 120-day agreement with Ohio. Note that multiple single case agreements are not allowed per 42 CFR 438.602.

42 CFR 438.602 also requires ODM to screen, enroll and revalidate MCOP network providers. This law does not require MCOP network providers to render services to fee-for-service (FFS) members. Screening is like a background check to make sure a provider is qualified and credible. Revalidation is a regular check-up to confirm that the provider still meets all the necessary standards and rules over time.

Organizational provider types will be required to pay an enrollment fee. The fee does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFR 455.460 and in OAC 5160-1-17.8. The fee for 2025 is $730 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, ODM will require that the enrolling organizational providers submit proof of payment with their application.

Termination, Suspension, or Denial of ODM Provider Enrollment

For a list of termination, suspension and denial actions initiated by the state against a provider or applicant **that allow for hearing rights** please refer to Ohio Revised Code 5164.38.

For a list of termination, suspension and denial actions initiated by ODM against a provider or applicant **that allow for reconsideration**, please refer to Ohio Administrative Code 5160-70-02.

Loss of Licensure

In accordance with Ohio Administrative Code 5160-1-17.6, a Medicaid provider agreement will be terminated when any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

Enrollment and Reinstatement After Termination or Denial

If a provider's Medicaid provider agreement is terminated or an applicant's application is denied, the applicant/provider should contact Ohio Medicaid via the Provider Enrollment Hotline (1-800-686-1516) to discuss the requirements to reapply. This process may include conversations with the ODM Compliance unit who will provide specific instruction on re-instatement requirements, if applicable.

ODM Provider Call Center (Integrated Help Desk)

If you have questions or need assistance with your Ohio Medicaid enrollment, call the ODM Integrated Help Desk at 1-800-686-1516 through the interactive voice response (IVR) system. It provides 24 hour, seven days a week access to information regarding provider information. Provider representatives are available via the IVR system weekdays from 8 a.m. through 4:30 p.m.

There are many resources available on the Ohio Department of Medicaid website about the requirements to become a participating provider. Please visit for several useful documents that

answer relevant questions: medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support

Helpful Information

Medicaid Provider Resources: Medicaid.ohio.gov/wps/portal/gov/Medicaid/resources-for-providers/ enrollment-and-support/enrollment-and-support

Federal guidelines for enrollment and screening (42 CFR 455 Subpart E): law.cornell.edu/cfr/ text/42/part-455/subpart-E

Ohio Revised Code: codes.ohio.gov/ohio-revised-code/chapter-5160

codes.ohio.gov/ohio-revised-code/chapter-3963

Ohio Administrative Code: codes.ohio.gov/ohio-administrative-code/5160

Provider Contracting (Administered by CareSource)

Contracting Process

If you offer medical services and want more information about becoming a participating provider, please submit the online New Health Partner Contract Form.

Once you submit your request, you will receive a confirmation email. **Please save this email, as it will contain your Application ID.**

We verify the following documentation and or items from the documentation you submitted.

- ✓ Complete W9 to include signed and dated
- ✓ IRS name matches IRS name on W9
- ✓ Debarment Form (Disclosure of Ownership)
- ✓ Group NPI
- ✓ Medicaid & Medicare number

If any items are missing, CareSource will contact you to request you resubmit missing documents to complete the contracting request.

If a provider is contracting with a managed care organization for MyCare credentials, the credentialing process will be done through ODM (PNM module). Providers will not be credentialed at the MCOP level.

Get Started Today

Providers can visit **CareSource.com** > Providers > Education > Become a Participating Provider to initiate the contracting process.

Sample Contract/Provider Agreement

Providers can view a sample contract **CareSource.com** > Providers > Education > Become a Participating Provider.

Sample Network Provider Agreement

We have provided sample copies of our provider agreement and addendum. CareSource Provider Agreement – View the CareSource Provider Agreement

Appendix C – Ohio Medicaid Provisions – view provisions applicable to health services rendered to Ohio Medicaid managed care covered persons

Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organization and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachments are only needed when providers are offering different services or practitioners through this plan contract than are identified in the PNM system. Attachment A is needed for all PCPs to identify the providers' capacity and service location. Attachment A is also required when a provider has specific practitioner affiliates identified in the PNM who agree to provide services under this plan contract. Attachment C is only required when the contract between the managed care entity and the provider includes particular specialties rather than all specialties the provider identified in the PNM system. The most current Medicaid Addendum is posted on the ODM website here:

medicaid.ohio.gov/resources-for-providers/managed-care/medicaid-addendum

The addendum must be completed along with the MCOP provider contract.

Medicare Addendum

LTSS/HCBS providers do not get a Medicare addendum since those services are only Medicaid. All other providers who contract for CareSource MyCare Ohio will get a Medicare addendum.

Termination, Suspension or Denial of Contract

CareSource may decide that an applying or participating provider 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 provider will be notified in writing.

Appeals Process

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: 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 provider 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 provider 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 provider is notified of the reconsideration decision.

Appeals Should Be Sent To:

CareSource
Attn: Senior Medicaid Director
P.O. Box 8738
Dayton, OH 45401-8738

Applying providers may submit additional documents for reconsideration by the credentialing committee to the address above. An application rejection due to the provider'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 visit CareSource.com/documents/fhp.

Provider Disputes
Provider 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

Provider disputes for issues that are contractual or non-clinical should be

sent to: CareSource
Attn: Provider Relations
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 provider 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 provider that is subject to a suspension or termination may dispute the action and request a hearing through the CareSource Fair Hearing Plan unless an exception applies. Exceptions are set forth in the CareSource Fair Hearing Plan.

Non-Contracted or Unenrolled Providers

Nonparticipating providers require a prior authorization for any services rendered to CareSource members, except in cases of emergency. Please reference the prior authorization procedures on pages 81-82 for more information.

Contracting and enrollment are two separate processes. Both should be completed if you want to provide services to managed care enrolled CareSource MyCare Ohio enrolled members. Contracting is the process a provider completes with the MCOP whereas enrollment is a process completed with the ODM. All providers who are billing for services for CareSource MyCare Ohio managed care enrolled beneficiaries should enroll with ODM through the PNM system. 42 CFR § 438.602 requires ODM to "screen and enroll, and periodically revalidate, all network providers of MCOPs". Federal regulations allow for a 120-day temporary agreement for providers who require more time to enroll in the PNM System. To complete the temporary 120 agreement while you wait for your ODM enrollment to process you must complete the ODM 10295 form. For more information on enrolling with ODM, please refer to the beginning of this section of the manual.

Provider education and training resources for PNM, including how to enroll, are located here: PSE Provider Registration Portal - Resources (maximus.com)

Provider Services

Providers may contact CareSource's Provider Services with any questions by calling **1-800-488-0134**. Our hours of operation are 8 a.m. to 6 p.m., Monday through Friday, ET.

Credentialing/Recredentialing Process (ODM Function)

ODM is responsible for credentialing all Medicaid Managed Care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the Provider Network Management system. This process adheres to NCQA and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.

Providers are not able to render services to Medicaid members until you are fully screened, enrolled and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. Medical students, residents, fellows and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with each managed care organization (MCOP) you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOPs.

When you submit your initial application to be an Ohio Medicaid provider, you can designate managed care organization interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOPs so they can start contracting with you.

SECTION VI – COVERED SERVICES

This section describes enrollment and covered services and exclusions to benefits to our CareSource members, as well as appeals rights. CareSource covers all medically necessary Medicaid and Medicare-covered services in accordance with OAC Rule 5160-58-03.

Abortion and Sterilization

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. Providers can also submit these forms on the Provider Portal at **CareSource.com** > Login > Provider.

Abortion

Abortion services are covered in the following circumstances with PA:

- 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 provider, 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 provider 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 provider performing the abortion.

Certification Form for Reimbursement of Abortion

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

- 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 provider, place the woman in danger of death unless an abortion is performed.
- 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.
- 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.
- 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.

Sterilization

Sterilization procedures are covered if the following requirements are met:

- 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.

Annual 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 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

CareSource also covers Annual Physical Exams for CareSource MyCare Ohio DSNP members. In addition to the Annual Wellness Visit, members are covered for the following exam once per year:

- Comprehensive preventive medicine evaluation and management, including an age and gender appropriate history, examination and counseling/anticipatory guidance/risk factor reduction interventions.

Please visit the Provider Portal on our website for up-to-date clinical and preventive care guidelines.

Benefit Managers

Dental

CareSource's covered routine dental benefits are administered by Delta Dental. Dental providers may find more information by contacting Delta Dental by phone: 1-844-470-2967.

Coverage includes up to $5,000 annual allowance for covered comprehensive and preventive services, plus two cleans/exams/fluoride two times per year and implants.

Vision

CareSource's covered routine vision benefits are administered by EyeMed. Vision providers may find more information by contacting EyeMed by phone: 1-877-857-2402.

Benefits include Medicaid-covered eye exams and eyeglass frames, eyeglass lenses or contact lenses.

Hearing

CareSource's covered hearing benefits are administered by TrueHearing. Providers may find more information on **CareSource.com**.

TruHearing Phone: 1-888-993-1955 (TTY: 711)

Benefits include two TrueHearing Advanced Level hearing aids every three years. This is limited to one hearing aid per ear every three years.

Laboratory

CareSource's laboratory testing services are administered by Avalon Healthcare Solutions. Laboratory service providers may find more information on **CareSource.com** > Providers > Education > Laboratory.

Phone: **1-844-227-5769**

Pharmacy

CareSource's pharmacy services are administered by Express Scripts. Providers may find more information on covered pharmacy services for Medicare and Medicaid benefits on **CareSource.com** > Providers > Education > Pharmacy.

Covered Services and Exclusions

For the most up-to-date list of CareSource's plan covered benefits, please visit **CareSource.com** > Ohio > Next Generation MyCare > Benefits and Services. You will find information on services, including dental services, the member's coverage status and other information about obtaining

services.

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 Provider Services at **1-800-488-0134**.

Non-Covered Services

CareSource will not pay for the following services or supplies which are not covered by Medicaid:

- *Services that are experimental in nature and are not performed in accordance with standards of medical practice.*
- *Services that are related to forensic studies.*
- *Autopsy services.*
- *Services for the treatment of infertility.*
- *Abortion services that do not meet the criteria for coverage in accordance with Ohio Administrative Code rule 5160-17-01.*
- *Services pertaining to a pregnancy that is a result of a contract for surrogacy services.*
- *Assisted suicide and other measures taken actively with the specific intent of causing or hastening death; and*
- *Services that do not meet the criteria for coverage set forth in any other rule in Ohio Administrative Code Agency 5160.*

Emergency Services

CareSource provides reimbursement for medically necessary emergency services when rendered by a qualified provider, in accordance with the provider's contract with CareSource.

CareSource reimburses for all medically necessary emergency services that are provided to stabilize the member. After a member's condition is stabilized, providers must notify CareSource as soon as reasonably possible for CareSource to issue any needed authorization.

CareSource will not:

- Deny or inappropriately reduce reimbursement for a provider's provision of emergency care services for any evaluation, diagnostics or treatment provided to a member who needs emergency medical assistance, or
- Reimburse emergency care services contingent upon the member or provider providing any notification, either before or after receiving emergency services.

Post Stabilization Services

Post-stabilization care services are 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. PA 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 provider. PA is required for post-stabilization services in an inpatient setting.

To request PA for observation services as a nonparticipating provider or to request authorization for an inpatient admission, please visit the Provider Portal at **CareSource.com** > Login > Provider Portal.

You can also request a PA by calling our Provider Services and selecting the option to request a PA. During regular business hours, your call will be answered by our Utilization Management department. If calling after regular business hours, your call will be answered by our 24-Hour Nurse Advice Line. "Post-Stabilization Care Services" are defined by 42 C.F.R 422.113.

If you have questions related to post-stabilization service, please call Provider Services at 1-800-488-0134.

Member Enrollment & Eligibility

The ODM is responsible for determining member eligibility and sending the information to CareSource monthly. ODM notifies CareSource of some eligibility changes throughout the month. New members are effective on the first day of the month.

Member Eligibility Verification

Except for emergency services, providers 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 MyCare Ohio member ID member eligibility . You will be directed 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, 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 preventive services exam . Log on to 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.

Members who temporarily lose their Medicaid coverage may remain in the CareSource MyCare Ohio plan for up to six months. This period is called a “deeming period.” After six months, if the members have not reinstated their Medicaid eligibility, the member will be disenrolled from CareSource MyCare Ohio. Please note during this deeming period, CareSource MyCare Ohio will only pay for Medicare covered services, not Medicaid services.

Next Generation MyCare Program: Important Information for Providers

In the Next Generation MyCare Ohio program, dual eligible recipients age 21 and over may qualify for benefits in two ways. They can choose to receive both their Medicare and Medicaid benefits from the MyCare Ohio Plan (MCOP) or they can opt to receive only their Medicaid benefits from the MCOP, referred to as "Medicaid Only Members."

For those who choose to enroll in an MCOP for their Medicare benefits, they will automatically be enrolled in the MCOP for both their Medicare and Medicaid benefits. This is called "exclusively aligned enrollment." This means that if a recipient selects one plan for their Medicare, they will also receive their Medicaid benefits from the same plan, simplifying their coverage.

Understanding Medicaid-Only Members

A Medicaid-Only Member is someone who:

- Does not receive Medicare benefits through the MCOP.
- Receives their Medicare benefits through regular fee-for-service (FFS) Medicare or a Medicare Advantage plan and has a standalone Part D plan for their prescription drugs.
- Only gets Medicaid services through the MCOP.

Billing Process for Medicaid-Only Members

When a Medicaid-Only Member visits your practice, it’s important to follow these steps for billing:

1. Bill the Primary Insurance First: Since the member has Medicare as their primary insurance, you must submit your claim to the Medicare FFS or Medicare Advantage plan first.
2. Get the Explanation of Benefits (EOB): After you submit the claim, wait for the primary insurance to send you the Explanation of Benefits (EOB). This document shows what they paid and what they did not cover.

3. Submit to CareSource as Secondary: Once you have the EOB from the primary insurance, you can then submit the claim to CareSource as the secondary payer.

Key Points to Remember

- Always bill the primary insurance first.
- Obtain the EOB before submitting to CareSource.
- This process ensures that claims are handled correctly and efficiently.

By following these steps, you help ensure that claims are processed smoothly for Medicaid-Only Members. Thank you for your attention to this important billing process!

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.

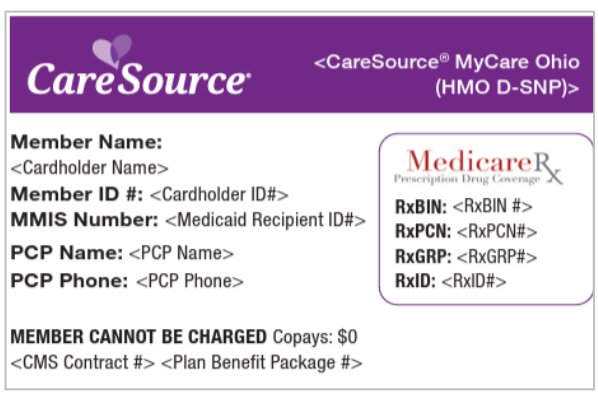
The member ID card is used to identify a CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their previous ID card. Likewise, members may lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to each service rendered.

Providers may use our secure Provider Portal to check member eligibility or call the Provider Services department at **1-800-488-0134** and follow the prompts to check member eligibility.

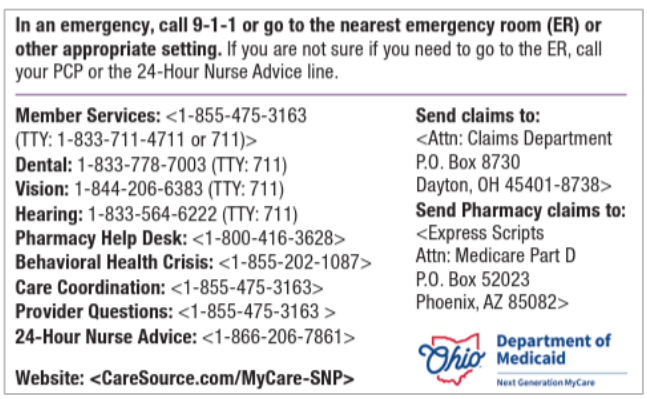
Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification.

The CareSource member ID card serves as a replacement for both the Medicaid card and the CMS Medicare card for members who are fully opted into the CareSource MyCare Ohio Program.

Dual Member ID Card

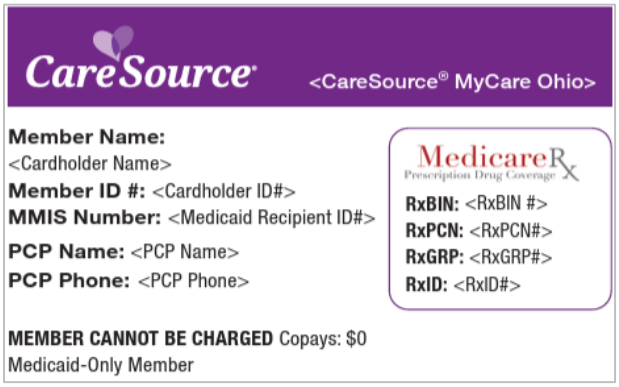


Front (example)

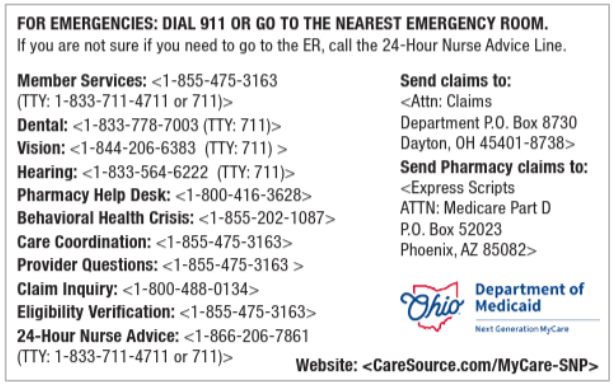


Back (example)

Medicaid Only Member ID Card



Front (example)



Back (example)

CareSource MyCare Ohio Medicaid Only members, as identified in the lower right corner of the ID card, are members who have CareSource for Medicaid but have another payor plan for their Medicare. If a member shows you this card, you should ask the member for their Medicare plan ID card. This plan would be the primary payor for billing purposes.

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.

New Member Welcome Kits

Each household received a new member kit, in addition to a welcome letter and an ID card for each person in the family who has joined CareSource.

New Member Welcome Kit Elements

- A CareSource Member Handbook, which explains plan services and benefits and how to access them
- A quick start guide for how to get started with CareSource
- 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, including how to select a PCP and how to complete an initial health screening

Please note: 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 participating CareSource providers and facilities within a certain radius of the member's residence. As the contents of the printed directory are subject to change, we encourage members to call CareSource or the provider directly to confirm they are in network.

Members are referred to the provider directory, which lists providers and facilities participating with CareSource. A current list of providers can be found at any time on CareSource's website, **CareSource.com** > Members > Tools & Resources > Find a Doctor.

Member Disenrollment

Members may disenroll from CareSource for several reasons. If members lose Medicare or Medicaid eligibility, they lose eligibility for CareSource MyCare Ohio benefits.

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. 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 providers 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, providers are asked to notify our Care Management department for assistance.

CareSource requires that a provider'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, providers may initiate the dismissal by following the guidelines below.

- The provider 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:

  CareSource
  Attn: Member Services Manager
  P.O. Box 8730

Dayton, OH 45401-1947
Fax: (937) 396-3095

- For PCPs only, the letter must contain specific language stating that:
  - The member must contact the 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.

Grievances, Appeals and State Hearing Procedures and Timeframes

Member Grievance and Appeals Procedure

As a CareSource provider, we may contact you to obtain additional documentation when a member has filed a grievance or appeal or has requested a State Hearing. State and federal agencies require CareSource to comply with all requirements, which include aggressive resolution time frames.

Members or providers, 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. To learn more about these procedures, members can contact **1-855-475-3163** and providers can contact **1-800-488-0134.**

Member Grievances

Any time a member informs us that they are dissatisfied with CareSource, or one of our providers, it is a grievance. CareSource investigates all grievances. If the grievance is about a provider, CareSource calls the provider'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
- 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 60 calendar days.

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 65 days from the date that the adverse benefit determination (NOA) was issued. CareSource has one (1) level of internal appeal. CareSource will respond to the appeal in writing within 15 calendar days of when it was received.

Per OAC 5160-58-08.4 (section G): Unless a member requests that previously authorized benefits not be continued, CareSource shall continue a member's benefit when an appeal or state hearing has been filed and all the following conditions are met:

- The member or authorized representative requests an appeal within 15 days of CareSource issuing the Notice of Action (NOA).;
- The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services.
- The services were ordered by an authorized provider
- The authorization period has not expired (9)

Per OAC 5160-58-08.4 (section G): If CareSource continues to reinstate the member's benefits while the appeal is pending, the benefits shall be continued until one of the following occurs:

- The member withdraws the appeal
- The member fails to request a state hearing within 15 days after CareSource issues an adverse appeal resolution; or
- The bureau of state hearings issues a state hearing decision upholding the reduction, suspension, or termination of service.

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. Providers may submit a verbal request for an expedited appeal by calling **1-800-488-0134**. Members can ask a provider to appeal on their behalf with their written consent.

CareSource will make a determination within one business 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 provider 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 provider will be notified in writing of the determination to process as a standard appeal within two calendar days of receipt of the appeal, including information that the member can appeal the decision. If 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.

State Hearings

CareSource members can request a state hearing through the Ohio Department of Job and Family Services (ODJFS) if CareSource decides to deny, reduce, suspend or stop care for a member. CareSource members can also request a state hearing if the resolution to a grievance is to uphold the denial, reduction, suspension, or termination of a service or billing of a member due to the denial of payment for that service. CareSource members are 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 appeal decision. 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. Providers 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 provider 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.

Provider Grievances, Appeals and State Hearing Procedures and Timeframes

If in your capacity as a member's provider you file an appeal on behalf of a member, please refer to the procedures set forth in this manual for member appeals and grievances.

In addition to requesting an appeal on behalf of a member, providers may also appeal on their own behalf.

Please note: If time frames in this manual differ from the provider agreement, the agreement will be the presiding authority.

Provider Claim Disputes – Clinical and Non-Clinical (Post-Service Only)

Provider claim disputes are defined as any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial.

- This includes post service provider claim disputes involving disagreements with the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity that are subject to external medical review that has already been completed.
- They do not include inquiries that come through ODM's Provider Web portal (HealthTrack).

Provider claim disputes can be submitted either verbally or in writing and must be received at

CareSource within 12 months (365 calendar days) from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later (ex: claim recovery/recoupments.) Disputes submitted after the required timeframe has expired will be dismissed for untimely filing.

Submitted disputes should include:

- The member's name, CareSource member ID number, and date of birth.
- The provider's name, CareSource provider billing number and rendering National Provider Identifier (NPI).
- The claim number, date, type, and place of service.
- Code/Service in dispute
- Reason(s) for the dispute request and reconsideration
- Copy of the EOP and any other documentation to support the dispute
- All clinical documentation pertinent to a Medical Necessity review of denied authorization

Claim Disputes may be submitted via:

- **Online:** Provider Portal
- **Fax:** 937-531-2398
- **Verbally:** via Provider Services
- **In writing:** CareSource Provider Claim Disputes and Appeals, P.O. Box 1947, Dayton, OH 45401

Providers will be notified that a dispute has been received within 5 business days from receipt. CareSource will make a determination for provider claim disputes within the following time frames:

- Clinical Claim Disputes – 30 business days from receipt of the dispute
- Non-clinical Claim Disputes – 15 business days from receipt of the dispute

If additional time is needed to resolve a dispute beyond the 15th business day,

- Clinical Disputes – a status update will be provided via US Mail on the 15th business day.
- Non-Clinical Disputes – the provider will be updated via US Mail every 5th business day starting on the 15th business day until the complaint is resolved.

Providers will be notified of the dispute decisions in writing, unless verbally resolved. If the dispute is approved, we will reprocess and pay disputed claims within 30 calendar days of the written notice of resolution unless a system fix is needed, then additional time is allotted.

Claim Disputes for Recovery Actions

Providers will receive notification in writing of any recovery action that CareSource will be taking due to identified overpayments. Utilize the dispute process described above if you do not agree with action being taken.

After the provider receives their dispute resolution, the provider will receive appeal rights to appeal the action to CareSource.

When the resolution determines claims were paid or denied incorrectly, CareSource will:

- Reprocess and pay disputed claims within 30 calendar days of the written notice of resolution unless a system fix is needed, then additional time is allotted; and
- Automatically apply the corrective action or claims resolution to correctly adjudicate all other provider claims affected by the same issue.

Provider Appeals (Pre-Service)

Pre-Service Appeal: any provider disagreement with the decision to deny, limit, reduce, suspend, or terminate a covered service for the lack of medical necessity prior to being completed. If the provider is appealing on the member's behalf with member consent, the process will follow the member appeal pathway. In addition to the requesting an appeal on behalf of a member, providers may also appeal on their own behalf.

Standard (Non-Urgent) Provider Clinical Appeals

Pre-Service appeals may be submitted either verbally or in writing. The request must be received at CareSource within 65 calendar days from the date that the adverse benefit determination was issued.

Submitted appeals should include:

- The member's name, CareSource member ID number, and date of birth.
- The provider's name, CareSource provider billing number and rendering National Provider Identifier (NPI), if available.
- Code/service being appealed.
- All clinical documentation pertinent to a Medical Necessity review of denied authorization.

Appeals submitted after the required timeframe has expired will be dismissed for untimely filing.

Pre-Service appeals may be submitted via:

- **Online:** Provider Portal
- **Fax:** 937-531-2398
- **Verbally:** via Provider Services (expedited requests)
- **In writing:** CareSource Provider Claim Disputes and Appeals, P.O. Box 1947, Dayton, OH 45401

Providers will be notified in writing that an appeal has been received within three business days from receipt.

All pre-service appeals will be completed within 10 calendar days from the receipt of the request.

Providers will be notified of the appeal decisions in writing via US Mail.

Expedited (Urgent) Provider Clinical Appeals

Pre-Service Expedited Appeal may be submitted either verbally or in writing when a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

The request must be received at CareSource within 65 calendar days from the date that the adverse benefit determination (NOA) was issued and must be clearly identified as Expedited or Urgent.

Submitted complaints should include:

- The member's name, CareSource member ID number, and date of birth.
- The provider's name, CareSource provider billing number and rendering NPI if available.
- Code/Service being appealed.
- Reason(s) for the appeal.
- All clinical documentation pertinent to a medical necessity review of a denied authorization.

CareSource will evaluate and determine within one business day of receipt whether to expedite the appeal resolution and make reasonable efforts to provide prompt oral notification of the decision to review expeditiously or convert to a standard.

- If CareSource denies a request for expedited resolution, the case will be reviewed and resolved with 10 calendar days from the date of receipt, unless resolution time frame is extended.

Expedited appeals will be completed within 48 hours from the receipt of the request. If we do not agree with your request for an expedited appeal, you may file a complaint with us.

Providers will be notified of the appeal decisions in writing via US Mail.

External Medical Review

Providers who disagree with CareSource's determination on appeal to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity may request an External Medical Review with Permedion. Services denied, limited, reduced, suspended, or terminated for reasons other than lack of medical necessity and for which no clinical review was completed by CareSource are not subject to External Medical Review. The request for External Review must be submitted to Permedion within 30 calendar days of the date of the internal appeal notification.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located at hmspermedion.com (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from CareSource (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing case.

Providers need to upload the request form and all supporting documentation to Permedion's provider portal located at ecenter.hmsy.com/

For more information about the External Medical Review, please contact Permedion at 1-800-473-0802, Option 2.

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.

Online Health Engagement

CareSource uses innovative technology to engage members to manage their own health. MyHealth is a technology-enabled enterprise solution to improve population health and well-being. It provides personalized wellness tools for all CareSource members. Through MyHealth, CareSource members have access to tools to help them manage health topics specific to their needs. MyHealth includes:

- Interactive health assessment
- Condition specific digital health tools
- Multi-dimensional daily wellness tracker
- Small steps guides

All the tools are accessible via web or mobile.

Healthchek

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 CareSource MyCare 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 Medicare or Medicaid.

Pregnant CareSource MyCare Ohio Mothers are informed of HealthChek.

Immunizations

Immunizations are an important part of preventive care and should be administered as needed. CareSource endorses the immunization schedule recommended by the Centers for Disease Control and Prevention and approved by the Advisory Committee on Immunization Practices. The schedule is updated annually, and the most current updates can be found at cdc.gov/vaccines/.

Immunization Codes

Effective Oct. 1, 2015, CareSource requires providers to use ICD-10-CM Codes and CPT Codes on claims. Please refer to the Code Tables located on the CMS website at cms.gov/medicare/coding-billing/ic-10-codes.

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

Statewide Web-Based Immunization Registry

CareSource encourages all participating providers to take advantage of the statewide web-based immunization registry called IMPACT SIIS, found at ohioimpactsiis.org/siisprod.

The registry consolidates immunizations from multiple providers 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.

Member Rewards

MyCareSource Rewards Program

CareSource offers the MyCareSource rewards program to members enrolled in both Medicare and Medicaid through CareSource. These members are automatically enrolled in the rewards program. They can earn rewards for completing preventive screenings including annual physicals, mammograms and colon cancer screenings. Rewards are automatically added to their Healthy Benefits+ cardeach time they complete an eligible healthy activity. Learn more at HealthyBenefitsPlus.com/MyCare-SNP.

OTC/Food/Flex Card

The plan includes a monthly allowance for members for:

- Over-the-counter items
- Healthy food
- Pest control
- Utility, rent and mortgage assistance
- And more!

Pharmacy

Prescription Drug Coverage

CareSource MyCare Ohio HMO-DSNP members have $0 copays for ALL medications.

CareSource provides a wide variety of support and educational services to our members to facilitate their use of Prescription Drug Coverage.

CareSource partners with Express Scripts, Inc. to process medication claims. Express Scripts, Inc. processes medication claims for CareSource MyCare Ohio plans to provide continuity for provider offices and CareSource members.

CareSource is not required to cover pharmacy services other than limited over-the-counter (OTC) pharmacy services. This includes prescription cough suppressants, prescription vitamins and mineral products except prenatal vitamins and fluoride, and non-prescription/OTC cough suppressants, vitamins, antacids, antidiarrheals, stool softeners, laxatives, wound protectants and artificial tears.

Medicare Part D Phone Numbers for Coverage Determinations

CareSource currently uses a pharmacy partner to handle coverage determination requests. All requests for coverage review requests should be directed to 1-800-935-6103 (phone) or 1-877-251-5896 (fax). Coverage determination requests can also be submitted at express-scripts.com.

For written requests, please send to:

Express Scripts
Attn: Medicare Reviews
P.O. Box 66571
St. Louis, MO 63166-6571

Medicare Pharmacy Coverage Determinations

CareSource utilizes Express Scripts to process coverage determinations and exception requests in accordance with Medicare Part D regulations. Requests will be handled through the coverage review process. A coverage determination requires a drug to be “pre-approved” in order for it to be covered under a benefit plan.

The Coverage Review Department staff will adhere to the Centers for Medicare & Medicaid Services (CMS) approved criteria. The Pharmacy Benefit Manager’s National Pharmacy and Therapeutics Committee established clinical guidelines, and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines.

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

Standard requests will be reviewed, and determinations will be made within 72 hours. An expedited coverage determination will be made within 24 hours.

Medicaid-Covered Drugs

Medicaid-covered drugs include:

- Prescription cough suppressants
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride
- Non-prescription drugs (over-the-counter products): cough suppressants, vitamins, antacids, antidiarrheals, stool softeners, laxatives, wound protectants and artificial tears.

These are not drugs covered by Medicare Part D.

A list of Medicaid-covered drugs is available at **CareSource.com**. For drugs not listed, CareSource utilizes Express Scripts to process prior authorization and exception requests in accordance with Ohio Medicaid regulations. Requests will be handled through the coverage review process. A prior authorization requires a Medicaid-covered drug to be "pre-approved" in order for it to be covered under a benefit plan. CareSource's P&T Committee established clinical guidelines approved by ODM and Express Scripts, Inc. utilizes these criteria when reviewing each case and rendering a decision.

Providers can submit prior authorization requests electronically, by phone, by fax or in writing. Providers will be required to submit persistent medical/drug history, prior treatment history, and any other necessary supporting clinical information or peer-reviewed, published literature with the request.

Requests will be reviewed and responded to within 24 hours per Ohio Medicaid regulations.

Requests should be directed to Express Scripts, Inc. at:

- express-scripts.com
- 1-800-935-6103 (phone)
- 1-800-251-5896 (fax)
- Mail:
  Express Scripts
  Attn: Medicare/Medicaid Reviews
  P.O. Box 66571
  St. Louis, MO 63166-6571

Appeals for Medicaid covered drugs should be directed to CareSource. Please call us at 1-855-475-3163 (TTY: 1-833-711-4711 or 711). An appeal can also be

- Faxed to 937-531-2398
- Sent in writing to:
  CareSource

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

- Submitted via the internet at caresource.com/providers/tools-resources/forms/

Medicare Part B Drug Coverage Determinations

CareSource partners with Evicore-Care Continuum (CCUM) for specialty drug management of Medicare Part B (medical drug) prior authorization service requests. CareSource providers will submit cases for utilization review to CCUM program through electronic portal at EviCore.com.

The EviCore platform will act as a single sign on portal, allowing the provider to submit an electronic request to be reviewed by CCUM.

Phone case initiation will be through CCUM at 866-264-7934 or faxed to 833-812-0187. Case status or inquiries will be either through the EviCore portal or by calling CCUM.

Send any appeals related to Part B (medical drug) denials to CareSource.

Note: Member eligibility will be managed through CareSource.

Drug Formulary

CareSource uses a list of covered drugs, called a drug formulary. The drug formulary contains information about drugs covered, formulary tiers and limitations of coverage (such as prior authorizations, quantity limits and step therapy protocols). Drugs are listed by therapeutic class and by alphabetical index so that therapeutic interchanges for most drug classes are easier to compare. To learn more about how to use our pharmaceutical management procedures, please visit our website's Pharmacy page at **CareSource.com** > Provider > Education > Pharmacy. Prior authorization and step therapy criteria can also be accessed here.

CareSource updates the drug formulary regularly and communicates any updates online on the Plan Documents page. The most up-to-date formulary may be found online at CareSource.com > Providers > Tools & Resources > Drug Formulary. Drugs not listed on the Drug Formulary are not covered without prior approval.

The CareSource formulary was selected in consultation with a team of providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. CareSource MyCare Ohio will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a CareSource network pharmacy, and other plan rules are followed.

Quantity, Supply, Duration and Benefit Limits Quantity limits and dosing limits are based on several factors such as the manufacturer's recommended dosing frequencies, long-term considerations, diagnosis and best practices, and/or Food and Drug Administration (FDA) recommendations. Limits on opioids or other substances with a high potential for abuse are based upon maximum morphine equivalent dosing limits or applicable law. Additionally benefit limitations may pertain to preventive coverage or as defined by applicable rights to coverage for our members.

Step Therapy Certain medications on the drug formulary are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a first step formulary medication used to treat the same condition be tried and failed prior to the approval of a step two formulary medication.

Generic Substitution/Therapeutic Exchange

Generic substitution occurs when a pharmacy dispenses a generic drug that is equivalent to the prescribed brand-name drug. Generally, generic drugs should be considered the first line of prescribing subject to applicable rules. Members and providers can expect the generic to produce the same effect and have the same safety profile as the brand-name drug.

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

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.

Biologic/Biosimilars

When we refer to covered drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have forms that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original (reference) biological products. Sometimes, CareSource may only include a biosimilar or biosimilars for a reference product on the formulary. Other times, CareSource may have prior authorization and step therapy requirements to encourage the use of one or more biosimilars first before the reference biological product. Some biosimilars are interchangeable biosimilars. Depending on state laws, biosimilars may be substituted for the original biological product by a pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs. For more information on biosimilars, see the FDA's Overview for Health Care Professionals at fda.gov/drugs/biosimilars/overview-health-care-professionals.

Medication Therapy Management

CareSource offers a medication therapy management (MTM) program for all eligible 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 costeffective manner. You may be contacted by a pharmacist to discuss your patients' medications. We also encourage members to talk with their pharmacist about their

medications, as we want to make sure they are getting the best results from the medications they are taking.

Our pharmacy directory gives members 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 for a complete list of network pharmacies at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions > Find A Pharmacy.

Pharmacy Appeals Procedures

Express Scripts, in compliance with CMS requirements, will manage redetermination requests for CareSource.

Express Scripts may also provide support for any level two or higher appeal filed where Express Scripts managed the initial coverage determination and redetermination.

Providers may contact Express Scripts to initiate the appeal process at:

Mail: Express Scripts
Attn: Medicare Appeals
P.O. Box 66588
St. Louis, MO 63166-6588

Phone: 1-800-935-6103

Fax: 1-877-852-4070

A request for redetermination, other than an at-risk redetermination, must be filed within 60 calendar days from the date printed or written on the initial coverage determination's denial notice. A request for the plan to vacate the dismissal of a redetermination must be filed within six months from the date printed on the redetermination's notice of dismissal.

A valid requestor may request a standard or expedited review. Express Scripts will provide written notice of its decision, whether favorable or adverse, as expeditiously as the enrollee's health condition requires, but no later than the following:

- **Standard Redeterminations** – within seven calendar days from the date the plan receives the request for a standard redetermination.
- **Expedited Redeterminations** – within 72 hours from the date and time the correct department within the plan receives the request for expedited redetermination. If Express Scripts denies a request to expedite a redetermination, the request will automatically be transferred to the standard redetermination process.
- **Direct Member Reimbursement Redeterminations** – within 14 calendar days from the date the plan or plan sponsor receives the request for redetermination.

How to Submit Appeals

CareSource MyCare Ohio pharmacy appeals go to ESI directly. Providers can submit via phone, fax or mail.

Phone: 1-800-935-6103

Fax: 877-857-4070

Mail: P.O. Box 66588
St. Louis, MO 63166-6588

Specialist Referrals

Generally, CareSource does not require referrals or PA before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, PAs are needed before CareSource will pay for services from out-of-network providers, except in cases of emergency.

Referral Procedures

Any treating doctor can refer CareSource members to specialists. Simply put a note about the referral in the patient's chart. Please remember, nonparticipating specialists require PA for any services rendered to CareSource members.

A referral is required for specialty services not listed below and for plan members to be evaluated or treated by most specialists. Any treating provider 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 PA for any services rendered to CareSource patients.

You can submit a PA request on the CareSource Provider Portal at **CareSource.com** > Login > Provider.

If you have difficulty finding a specialist for your CareSource member, please use our online Find a Doctor/ Provider tool at **CareSource.com** > Members > Tools & Resources > Find a Doctor or call Provider Services at: **1-800-488-0134**.

Services That Do Not Require a Referral

Some health care services provided by specialists do not require a referral from a PCP or dental provider. Members may schedule self-referred services from participating providers themselves, provided the service is covered under their specific plan. Note that although CareSource does not require members obtain referrals for the providers below, some specific services rendered may still require prior authorization from CareSource. In addition, all services rendered are still subject to benefit limits. PCPs or dental providers do not need to arrange or approve these services for members as long as any applicable benefits 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 provider)
- Podiatric care
- Psychiatric care at Community Behavioral Health Centers (CBHCs) only
- Psychological care (from private providers or at CBHCs)
- Care at public health clinics
- Care at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Most radiology services (must be ordered by a participating provider)
- Routine eye exams (at participating vision centers, within benefit limits)
- Care from obstetricians (OBs) and gynecologists (GYNs)
- Care at urgent care centers after hours
- Services for children with medical handicaps

Please visit **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization for the most up to date list of services requiring prior authorization.

Members May Go to Nonparticipating Providers For:

- Emergency care
- Family planning services provided at qualified family planning providers (e.g., Planned Parenthood)
- Care at CBHCs and RHCs
- Care at Ohio Department of Mental Health and Addiction Service (ODMHAS) facilities that are Medicaid providers

Referral Requirements

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

who meet the definition of Children with Special Health Care Needs (CSHCN) may access specialty care providers directly by a standing referral.

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

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. However, providers 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 provider for second opinion:

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

Transportation

Contact Information

CareSource provides our MyCare members transportation services through Provide A Ride. To arrange transportation for a MyCare member, providers may call Provide A Ride's Facility Line at 1-833-297-3064 (TTY 1-833-711-4711).

Members should contact CareSource's member services by calling **1-855-475-3136** (TTY: 1-833-711-4711 or 711) to schedule rides.

Policies and Coverage

Transportation can be provided for covered appointments and community events, Women, Infants and Children (WIC) appointments and CareSource MyCare Ohio redetermination appointments with the County Department of Job and Family Services (DFJS). CareSource will cover unlimited trips with our Medicare supplemental benefit coverage. 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 requesting transportation. Members receive information upon enrollment that indicates how far in advance they need to plan

Transportation Services for Members Enrolled in OhioRISE

CareSource arranges and provides transportation for members who are enrolled with the OhioRISE plan in a manner that ensures that children, youth, and their families served by the OhioRISE plan do not face transportation barriers to receive services regardless of

Medicaid payer. CareSource is responsible for arranging transportation in cases where transportation of families, caregivers, and sibling(s) (other minor residents of the home) is needed to facilitate the treatment needs of the member, even when the member is not being transported.

SECTION VII – UTILIZATION MANAGEMENT

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The UM department performs activities such as: PA, preservice review, urgent concurrent review, post-service 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 and refer members to CareSource's case management, if needed. CareSource's UM criteria are available in writing by mail, fax or email and via the web.

Phone
1-800-488-0134

Fax
1-888-752-0012

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

Services that Require Prior Authorization

Services are provided within the benefit limits of the member's enrollment. Please visit **CareSource.com** > Providers > Provider Portal > Prior Authorization> for the most up-to-date information of services that require PA.

Inpatient psychiatric prior authorization requests for members under the age of 21 should be submitted to the OhioRISE Plan. CareSource will deny these authorization requests because this service is covered by another payer.

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

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

These services require a PA from NIA Evolent. Providers can obtain PA from NIA Evolent for an imaging procedure in the following ways:

- Online – 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. ET.

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

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

In addition, any provider who is not a participating provider with CareSource must obtain PA for all nonemergency services provided to a CareSource member.

CareSource does require PA for unlisted procedure CPT codes. It requires a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code. Submission of clinical information does not guarantee payment.

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. To avoid claim denials providers need to submit supporting clinical documentation with the claim submission.

Prior Authorization Process

CareSource utilizes the Provider Portal for the prior authorization process. Visit **CareSource.com** > Login > Provider Portal.

Authorization Determination Time Frames

CareSource's time frames to make authorization determinations vary depending upon the member's health condition, completeness of submission information and state requirements.

Review Type	Determination Time Frame	Extension	Notification Time Frame
Initial Inpatient	48 hours from receipt of request	N/A	48 hours from receipt of request
Concurrent/ Continued Stay Review	48 hours from receipt of request	N/A	48 hours from receipt of request

Pre-Service Urgent	48 hours from receipt of request	May extend the time frame for 14 calendar days for the member or member's representative to provide additional information in cases where the information provided initially fails to provide sufficient information to determine whether or to what extent, benefits are covered or payable. Notification of the benefit determination is made as soon as possible but no later than 14 calendar days after the earlier of the receipt of the additional information or the end of the period afforded the member or member's representative to provide the specified additional information.	Within 48 hours of receipt of request Within 14 calendar days of receipt of request when an extension is taken
Standard Pre-Service	7 calendar days from receipt of the request	May extend time frame once due to lack of information, for up to 14 calendar days, if the member requests the extension. Must notify the member and member's authorized representative of decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension time frame.	Within 7 calendar days of receipt of request Within 14 calendar days, if extension is granted
Retrospective	Within 30 calendar days from receipt of request	N/A	Within 30 calendar days of receipt of request

Peer-to-Peer Consultations

Providers may request a peer-to-peer consultation when CareSource denies a prior authorization request. The peer-to-peer consultations will be conducted amongst health care professionals who have clinical expertise in treating the members' condition, with the equivalent of higher credentials as the requesting/ordering provider. The peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon the accepted clinical guidelines. CareSource will offer a peer-to-peer consultation within a mutually agreed upon time within 24 hours of a provider's request for a peer-to-peer consultation.

CareSource provides the opportunity for providers to discuss the UM medical necessity determination of a denial or decrease in level of care with CareSource's Medical Director/ Behavioral Health Medical Director or designee within five business days of the notification of the determination. The peer-to-peer process is independent of the process and does not impact the time frame a member and/or provider has to appeal.

To initiate the peer-to-peer process, please call CareSource's Utilization Management team at **1-833-230- 2168**.

Provider Appeals

Providers may request a provider appeal if CareSource denies a prior authorization request in accordance with ORC 5160.34. The provider appeal is separate from the peer-to-peer or member appeal processes. Provider appeals will be responded to within 48hours for urgent care services and within ten calendar days for all other matters.

External Medical Review

The review process is conducted by an independent, external medical review (EMR) entity that is initiated by a provider who disagrees with a MCOP's decision to deny, limit, reduce, suspend, or terminate a covered service for a lack of medical necessity. MCOPs are required to notify providers of their option to request an EMR as part of any medical necessity denial.

In the CareSource MyCare Ohio managed care program, the EMR will be conducted by Permedion. This vendor has a contract with ODM to complete the third-party medical review.

To request an EMR, providers must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the MCOP's internal provider appeal or claim dispute resolution process. Failure to exhaust the MCOP's internal appeals or claim dispute resolution process will result in the provider's inability to request an EMR.

An EMR can be requested by a provider as a result of:

- An MCOP's service authorization denial, limitation, reduction, suspension, or termination

(includes pre- service, concurrent, or retrospective authorization requests) based on medical necessity; or

- An MCOP's claim payment denial, limitation, reduction, suspension, or termination based on medical necessity.

Denials, limitations, reductions, suspensions, or terminations based on lack of medical necessity include, but are not limited to decisions made by the plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent, and retrospective reviews).
- Clinical judgment or medical decision making (i.e., referred to a licensed practitioner for review) is involved.
- A clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC 5160- 1- 01, including EPSDT criteria, and/or the MCOP's clinical coverage or utilization management policy or policies) is not met.

MCOPs are required to notify providers of their option to request an EMR as part of any denial notification.

Requesting an EMR

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or provider claim dispute process has been exhausted.

Providers must complete the "Ohio **Medicaid** MCE External Review Request" form located at hmspermedion.com (select Contract Information and Ohio **Medicaid**) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from MCOP (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing the case.

Providers must upload the request form and all supporting documentation to Permedion's provider portal located at ecenter.hmsy.com (new users will send their documentation through secured email at IMR@ gainwelltechnologies.com to establish portal access).

Note: When requesting an EMR, providers may submit new or other relevant documentation as part of the EMR request.

If the MCOP determines the provider's EMR request is not eligible for an EMR and the provider disagrees, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with the provider's right to request a peer-to-peer review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions.

Once the provider has submitted the EMR request, they do not need to take further action.

Completing the EMR:

After the EMR request has been submitted, Permedion will share any documentation from the provider with the MCOP. Following its review of this information the MCOP may reverse its denial, in part or in whole. If the MCOP reverses any part of its decision the provider will receive a written decision within one business day for expedited prior authorization requests and five business days for standard prior authorization requests and notify the EMR entity. If the MCOP decides to reverse its decision in part, the remaining will continue as an EMR.

Permedion has 30 calendar days for a standard request and three business days for an expedited request to perform its review and issue a decision.

- If the decision reverses the MCOP's coverage decision in part or in whole, that decision is final and binding on the MCOP.
- If the decision agrees with the MCOP's decision to deny, limit, reduce, suspend, or terminate a service, that decision is final.

For reversed service authorization decisions, the MCOP must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the MCOP receives the EMR decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the MCOP must pay for the disputed services within the timeframes established for claims payment in Appendix L of the Provider Agreement.

For more information about the EMR, please contact Permedion at 1-800-473-0802, and select Option 2.

Medical Necessity Criteria

CareSource utilizes nationally recognized criteria, MCG, to determine medical necessity and appropriateness of services. These criteria are designed to assist providers 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 applicable criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available within five business days of decision to discuss individual cases with attending physicians upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward providers 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 underutilization.

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 UM department. If you would like to discuss an adverse decision with CareSource's physician reviewer, please call the UM department within five business days of the determination at **1-800-488-0134.**

Access to Staff

Providers may call Provider Services to contact UM staff with any questions at **1-800-488-0134**.

Staff Availability

- Staff members are available via the toll-free telephone line or direct dial telephone number from 8 a.m. to 5 p.m. ET Monday through Friday for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours. Providers may leave voice mail messages on these telephone lines after business hours, 24 hours a day, seven days a week. A dedicated fax line and Provider Portal for medical necessity determination requests are available 24 hours a day, seven days a week.
- 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.

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 physical and behavioral health care providers.

SECTION VIII – CLAIMS INFORMATION

Process and Requirements for the Submission of Claims and Link to Provider Network Management (PNM) System

ODM Provider Network Management System Direct Data Entry

Before submitting claims, it is critical to validate the eligibility of the member receiving service and verifying that provider information is accurately reflected in ODM's PNM

system. Information such as provider enrollment status and the association with the billing group.

Providers may submit eligibility inquiries through the Provider Network Management (PNM) system: managedcare.**Medicaid**.ohio.gov/managed-care/centralized-credentialing.

ODM's expectation is that for each Medicaid provider, CareSource's system and data are current and consistent with information held by ODM's system of record, the PNM system. Therefore, it is important that providers keep their records up to date in ODM's PNM system. With the PNM system as the ODM's system of record, MCOPs have been instructed to direct providers to update their ODM record in the PNM system when discrepancies are identified between the MCOP's data and the PNM PMF. CareSource is instructed by ODM to not accept changes from providers into their own systems that are inconsistent with PNM system data shared through the PNM for their **Medicaid** line of business.

- The Provider Network Management (PNM) module is a component of the Ohio Medicaid Enterprise System (OMES), which replaced the Medicaid Information Technology System (MITS) provider enrollment subsystem and provider portal.
- CareSource is required to use provider data from the Provider Network Management (PNM) module as it is the official system of record.
- To ensure the provider data sent from the PNM module to CareSource is accurate, it is imperative that providers update all address and affiliation information in the PNM module so that claims payments, provider directories, and network adequacy measurements are not negatively impacted.
- Click on the following links for step-by-step instructions on how to complete these actions:
    - Updating or Adding Owner Information
    - Updating or Adding Practice Locations
    - Updating or Adding a Specialty in PNM

PNM Support:

- Phone: ODM Integrated Helpdesk (IHD) 800-686-1516
- Email: IHD@medicaid.ohio.gov
- Website: PNM & Centralized Credentialing | Ohio Medicaid Managed Care

Electronic Data Interchange (EDI) Submission of Provider Claims

As part of Ohio Department of Medicaid's (ODM) effort to modernize the Ohio Medicaid Enterprise System (OMES), the Electronic Data Interchange (EDI) transaction process has been streamlined. Trading partners facilitating electronic claims reimbursement for Ohio Medicaid providers now exchange all EDI transactions through a single connection. This applies to the ODM fee-for-service (FFS), managed care entities (MCEs), and OhioRISE transactions. (medicaid.ohio.gov/resources-

for-providers/billing/trading-partners/content)

Providers may submit claims, eligibility inquiries and claim status inquiries using electronic data interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM-authorized TP: Medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners.

Providers submitting claims through the ODM-authorized TP must utilize the CareSource ODM Payer ID, 0021599, to ensure appropriate routing of the claim records.

- Providers submitting MyCare claims destined for one of the MCOPs must be submitted through the Ohio Medicaid Enterprise System (OMES) one front door hosted by Deloitte EDI

    - Each file must only contain the claims for the MCOP identified by the Receiver ID.
    - Claims must include the appropriate Payer ID in the 2010BB loop, so claims are appropriately routed by the receiving MCOP.
    - Information on the Receiver ID and 2010BB Payer ID can be found in Section 7 of the ODM Companion Guides: medicaid.ohio.gov/resources-for-providers/billing/hipaa-5010-implementation/companion-guides/guides.

- More information on EDI billing including companion guides can be found on the State's website at Fiscal Intermediary | Ohio Managed Care managedcare.medicaid.ohio.gov/managed-care/fiscal-intermediary/ and Ohio Medicaid Enterprise System Ohio medicaid.ohio.gov/resources-for-providers/billing/trading-partners/content.

Electronic Visit Verification (EVV)

Electronic Visit Verification, or EVV, is a process for electronically capturing point-of- service information for certain home and community-based services. CMS established requirements for all states to use EVV in accordance with the 21st Century Cures Act.

This act requires CareSource to use EVV when processing Personal Care Services claims and Home Health Care Services claims. CareSource complies with the requirements of CMS and the applicable state regulatory body as required by EVV and is dedicated to helping providers navigate this process successfully.

EVV is part of a federal law that requires direct care workers (DCW) who provide certain personal care and home healthcare services to electronically report the following to make sure individuals are receiving the services they need:

- The type of service performed
- The individual receiving the service
- The date of the service

- The location of service delivery
- The DCW providing the service
- The time the service begins and ends
- Independent Providers must use the state-provided Sandata system to document visit capture
- Claims may deny if required EVV data is incomplete or a mismatch occurs
- Each visit/service date should be billed on a separate claim line in order for EVV validation to work correctly. Claims with lines billed with date of service spans will be rejected or denied for improper billing.

EVV Support:

- If you need additional help regarding the EVV processes, please visit the Electronic Visit verification page located on **CareSource.com** at caresource.com/oh/providers/education/patient-care/electronic-visit-verification/mycare/.
- Phone: 855-805-3505
- Email: ODMCustomerCareEmail@Sandata.com
- Website: medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/electronic-visit-verification/electronic-visit-verification

Non-Contracted Providers

In February 2023, Ohio Medicaid implemented the Electronic Data Interchange (EDI) system alongside the Fiscal Intermediary (FI) as part of the Next Generation Ohio Medicaid program. Below are the steps and important information you need to know to submit MyCare Next Generation claims effectively:

1. Understanding EDI and FI:

- The EDI serves as the central hub for all claims-related activities, providing transparency and visibility into care and services.
- The FI processes claims through the EDI. Please note that providers, trading partners, and managed care entities do not interact directly with the FI.

2. Streamlined Claims Process:

- The EDI transaction process was modernized as part of the Ohio Department of Medicaid's (ODM) efforts to enhance the Ohio Medicaid Enterprise System (OMES).
- All electronic claims for MyCare Ohio Plans are exchanged through a single connection with authorized trading partners.
- CareSource MyCare Ohio providers may submit just one claim for Medicare and Medicaid

covered services. CareSource will process all services under one claim.

3. **Prior Authorization Requirement:**

- Nonparticipating (out-of-network) providers must obtain prior authorization for any services rendered to CareSource members, except in emergency situations.
- To request prior authorization, call CareSource at **1-833-230-2176**.

4. **Enrollment Requirement:**

- All providers billing for services to MyCare Ohio-enrolled members must enroll with ODM through the Provider Network Management (PNM) system. For more information, visit the PNM & Centralized Credentialing.

5. **Claim Submission Process:**

- Claims can be submitted electronically through the EDI using an ODM-authorized trading partner (TP). Trading Partners
- When submitting claims, ensure you use the CareSource ODM Payer ID: **'0021599'** to guarantee proper routing of your claim records.
- Please note members with MyCare Medicaid Only ID cards have another payor for their Medicare. Please ask for the member's Medicare ID card and submit Medicare claims to the plan on their Medicare ID card. Once you have done so, you may submit a claim to CareSource MyCare Ohio for the secondary Medicaid services.
- If you have any questions about submitting claims for services rendered to a CareSource member, please contact CareSource Provider Services at **1-800-488-0134**.

For more detailed information about the Ohio Medicaid Enterprise System and EDI transactions, please visit the Ohio Medicaid Enterprise System Transactions Overview page.

Portal Submission of Provider Claims

Providers may also electronically submit claims through CareSource Provider Portal. The portal provides the ability to manually key claim data elements through its intuitive screen layout or upload claims written or keyed into a standard claim form that is saved on the user's computer network. In addition to the first claim entry, providers can submit claim corrections and void request through the interface.

CareSource Portal Access: Claims | Ohio – MyCare | CareSource

providerportal.caresource.com/OH/User/Login.aspx?ReturnUrl=%2fOH

Paper Submission of Provider Claims

Providers unable to submit electronically can submit claims via mail using standard claim billing forms. The CMS-1500 claim form is utilized for submission of Professional claims while the UB-04 (also known as the CMS-1450) form is used for Institutional claims. Paper claims may be sent using standard or certified mail to:

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

Billing Codes and Modifiers

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 providers 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 (202) 512-1800, (202) 512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at ama-assn.org/amaone/cpt-current-procedural-terminology.
- HCFA Common Procedure Coding System (HCPCS). Available at cms.gov/medicare/coding-billing/healthcare-common-procedure-system?redirect=/%20medhcpcsgeninfo/%20www.cms.gov/.
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or ada.org.
- NDC available at fda.go

Other Billing Tips and Requirements

- Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claims.
- ORP is an ODM requirement for certain provider types for both electronic and paper claim submissions. Providers should submit this information under Box 17 of CMS 15000A
- CareSource will coordinate benefits between Medicare and Medicaid on the same claim
- Prior Authorization requirements will be validated during claim processing. Claims will be matched to authorizations on file and processed accordingly.

Timely Filing Requirements

Providers will have 365 days to timely file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim.

For claim denials, providers must adhere to the following time frames for submitting a dispute:

- Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. Providers may submit claim disputes verbally or in writing, including through the Provider Portal.

- If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claims, you should submit a corrected claim. You should not file a dispute or appeal. A Correct Claim should be submitted. Refer to the Claims page or the Provider Manual for further information related to claims submission.

- Please note: All non-contract providers should submit their claim denial issues as Claim Appeals and not as a Payment Dispute. A non-contract provider, on his or her own behalf, may request a reconsideration (i.e., an appeal). It must be filed within 65 calendar days from the date of the notice of the initial determination and the non-contract provider must submit a completed Waiver of Liability (WOL) statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal. If an appeal is submitted, the WOL must be filed with the appeal. The appeal should include other supporting documentation (e.g., copy of remittance advice/notice and clinical records).

Provider Claims Dispute Process

Provider claim disputes are any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial. They include any level of dissatisfaction with claims determination, such as reconsiderations, appeals, and escalated provider claim inquiries. While these disputes can come in through any avenue (e.g., provider services call center, provider advocates, MCOP's provider portal), they do not include inquiries that come through ODM's ProviderWeb portal (HealthTrack).

Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. Providers may submit claim disputes verbally or in writing, including through the Provider Portal. Each provider call is limited to a maximum of three members. This means that the provider may discuss or address claims for up to three different members during one call. For each member included in the call, the provider can have multiple claims. All claims associated with a member will be addressed within the same call, provided that the total number of distinct members discussed does not exceed three.

External Medical Review: After exhausting CareSource's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more

information on EMR, please see the Utilization Management section of this manual. Additional information regarding the submission of a Dispute or Appeal is located here: Provider Disputes or Appeals > Ohio Next Generation MyCare > CareSource. For additional information regarding provider grievances or if you have an issue, please contact Provider Services at 1-833-230-2176.

Claim Processing Guidelines

- Providers 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 a member has other insurance and CareSource is secondary, the provider 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 provider 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 for timely filing.
- To obtain another payer's information for a member, visit the CareSource Provider Portal at: caresource.com/providers/provider-portal
- If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claims, you should submit a corrected claim. **You should not file a dispute or appeal.** A Correct Claim should be submitted. Refer to the Claims page or the Provider Manual for further information related to claims submission, which is located here: caresource.com/oh/providers/provider-portal/appeals/mycare/.
- Please note: All non-contract providers should submit their claim denial issues as Claim Appeals and not as a Payment Dispute. A non-contract provider, on his or her own behalf, may request a reconsideration (i.e., an appeal). It must be filed within 65 calendar days from the date of the notice of the initial determination and the non-contract provider must submit a completed Waiver of Liability (WOL) statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal. If an appeal is submitted, the WOL must be filed with the appeal. The appeal should include other supporting documentation (e.g., copy of remittance advice/notice and clinical records).

Monitoring Claims and Explanations of Benefits (EOBs)

Per 42 CFR 455.20, CareSource has a responsibility to monitor services billed by providers and to verify the receipt of such services with our members. This is accomplished through various methods included Explanation of Benefit mailings, data analytics and follow up calls to members when discrepancies are found. Providers should ensure they are billing for services appropriately to support this process.

Checking Claim Statuses

Claim statuses are 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 or patient number.

Additional Claim Enhancements on the Provider Portal

- Claim history available up to 24 months from the date of service
- Submission of claim appeals
- Reasons for payment, denial or adjustment
- Checking for numbers and dates
- Procedure/diagnostic
- Claim payment date
- Dental claim information
- Submission of attachments for denied claims
- Easy submission for corrected claim when the claim was submitted online via the portal
- Accessibility to claim recovery letters

Reimbursement Guidelines

CareSource follows the Ohio Department of Medicaid fee schedule and reimbursement guidelines per the Ohio Administrative Code (OAC) Rules: 5160-46-06; 5160-12-05

- **Timely Filing Requirement:** Providers must submit claims within 365 calendar days from the date of service
- Forms and instructions for Claims Refund Check Form and Overpayment Recovery Form can be found at caresource.com/oh/providers/tools-resources/forms/
- We may request an itemized bill and medical records per our administrative policies. Please visit our website for further information on caresource.com/oh/providers/tools-resources/health-partner-policies/administrative-policies/mycare/.

Electronic Funds Transfer

CareSource offers electronic funds transfer (EFT) as a payment option. We work with ECHO Health Inc. as our claims processing vendor. Visit the Provider Portal for additional information about the program and to enroll in EFT. Providers who elect to receive EFT payment will receive an EDI 835 (electronic remittance advice). Providers can download their explanation of payment (EOP) from the Provider Portal or receive a hard copy via the mail.

Choose EFT as your payment preference for CareSource. Enroll with ECHO by visiting enrollments.echohealthinc.com/EFTERADirect/CareSource.

You can also complete the ECHO enrollment form and fax, email, or mail it back to ECHO. caresource.com/documents/cs-p-0447-eft-enrollment-form

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 providers.
- **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.
- **Enhanced Information** – Receive member specific third-party liability (TPL) information.

Please Note: TPL/coordination of benefits (COB) information can be found in loop xxx/segment xxx on the 835 file.

CareSource provides TPL/COB information for EFT. This can be found in segment 2100 Claim Payment Information and loop 2110 Service Payment Information on the 835 file in this format:

- NM1*PR*AETNA US HEALTHCARE
- NM1*GB*1*DOE*JANE
- REF*6P*W246632770
- The NM1*PR (COB carrier), NM1* GB (other subscriber information from other payer) and REF*6P (other insurance group number)

To enroll in EFT, complete the enrollment form, available on **CareSource.com** > Providers > Claims and fax it back to our payment processing vendor, ECHO Health Inc. Providers may also call ECHO support at 1-888-834-3511 for assistance with registration.

Member Billing Policy

State and federal regulations prohibit providers from billing CareSource MyCare Ohio 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 providers to resolve any member billing issues that includes notification of excessive member complaints and education regarding appropriate practices.

A MyCare recipient cannot be billed when a medical claim has been denied for any of the following reasons: unacceptable or untimely submission of a claim; failure to request a prior authorization; or a retroactive finding by a peer review organization (PRO) that rendered services was not medically necessary.

Failure to comply with regulations after intervention may result in potential termination of your agreement with CareSource.

Regulations on Billing CareSource MyCare Ohio Members

Federal regulations as well as the Medicaid Addendum, part of your executed contract with CareSource, prohibit providers from billing members except in very limited situations. To bill a member all the following must have occurred:

- Provider has submitted a prior authorization request to CareSource and CareSource has denied the prior authorization request.
- After receipt of denial and prior to rendering the services the provider has notified the member, in writing, of the financial liability to the member should member elect to proceed with the services.
- 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.
- 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 MyCare Ohio 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 member make it to needed appointments.

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

Payment in Full

CareSource requires, as a condition of payment, that a provider (network or out-of-network) accepts the amount paid by the MCOP or appropriate denial made by the MCOP (or, if applicable, payment by the MCOP that is supplementary to the member's third-party payer), and, in addition, any applicable co-payment or patient liability amount due from the member as payment in full for the service.

Member Copayments

Except for collecting member copayments, providers may not charge members or ODM any additional copayment, cost sharing, down payment or similar charge, refundable or otherwise.

MyCare Waiver Providers

Claims Submission

- Claims for Waiver services can be submitted through the Provider Portal however; the view and claims submission process are different than standard Medicaid claims.

    - How to Submit a Claim
    - How to Submit a Corrected Claim Waiver payments

- CareSource will pay according to the Ohio Administrative Rules (OAC) - Rule 5160-46-06 - Ohio Administrative Code | Ohio Laws and all other waiver service statutes listed here: medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/hcbs/waivers/waiver-comparison-chart.
- Payments are made through ECHO and initial check will be sent via paper but strongly recommend contacting ECHO to setup Electronic Funds Transfer (EFT) 1-888-485-6233.

    - Opt out of the V-card option – these cards cannot be used at a local retail store
    - Once you sign up for EFT, it can take up to 2 pay cycles to switch to EFT

Checks are generated twice a week, normally on Tuesday and Saturday.
CareSource follows payer sequencing. Waiver is the payer of last resort following Medicare and Medicaid if the service is medically necessary.

For more detailed billing guidance on specific Long-Term Services and Support (LTSS) services, please refer to the billing guide for the LTSS service you are performing, which is located on the claims page caresource.com/providers/provider-portal/claims/.

Provider Support

Provider Services

To support our providers, we have dedicated Provider Services teams specialized with each plan to help assist with questions and concerns. Additionally, an external team of Provider Relations Account Managers is available to provide onsite training and work with our providers in their communities.

Provider Services	
Provider Services Number	**1-800-488-0134**
Hours of Operation	Monday through Friday, 8 a.m. to 8 p.m. ET
Provider Portal	**ProviderPortal.CareSource.com/OH**

Holiday Hours

Representatives are available by telephone Monday through Friday, except on observed holidays. Please visit **CareSource.com** > Providers > Contact Us for the holiday schedule or contact Provider Services for more information.

Website

Accessing our website, **CareSource.com** is quick and easy. On the Provider section of the site, you will find:

- Commonly used forms
- Frequently asked questions
- Clinical and preventive guidelines
- CareSource preventive services member rewards information
- And more!

Network Notification

CareSource communicates claim processing updates to our provider network regularly via network notifications available on the Updates & Announcements page at **CareSource.com** > Providers > Tools & Resources > Updates and Announcements and on our secure Provider Portal at **CareSource.com** > Login > Provider.

Provider Policies

CareSource maintains medical, pharmacy, reimbursement and administrative policies on our website which may impact claim reimbursement. Approved policies may be found at **CareSource.com** > Providers > Tools & Resources > Provider Policies. Policies are regularly reviewed, updated, withdrawn or added; and therefore, subject to change. CareSource providers notice to providers regarding a change in policy at least 30 calendar days prior to implementation.

Providers may access plan forms at **CareSource.com** > Providers > Tools & Resources > Forms. Select forms are highlighted below and linked for your convenience.

Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway at CareSource. Newsletters are found on our website at **CareSource.com** > Providers > Education > Newsletters & Communications.

SECTION IX – CARE COORDINATION/CARE MANAGEMENT

Care Management/Outreach

CareSource offers members the ability to direct their own care with the support of effective case management, a diverse provider network and an enhanced system of community stakeholder relationships specially crafted to a member's unique needs. CareSource's model of care focuses on an empowerment approach to improve quality, access and effectiveness that coordinates comprehensive care needs and preferences to improve member health outcomes. CareSource empowers members of all ages to direct their own care through provision of on-demand tools to learn about a condition, connect with local services and resources, and by streamlining support through care coordination.

The purpose of the CareSource Integrated Care Management (CM) program is to proactively identify and manage members with a mixed acuity of needs; including members who prospectively need to address preventive health/wellness opportunities to those at high risk for complex, chronic, and costly physical health, behavioral health and psychosocial needs. Regardless of a member's biopsychosocial needs or placement on the care continuum, our Integrated Care Management program builds on strength-based capabilities to enable members to improve their own quality of life.

CareSource encourages you to take an active role in your patient's care management program through the Member Profile feature of the Provider Portal. The profile provides 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 participate in the development of a care plan individualized to the needs of your patient. We believe communication and coordination are integral to ensure the best care for these patients.

We offer individualized education and support for many conditions and needs, including, but not limited to:

- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Members with special health care needs
- Behavioral health needs

To make a patient referral to the CareSource Care Coordination team, please call **1-844-438-9498**.

Care Management

CareSource provides care management services, delivered by medical and behavioral health nurses, social workers counselors, community health 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.

Interdisciplinary Care Team

At CareSource, we believe in working together to provide the best care for our members. Each member has an Interdisciplinary Care Team (ICT) with a care coordinator who is their main point of contact. Per ODM requirements, the care coordinator will lead the ICT, ensuring the coordination of the member's medical, behavioral health, and LTSS needs. Home and Community-Based Services (HCBS) providers are key partners in meeting our members' needs and an integral part of the ICT. Their support helps ensure that our members can live independently and access the services they require. We encourage everyone on the interdisciplinary care team, including HCBS providers, to work together to provide our members with the best possible care.

Direct Access for Medicaid

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

Care Management of Complex Members

CareSource provides a community-based care coordination model for our highest-risk members. Utilizing nurses, social workers and community health workers, this multi-disciplinary approach integrates the Case Management Society of America (CSMA) Standards of Practice utilizing "Community Health Workers" to help patients overcome health care access barriers. It also strengthens our provider and community resource partnerships through collaboration.

Our services include face-to-face meetings, when appropriate, 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 complex-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 coordination programs and participate in the development of individualized care plans to help meet their needs. You are also encouraged to participate in interdisciplinary care team (ICT) meetings to coordinate the self-identified member care preferences and goals. Together, we can make a difference.

Disease Management Program

Our free disease management programs help our members find a path to better health through information, resources and support.

We help our members through:

- The MyHealth online program for members 18+ to participate in a journey to improve their health
- Materials with helpful tips and information to manage their condition
- Coordination with outreach teams
- One-to-one care management (if they qualify)

Members with specific disease conditions such as asthma, diabetes or hypertension are identified by criteria or triggers, such as emergency room visits, hospital admissions or the health assessment. These members are automatically mailed condition specific newsletters. The materials are available in English and Spanish. Any member may self-refer or be referred into the disease management program to receive condition-specific information and outreach.

Benefits to Members and Providers

Members identified in a disease management program receive help finding the appropriate level of care for their condition, and they are encouraged to actively participate in the patient-provider relationship. Programs improve the percentage of CareSource members who receive their recommended screenings.

24-Hour Nurse Advice Line

Members can call our nurse advice line 24 hours a day, seven days a week. With our 24-Hour Nurse Advice Line, 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.

Our 24-Hour Nurse Advice Line nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the PCP by explaining the importance of their role in coordinating the member's care. For improved care coordination with PCPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse provided.

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 may access the 24-Hour Nurse Advice Line any time night or day. The phone number is on the member's ID card.

Emergency Department Diversion

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.

We instruct members to call their primary care provider (PCP) or the 24-Hour 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 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.

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.

Provider Care Coordination Roles and Responsibilities

Care coordination responsibilities include at a minimum, the following:

- Assisting with coordination of the member's overall care, as appropriate for the member
- Serving as the ongoing source of primary and preventive care
- Recommending referrals to specialists, as required
- Triaging members
- Participating in the development of case management care treatment plans and notifying CareSource of members who may benefit from case management

Care Coordination Delegation

CareSource remains accountable for all delegated functions and performs oversight of the arrangement. Through ongoing market review of best-in-class community and provider-based services, we will identify potential delegates for incorporation into the model.

When a delegate is identified and contracted, a pre-delegation assessment is the process by which CareSource evaluates a potential vendor or provider's capability to manage and perform delegated functions in accordance with state and federal laws, rules and regulations; accreditation organization standards; and CareSource business requirements. The evaluation is done prior to the effective date of the delegation and assess multiple areas including but not limited to the vendor's infrastructure, policies and procedures and tools and systems.

Upon delegation, oversight includes review and evaluation of monthly reports and quarterly Joint Operating Committee meetings. A complete evaluation of the delegate is conducted annually or more frequently as needed to review the overall quality of care coordination. Any opportunities for improvement identified during the annual review require a corrective action plan or ongoing oversight. Care coordination oversite audits are conducted monthly upon initial delegation, then quarterly once proficiency is obtained. Delegation oversight is provided through the Enterprise Quality team and Oversight team, as well as Ohio Market Care Coordination. Audit findings, care coordination operational reports, and corrective actions are reported to the Ohio UM CM Committee.

Upon receipt, CareSource will adhere to timelines for the development of collaborative agreements aligning with the requirements and stipulations set by ODM.

Prescription Drug Monitoring Program and Requirement for Providers

We employ opioid dispensing rules that align with CMS policy and guidance. These include safety edits at the pharmacy and a Drug Management Program (DMP).

The purpose of the opioid safety edits and DMP is to prompt prescribers and pharmacists to conduct additional safety reviews to determine if the beneficiary's opioid use is appropriate and medically necessary. Plans are expected to implement these safety edits and conduct the DMP in a manner that minimizes any additional burden on prescribers, pharmacists and beneficiaries.

Opioid Point of Sale (POS) Pharmacy Safety Edits

1. Opioid care coordination edit
    - Any opioid claim will reject at the pharmacy if:
        - It exceeds a morphine milligram equivalent (MME) dose of 90 mg per day and
        - There is more than one opioid prescriber in the previous six months. This rejection ensures care is being coordinated among providers when there are multiple opioid

prescribers. Pharmacies can consult with providers and override this rejection at the point of sale.

2. Seven-day supply limit for opioid naïve patients
    - Opioid claims are limited to a seven-day supply when prescribed for opioid-naïve patients, i.e., for acute pain. An opioid-naïve patient is identified at the dispensing pharmacy based on the prescription claims history of opioids dispensed. If a beneficiary has not had opioid prescriptions filled in the previous 108 days, the rule set assumes that an opioid is being prescribed to an opioid-naïve beneficiary for treatment of acute pain. The pharmacy cannot override this edit.
3. Multiple long-acting opioid medications
    - If a beneficiary has overlapping prescriptions for two long-acting opioid medications, the new prescription will reject. Pharmacies may override this rejection at the point of sale after confirming with the prescriber that the drug therapy is appropriate.
4. Concomitant use of benzodiazepines
    - If a beneficiary has overlapping claims for benzodiazepine and opioid medications, the new prescription will reject. Pharmacies may override this rejection at the point of sale after confirming with the prescriber that the drug therapy is appropriate.

The DMP helps ensure beneficiaries use their prescription opioid medications safely. A beneficiary may be eligible for enrollment in the DMP based on the following criteria:

1. Aggregate opioid prescriptions exceed 90 mg MME for any duration during the past six months, AND
2. The beneficiary has three or more prescribers contributing to opioid claims in the past six months, AND
3. The beneficiary has three or more pharmacies contributing to the opioid claims in the past six months, OR
4. More than five prescribers contribute to opioid claims regardless of the number of pharmacies dispensing opioids in the past six months.

Beneficiaries who meet the prescription claims criteria undergo a second review for any potential exclusions based on medical criteria. The DMP may not apply to beneficiaries who are residents of a long-term care facility, in hospice care or receiving palliative or end-of-life care, are being treated for active cancer-related pain or have sickle cell disease.

Beneficiaries who meet prescription claims criteria and do not have medical exclusions undergo case management coordinated by personnel with appropriate credentials (such as a pharmacist) to determine whether enrollment in the DMP is appropriate. This is a collaborative process with the prescribers of opioids and may also include CareSource MyCare Ohio's professional staff of care management nurses, social workers, mental health experts, or physician medical directors.

If a member is at risk for overuse, misuse or abuse of opioid prescription medications, CareSource MyCare Ohio may limit access to opioids and/or benzodiazepines and/or opioid potentiators (i.e. gabapentin and pregabalin) by utilizing a variety of opioid control tools:

- Requiring the beneficiary to obtain all prescriptions for opioid medications from selected pharmacies.
- Requiring the beneficiary to get all prescriptions for opioid medications from selected prescriber(s).
- Limiting the coverage or amount of opioid medications in a specified time period.

We communicate, in writing, with beneficiaries and prescribers prior to putting any limitations or restrictions in place. Members and prescribers have rights to appeal these decisions.

The dispensing pharmacy or a CareSource pharmacist may contact you about a patient's opioid prescription(s) to determine if opioid use is appropriate and medically necessary. During normal business hours, your office will be contacted, or you may be paged. After hours contact will follow your after-hours process as instructed by telephonic recordings or answering services. For more information on the Medicare Part D opioid safety policies, please visit A Prescriber's Guide to Medicare Prescription Drug (Part D) Opioid Policies.

Additional resources to explain federal governmental programs to manage the opioid epidemic are posted here: cms.gov/About-CMS/Story-Page/prescribing-opioids.

SECTION X – REPORTING

Member Medical Records

Confidentiality

CareSource complies with the Privacy Rule and the HITECH Act which relate to the privacy and security of protected health information, as well as all related regulations, including 45 CRF Parts 160 and 164. In compliance with federal law, CareSource is required to comply with the provisions of this policy so that the rights afforded to members under HIPAA are provided to them.

Access to Medical Records

Member Rights

CareSource members are informed of how CareSource uses and discloses member Protected Health Information (PHI) in accordance with the CareSource Notice of Privacy Practices (NPP). Members are informed via the NPP of their rights, including the right to get a copy of health and claim records and the right to ask us to fix their health and claim records.

Except in certain circumstances, members have the right to review and obtain a copy of their PHI. Because there are some exceptions to the member's right to have access to PHI, CareSource may deny a member access in those specified situations. Requests must be received in writing, and members are informed of this requirement upon their request.

Personal Representatives

The HIPAA Privacy Rule requires CareSource and its business associates to treat a personal representative the same as the member, with respect to uses and disclosures of the member's PHI,

as well as the member's right to access. However, CareSource and its business associates do not have to treat the personal representative the same as the member for purposes of access in the situation where CareSource has reasonable belief that the personal representative may be abusing or neglecting the member or treating the person as the personal representative could otherwise endanger the member.

Response

When a written request for access is received, notice of approval or denial of the request must be sent to the requestor no later than 30 days from receipt of the request. When a written request for access is received, the reviewer must, to the extent possible, grant the member's request for access to the information sought after excluding or redacting the information for which there is a ground to deny access.

If CareSource is unable to process a request for access within the required 30 days, CareSource may take one 30-day extension. The member must be notified of the extension in writing, and the notice must be sent before the original 30 days have lapsed. CareSource can only take one extension and the notice must inform the member of the reasons for the extension and the date by which CareSource intends to respond.

After review and within the applicable response time defined above, the requestor shall be notified of the determination.

Grounds to Deny in Whole or Part

If, after review of the request, any of the following circumstances exist, the request should be denied in part or in total, as appropriate, and notice provided accordingly:

- Part or all of the access request relates to a record that is not maintained by CareSource.
- Part or all of the access request relates to information or a record that is not part of the member's designated record set.
- Part or all of the access request relates to psychotherapy notes.
- Part or all of the access request relates to information that has been compiled in anticipation of or for use in a civil, criminal or administrative proceeding. This would include any documents marked "Attorney-Client Privileged" or similar.
- Part or all of the access request relates to information that is not accessible pursuant to the Clinical Laboratory Improvements Act.
- Part or all of the access request relates to information created or obtained by us in the course of research still in progress that includes treatment of the member and the member agreed to the denial of access when consenting to participate in the research.
- Part or all of the access request relates to information obtained by us from a non-health care provider under a promise of confidentiality and access would likely reveal the source of the information. Part or all of the access request to Protected Health Information is contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, if

the denial of access under the Privacy Act would meet the requirements of that law.

- A licensed health care professional has determined that part or all of the access requested is reasonably likely to endanger the life or physical safety of the member or another person.
- Part or all of the access request relates to information that refers to another person (unless such other person is a health care provider) and a licensed health care professional has determined that the access requested is reasonably likely to cause substantial harm to such other person.
- The request for access is made by the member's personal representative and a licensed health care professional has determined that access by such personal representative is reasonably likely to cause substantial harm to the member or another person.

Providing the Information

Under certain circumstances, members may request a review of the denial of their request. All such member requests for review should be directed to the Privacy Office.

Providing the Information. CareSource shall provide the approved access request in the form or format requested by the member, if readily producible in such form.

Otherwise, CareSource shall provide the information in a readable hard copy or such other form as is agreed to by the member. The member has the right to receive a copy by mail, by email upon request, may request to pick up at their nearest CareSource office. The member also has the right to come the nearest CareSource office to inspect their information.

The member has the right to direct that the copy be transmitted directly to an entity or person designated by the member, provided that any such designation is clear, conspicuous and specific with complete name and mailing address or other identifying information. If the copy is to be picked up onsite by the designee, full identification must be provided. If the copy is to be emailed, the email address must be verified before the transmission, either by sending a test email or telephoning the recipient to verify the address.

Amendments and Corrections to Medical Records

Members' requests to amend information contained in their designated record set will be honored in accordance with the HIPAA Privacy regulations.

Requests for amendments, whether from the member or another covered entity (provider, pharmacy, etc.) must be submitted in writing.

CareSource is not required to approve amendments in certain circumstances:

- **Amendment Request Form Not Signed and/or Does Not State a Reason for the Amendment Request.** In these cases, the request will not be further processed. The form should be noted accordingly, logged and tracked electronically. Notice of denial must be provided to the requestor within 60 days of the receipt of the amendment request.

- **Amendment Request Form Signed by a Member's Representative and Authority Not Documented.** If the amendment request is signed by a member's representative, the representative must include documentation or information to support his/her authority to act for the member. If such information, in accordance with our HIPAA Privacy- Uses and Disclosures of PHI, is not included, the request does not need to be further processed. The form should be noted accordingly, logged and tracked electronically. A denial notice must be provided to the requestor within 60 days of the receipt of the amendment request.

- **The Amendment Request Relates to a Record that was Not Created by CareSource.** It must be determined whether the amendment request relates to a record that was created by CareSource.
  If it was not created by CareSource, the form should be noted accordingly, logged and tracked electronically. The requestor must be notified of the denial within 60 days of the receipt of the amendment request. The denial notice should indicate to the member where the amendment request should be sent (i.e. the creator of the record), if known. Note that in those cases where the record was not created by CareSource, we will process the request if the member has provided credible information that the originator of the record is no longer available to act on the request.

- **The Amendment Request Relates to Information or a Record that is Not Part of the Designated Record Set.** If the amendment request relates to information or a record not within the member's Designated Record Set, the form should be noted accordingly, logged and tracked electronically. The requestor must be notified of the denial within 60 days of the receipt of the amendment request indicating that the record is not part of the Designated Record Set.

- **The Amendment Request Relates to Information that the Member is not Authorized to Inspect by Law.** If the amendment request relates to information or a record that the member is not authorized by law to inspect, the form should be noted accordingly, logged and tracked electronically. The requestor must be notified of the denial within 60 days of the receipt of the amendment request indicating that because the record is not available by law for the member to inspect, it is also not available for amendment. CareSource is not required to accept amendments to records that the member would not have the right to inspect. These include psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.

If, after consultation with the author of the record or information in question, it is determined that the record is accurate or complete as written and does not require amendment, that fact should be noted on the form accordingly. The requestor must be notified of the denial within 60 days of the receipt of the amendment request indicating that the record is complete and accurate as written.

If, after consultation with the author of the record, it is determined that the amendment request is appropriate, that fact should be noted on the form. The requestor must be notified of the approval within 60 days of receipt of the amendment request indicating that the amendment has been accepted and the records amended as requested.

Reporting Provider Preventable Conditions/Health Care-

Acquired Condition

Definition

CareSource defines health care-acquired conditions (HACs) and provider preventable conditions (PPCs) according to 42 CFR § 447.26.

Identification of PPCs

CareSource identifies PPCs/health care acquired conditions from claim reporting and reviews a list on a quarterly basis. The events confirmed by medical records not to be present in admission, get submitted to the Provider Advisory Council (PAC) for review and potential development of Corrective Action Plans (CAPs). Providers are expected to submit their PPCs utilizing a form on the CareSource Provider Portal. You can access the CareSource Provider Portal at **CareSource.com** > Login > Provider Portal.

Reimbursement of PPCs

CareSource does not use Medicaid funding to pay for services resulting from a PPC, in accordance with 42 CFR 447.26. Diagnoses identified as PPCs (based on present on admission data) are excluded from calculation of the claim DRG and are thereby excluded from reimbursement. These claims are also subject to post-payment review during DRG Validation audits. CareSource ensures that the prohibition on payment for PPCs does not result in a loss of access to care or services for our members.

Reporting PPCs

In accordance with 42 CFR 438.3(g), CareSource identifies and reports all PPCs, regardless of the provider's intention to bill for that event, to ODM in the manner specified by ODM.

Response to Undelivered, Inappropriate or Substandard Health Care Services

CareSource's Enterprise Quality Improvement (EQI) department is responsible for investigating, processing and tracking quality of care (QOC) issues. EQI maintains policies and procedures to address quality of care issues which have the potential to negatively impact member health, safety and welfare. These events include:

- Inappropriate, inconsistent, substandard and delayed delivery of health care treatment and services
- Adverse events or outcomes
- Sentinel events which occur in facilities that cause death, permanent harm or severe temporary harm

The EQI Clinical Quality Analyst team consists of registered nurses who collect and review relevant data and evaluate a potential quality of care issue. The Analyst often assigns a severity level using CareSource's internal severity leveling system. When review of a case determines proper standards of care were not met, or determines the case to be complex

in nature, the Analyst refers the case to a designated panel of Medical Directors for review.

Medical Director review may result in CareSource initiating mitigation with the provider, including:

- Review at the Ohio Provider Advisory Committee (PAC)
  - Institution of peer review activities, for example corrective action plans (CAPs) or performance improvement projects (PIPs)
- Notification of the Credentialing committee
- Reporting of findings to the Program Integrity department
- Reporting to regulatory agencies or other appropriate authorities, if required

CareSource's EQI tracks QOC issues and documents case outcomes. Information is shared on a regular basis with the appropriate internal quality committees.

Health, Safety and Welfare

The CareSource Health, Safety and Welfare (HSW) Program ensures that member safeguards and processes are in place that detect, prevent and mitigate member harm and/or risk factors. The HSW Rapid Response Team (RRT) exists to mitigate and resolve urgent and emergency HSW events.

CareSource employees who identify an HSW risk situation, involving a member, will take steps to initiate services to mitigate and address the identified issues as expeditiously as the situation warrants.

Upon identification of an HSW concern, team members follow department-specific procedures for intervention and documentation.

Incident Reporting

Providers are required to assure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500 and accidental/unnatural deaths. If
actions were not taken to assure the immediate health and safety of the member, the provider will do so immediately. Such actions may include calling police or EMS, reporting to county Adult Protective Services (APS), the county Public Child Services Agency (PCSA) or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to CareSource within 24 hours of becoming aware of the incident in accordance with OAC rule 5160-44-05.

How to Submit an Incident to CareSource

Any provider-related concerns are relayed to the member's assigned Care Manager, who will report the incident per CareSource's internal processes. Per provider conditions of participation rules, providers are required to report any health and safety issues involving our waiver members within 24 hours of occurrence or discovery.

SECTION XI – CARESOURCE MYCARE OHIO MANAGED CARE PROGRAM

OhioRISE

OhioRISE is a Medicaid prepaid inpatient health plan contracted with ODM to administer the OhioRISE program.

**CareSource intent to add Transitions of Care for Member Transitioning from the OhioRISE Plan once the requirements are outlined in the final agreement.

SECTION XII – OHIO MYCARE WAIVER

Introduction to the LTSS and Home and Community-Based Services Section

The Ohio Next Generation MyCare Program is designed to enhance the delivery of Long-Term Services and Supports (LTSS) including Home and Community-Based Services (HCBS) for individuals with complex needs. This program emphasizes a person-centered approach, ensuring that members receive tailored support that aligns with their unique preferences and goals. By integrating physical, behavioral, and social services, the MyCare Ohio Program aims to improve health outcomes and quality of life for members while promoting independence and community engagement.

In this section of the Provider Manual, Providers will find essential information regarding their roles and responsibilities within the MyCare Program, particularly in relation to LTSS and HCBS. Key topics covered will include:

- Provider Responsibilities
- Role of the Waiver Service Coordinator
- Covered Services
- Provider Relations Support
- Peer Support Program
- Provider Training and Requirements

This section aims to provide Providers with the necessary tools and resources to navigate the Ohio Next Generation MyCare Program successfully, ensuring that they can deliver high-quality, person-centered care to members receiving LTSS and HCBS in accordance with Ohio Administrative Code 5160-58-04.

LTSS Provider Responsibilities

Authorized Care Delivery

Providers are responsible for delivering all authorized care to each assigned member. This includes:

- Ensuring receipt of prior authorization for all waiver services from the member's Waiver Service Coordinator.
- Maintaining continuity of care for each member by adhering to the Person-Centered Service Plan (PCSP).

Compliance with CareSource Policies and Regulatory Requirements

Providers must comply with all regulatory requirements and CareSource policies and procedures, including:

- Participation in the Interdisciplinary Care Team (ICT) to promote holistic care planning.
- Adherence to Electronic Visit Verification (EVV) requirements as applicable.
- Reporting any changes in the member's condition or care needs to the Care Coordinator and/or Waiver Service Coordinator promptly.
- Reporting incidents, as defined in the OAC 5160-44-05 promptly, within 24 hours
- Adherence to service delivery wait time standards
- Complete Provider Orientation, Model of Care, and annual training requirements.

Role of the Waiver Service Coordinator

The Waiver Service Coordinator (WSC) plays a vital role in helping members access LTSS services. The WSC is responsible for initiating and overseeing the PCSP process, which includes:

- Identifying the member's waiver service needs and preferences.
- Coordinating access to covered waivered services
- Facilitating the development and implementation of the PCSP.
- Conducting evaluations and assessments to establish the appropriate level of care.
- Keeping members informed of waiver service array and available providers

Provider's Role in Service Planning and Coordination

Collaboration with Waiver Service Coordinators
Providers must actively collaborate with Waiver Service Coordinators to ensure:

- The delivery of authorized services aligns with the member's PCSP.
- Any necessary adjustments to services or supports are communicated effectively.

Participating in Care Planning

Providers are expected to:

- Participate in the Interdisciplinary Care Team, where applicable.
- Share insights and updates on the member's progress and any changes in their condition or support system.
- Assist in identifying additional services or supports that may benefit the member.

Service Request Process for LTSS Services

Authorization and Approval

LTSS services require prior approval and authorization. The process includes:

1. Completion of a comprehensive needs assessment performed by the Waiver Service Coordinator.
2. Development and agreement to the PCSP with the member and their caregivers.
3. Coordination of service requests to the appropriate Providers once the PCSP is finalized.

Monitoring and Adjustments

Person Centered Service Plans(PCSP) are reviewed during regular face-to-face visits, significant change event, and assessments. The PCSP may be amended to better meet the member's evolving needs.

Covered Services

Overview

This section outlines the covered services available under Long Term Services and Supports (LTSS) MyCare Waiver as specified in the Ohio Administrative Code Rule 5160-58-04. These services are designed to meet the diverse needs of members and facilitate their ability to live independently in the community.

Covered Services Grid

Service	Procedure/ HCPCS Code	Definition of Service	Unit of Delivery
Personal care services	**T1019**	Assistance with activities of daily living (ADLs), such as bathing, dressing and grooming.	Base Rate = First 35-60 minutes of the visit Unit Rate = Each additional fifteen-minute unit
Waiver nursing RN	**T1002**	Nursing care provided by a licensed RN nurse to manage medical needs in the home.	Base Rate = First 35-60 minutes of the visit Unit Rate = Each additional fifteen-minute unit
Waiver nursing LPN	**T1003**	Nursing care provided by a licensed LPN nurse to manage medical needs in the home.	Base Rate = First 35-60 minutes of the visit Unit Rate = Each additional fifteen-minute unit
Homemaker services	**S5130**	Non-medical assistance in the home, including light housekeeping and meal preparation.	Per fifteen-minute unit
Out-of-home respite services	**H0045**	Temporary relief for primary caregivers, allowing them to take a break from caregiving.	Per day
Supplemental transportation services	**SO215**	Non-emergency transportation services to and from medical appointments or community activities.	Per mile
Adult daycare/half day	**S5101**	Supervised care and social activities provided in a community setting during the day.	Per half day
Adult daycare/full day	**S5102**	Supervised care and social activities provided in a community setting during the day	Per day
Assisted living services	**T2031**	Basic service or memory care that promotes aging in a facility by supporting the individual's independence, choice and privacy.	Per day
Structured family caregiving/full day	**S5136**	Assistance with daily personal care and household support, and assistance with activities needed to promote independence and integration into the community.	Per day

Structured family caregiving/half day	**S5136**	Assistance with daily personal care and household support, and assistance with activities needed to promote independence and integration into the community.	Per half day
Personal emergency response systems	**S5160**	Personal emergency response systems installation and testing	Per installation and testing
Personal emergency response systems	**S5161**	Personal emergency response systems	Per monthly fee
Home modification services	**S5165**	Modifications to enhance accessibility and safety for the member.	Per job
Supplemental adaptive and assistive devise services	**T2029**	Devices and equipment that assist members with disabilities in daily living activities.	Per item
Home delivered meal services – standard meal	**S5170**	Meals prepared and delivered by an authorized meal delivery service.	Per meal
Community integration services	**S5135**	Services that promote social inclusion and community engagement for members.	Per fifteen-minute unit
Community transition services	**T2038**	Service that provides non-recurring start-up living expenses for individuals transitioning from an institutional setting to a home and community-based services (HCBS) setting.	Per job
Home maintenance and chore services	**S5121**	Service that maintains a clean and safe living environment through the performance of tasks in the individual's home that are beyond the individual's capability	Per job
Social Work Counseling	**G0155**	Service to an individual or to an individual's caregiver to promote the individual's physical, social, or emotional well-being; and the development and maintenance of a stable and supportive environment for the individual.	Per fifteen-minute unit
Nutritional Consultation Services	**S9470**	Service that provides advice on healthy eating and lifestyle to achieve desired results.	Per fifteen-minute unit

Enhanced Community Living Services (ECLS)	**T2025**	Service promoting aging in place, in multi-family affordable housing, through access to on-site, individually-tailored, health-related, and supportive interventions for individuals who have functional deficits resulting from one or more chronic health conditions.	Per fifteen-minute unit
Home care attendant	**S5125**	Services or tasks that would otherwise be performed by an RN or an LPN at the direction of an RN.	Per fifteen-minute unit
Home medical equipment	**T1999**	Service providing rented or purchased home medical equipment and supplies to individuals to enable those individuals to function safely in their homes with greater independence, thereby eliminating the need for placement in a nursing facility.	Per item

Authorization and Monitoring

All covered services listed above require prior authorization through the Person-Centered Service Plan (PCSP). Providers must ensure that services are rendered in accordance with the approved plan. CareSource will monitor compliance to verify that services are provided and billed correctly as per the PCSP.

MyCare Waiver Person Centered Service Plans

A Waiver Person Centered Service Plan is designed for CareSource members to receive the extra help they need to live in their community. This plan, identifies specific goals, objectives and measurable outcomes for a waiver-enrolled member's health and functioning expected as a result of HCBS provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the individual, such as assistance with personal care or modifications to their home.

Providers can access MyCare PCSPs through the CareSource Portal by logging in with their CareSource ID. In the portal, providers will find the services approved for each member, which are loaded into the service plan by the member’s care manager. Providers should only perform the services in the amount, scope, and duration that have been approved by the care manager and included in the service plan.

Claims Submission Process

When a provider wants to submit a claim, they will:

- Click on the member’s service plan to submit a claim for the approved service codes.
- Enter the date of service, ensuring each date is on its own line.

- Enter the number of units of service provided for each approved code.

After entering this information, the provider can submit their claim for processing.

Important Items
Enter all units and costs for one visit in one line. If you enter multiple lines for the same date of service, CareSource will deny the claim for duplicate. You can enter multiple dates of service on one claim. However, each claim can only have one procedure code.

Corrected Claims Process

If a provider needs to correct a claim they have already submitted, they can do this through the CareSource Portal by following these steps:

1. Under the Providers menu option, choose Waiver Claims.
2. This will show the list of claims that have been submitted.
3. At the end of each row is the option to click on the Correct Claim link.
4. That will lead back into the claim to make the corrections—exactly the same as submitting a new claim, but with the corrected data.
5. Enter the updated information and submit.

VERY IMPORTANT:
The corrected information should contain the total corrected units and charge. We will subtract what we already paid and pay the provider the difference. If you only submit the amount you did not get paid, we will recoup the original payment and only pay you the new time submitted.

EVV Process for MyCare Home Health Claims (effective March 1, 2026)

The 21st Century Cures Act mandates that states implement electronic visit verification (EVV) for certain Medicaid personal care and home health services provided in home or community-based settings. This requirement enhances service delivery, promotes transparency and ensures that individuals receive timely care. The Ohio Department of Medicaid (ODM) launched its EVV solution in 2018.

What Is EVV?

Electronics Visit Verification (EVV) is a system that confirms when and where home health services are provided, ensuring that care is delivered as planned.

Effective March 1, 2026:

MyCare Waiver service claims will require an approved EVV for the following service codes: S5125, T1002, T1003, T1019 and T2025 (UB/U1).

Claim Requirements

To process claims, providers must have a valid EVV visit record on file with SanData. Every visit must be documented in the SanData EVV system.

Service Verification

Providers must enter the date and time of each service provided, along with the type of service, into the EVV system. This information must match the member's approved services, and claims should align with the data submitted for that member in the EVV system.

Claim Denials

Claims submitted without a matching EVV record will be denied. To prevent this, ensure that all EVV documentation is complete and accurate before submitting claims.

Non-Compliance Reasons

Common reasons for non-compliance include:

- Provider ID does not match
- Recipient ID does not match
- Procedure code does not match
- Unmatched units

Training and Support

CareSource will provide training and resources to help providers effectively understand and use the EVV system.

By following these guidelines, providers can ensure the smooth processing of MyCare Waiver service claims and compliance with EVV requirements. All providers should reference the ODM EVV Homepage for all current program details.

LTSS Service Delivery Wait Times

In accordance with ODM requirements, CareSource must ensure members' access to services within the following standards.

Service Type	Wait Time to Receive Service
Home Delivered Meals	No more than 20 business days from the waiver service plan request or authorization.
Home Modification	No more than 60 business days from the waiver service plan request or authorization.
Personal Emergency Response Services	No more than 30 business days from the waiver service plan request or authorization.
Private Duty Nursing	No more than 20 business days from the time-of-service order or authorization.
Home Health Nursing	No more than 20 business days from the time-of-service order or authorization.
Waiver Nursing	No more than 20 business days from the waiver service plan request or authorization.
Specialized Medical Equipment and Supplies	For common items, no more than 30 business days and for highly specialized items, no more than 120 business days from waiver service plan request or authorization.
Non-Medical Transportation	No more than 20 business days from the waiver service plan request or authorization.
Home Health Aide	No more than 20 business days from the time-of-service order or authorization.
Personal Care	No more than 20 business days from the waiver service plan request or authorization.
Homemaker	No more than 20 business days from the time-of-service order or authorization.

LTSS Home and Community-Based Providers Support

Provider Relations Team

Overview
At CareSource, we understand that having access to reliable support is essential for Providers to deliver high-quality care to our members. Our Provider Call Center is available to answer your questions Monday through Friday from 8 AM to 8 PM at 800-488-0134, except for some holidays. Additionally, each Provider is assigned a dedicated LTSS Provider Relations Account Manager upon contracting with CareSource. Your Account Manager will reach out to schedule a provider orientation and ensure that you understand the plan's requirements, providing concierge support tailored to your needs. You may contact the LTSS Provider Relations Team at CareSourceOHLTSSHCBSSupport@caresource.com.

Support from Provider Relations Team
The Provider Relations (PR) team is committed to offering comprehensive support, including:

- **Personalized Assistance:** Your Account Manager will guide you through the onboarding process, helping you navigate CareSource policies and procedures.
- **Provider Orientation:** A thorough orientation session will be scheduled to familiarize you with the services, billing practices, and compliance requirements.
- **Proactive Ongoing Support:** The Account Manager will be available for any questions or concerns you may have as you begin your partnership with CareSource. The PR team is dedicated to working closely with you to address any challenges you encounter, ensuring you feel confident and supported throughout your engagement with CareSource.

Technical Assistance

CareSource is committed to providing comprehensive technical support to LTSS home and community-based service Providers to enhance operational efficiency and ensure seamless service delivery. This support encompasses a variety of resources and assistance designed to address the unique challenges Providers may face. Key components of the technical support include but are not limited to:

- Billing Guides to enhance operational efficiency
- Easy-to-use quick reference guides
- Claims submission
- EVV compliance and troubleshooting
- Authorization and service plan navigation
- Documentation and service verification
- On-site visits (as appropriate)
- One on one virtual or phone-based technical assistance
- Drop-in office hours and live Q&A sessions
- Email and portal-based ticketing support

Peer Support Program

Overview of the Peer Support Program

The Peer Support Program is an initiative designed to provide home and community-based service providers with specialized support from their peers. This program connects providers with experienced individuals who have demonstrated success in delivering quality care to members while navigating the administrative requirements of managed care. By fostering a collaborative environment, the Peer Support Program aims to enhance the overall effectiveness of service delivery and ensure that providers are well-equipped to meet the needs of CareSource members.

Objectives of the Peer Support Program

- **Enhance Provider Competence:** The program is structured to offer training and instruction tailored to the specific challenges and requirements of Providers working within the LTSS and HCBS framework.
- **Foster Collaboration:** By connecting Providers with peers who have successfully navigated similar experiences, the program encourages the sharing of best practices and innovative solutions to common obstacles.
- **Support Administrative Compliance:** Peer Support Providers will assist their counterparts in understanding and adhering to the administrative requirements of the CareSource plan, ensuring compliance and reducing the risk of errors.

Key Features of the Peer Support Program

- **Mentorship:** Each participating Provider will be paired with a Peer Support Provider who will serve as a mentor, offering guidance and insight based on their own experiences.
- **Training Sessions:** Regular training sessions will be held to cover various topics relevant to service delivery, compliance, and quality care practices. These sessions will be interactive, allowing for questions and discussions.
- **Resource Sharing:** Peer Support Providers will share valuable resources, tools, and strategies that have proven effective in their own practice, facilitating knowledge transfer among Providers.
- **Ongoing Support:** The program promotes continuous engagement, allowing Providers to reach out to their Peer Support Provider as needed for advice, encouragement, and troubleshooting.

Provider Training and Requirements

To ensure that all Providers are equipped with the necessary knowledge and skills to deliver quality care, CareSource offers a range of training programs. These trainings are mandatory and will be monitored through our Learning Management System (LMS), Health Plan Resources to track completion and compliance.

Required Training for LTSS Providers

1. **Provider Orientation:** Introduction to CareSource policies, procedures, and service expectations.
2. **Incident Management:** Training on how to report and manage incidents effectively.
3. **Managed Care:** Overview of managed care purpose, principles and practices.
4. **Model of Care Training:** Training to equip Providers with the knowledge and resources essential for effectively managing the unique needs of our members.
5. **Translation Services:** Information on available translation and interpretation services for members with language needs.

6. **Member Rights:** Training on the rights of members and how to uphold those rights in service delivery.
7. **Service Delivery Wait Times:** Understanding expected service delivery timelines and adherence to these standards.
8. **Fraud, Waste & Abuse:** Education on identifying and preventing fraud, waste, and abuse in service delivery.
9. **Electronic Visit Verification (EVV) Training:** Education on technology-based system used to verify that in-home services are delivered as authorized and essential information such as the date, time, location, and type of service are provided.
10. **ODM Required Training:** Additional training as mandated by the Ohio Department of Medicaid.

By participating in these training modules, Providers will be better prepared to meet the needs of CareSource members and comply with regulatory requirements. Our commitment to training ensures that Providers are well-informed and capable of delivering high-quality, person-centered care.

In addition to the required training for Providers, CareSource is committed to offering a variety of additional training opportunities designed to address emerging regulations, operational efficiencies, and specific needs identified through Provider feedback. We aim to tailor our training offerings to meet the evolving landscape of healthcare and ensure that Providers are well-equipped to adapt to changes in policy and practice.

Self Direction Services

Self-direction is a service model for Ohioans served by certain Medicaid waivers that empowers their individual choice and control over the long-term services and support needed to live at home. People involved in self-direction make decisions about the type of care they receive, the way certain services are delivered, and the caregivers who provide those services.

For more information and resources on Self Direction Services and how to enroll as a caregiver, please visit Self-Direction Services and Information | Medicaid.

You may also email selfdirection@medicaid.ohio.gov with any questions.

Conclusion

The Ohio Next Generation MyCare Program, along with the LTSS and Home and Community-Based Services, represents a significant commitment to improving the quality of care for members with complex needs. By providing comprehensive support through the Provider Relations Team, the Peer Support Program, and mandatory training, CareSource empowers Providers to deliver exceptional care while ensuring compliance with administrative requirements. Together, we can enhance the lives of members and promote their independence within the community.

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