CareSource

Nevada Medicaid Provider Manual

This content has been reviewed; however, changes and/or revisions occur frequently. Providers should check our website at **CareSource.com** for the most current version of this manual.

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 Medicaid. 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 programs and 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 **1-833-230-2112**. Our hours of operation are Monday through Friday from 8 a.m. to 6 p.m. Pacific Time (PT).

CareSource communicates updates to our provider network regularly at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements. You can also find the most up-to-date information on our CareSource Provider Portal. In an effort to better support our providers and offer an immediate response to questions, concerns and inquiries, we offer claims, policy and appeals assistance through our call center by calling **1-833-230-2112** 8 a.m. to 6 p.m. PT, Monday through Friday.

To support our providers, we have dedicated Customer Care teams specialized with each plan to help assist with questions and concerns. Additionally, an external team of specialists 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 help attain better outcomes for our CareSource members.

Sincerely,

CareSource

About Us

Welcome

Welcome and thank you for partnering with CareSource.

At CareSource, we call health care providers our health partners. A “health partner” is any health care provider who participates in CareSource’s provider network. You may find “health partner” and health care provider used interchangeably in our manual, agreements and website.

We look forward to working 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, or hassle-free claims payments. It’s our strong partnership that allows us to work 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. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy.

As a managed care organization (MCO), we improve the health of our members by utilizing a contracted network of high-quality participating health partners. 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 that members have timely access to health care services and receive all appropriate preventive services.

CareSource also distributes the member rights and responsibility statements to the following groups upon their enrollment and annually thereafter:

- New members
- Existing members
- New providers
- Existing providers

We founded CareSource 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 efficiency and value-added benefits for our members and participating providers.

Vision and Mission

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

Our mission: 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 to it is the hallmark of our success.

Plan Descriptions

Medicaid

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

State Specific Medicaid Description

The Nevada Health Authority (NVHA) was established in the 2025 state legislative session with the passage of Senate Bill 494. The purpose of this new agency has been resoundingly clear since the beginning when it was proposed by the Governor's office: to unify similarly aligned agencies to leverage the state's buying power, lower health care costs for Nevadans, bring more providers to the state, improve health care quality, and streamline services and programs. Our goal is to accomplish these goals while staying true to our values of public service, fiscal discipline, and accountable leadership.

CareSource

CareSource is a nationally recognized, nonprofit managed care organization serving over two million members. Founded in 1989, CareSource administers one of the largest Medicaid managed care plans in the U.S. The organization offers a variety of health insurance plans, including Medicaid, Medicare and Health Insurance Marketplace products. As a mission-driven and member-centric organization, CareSource is transforming health care by providing innovative programs to members in a growing number of states, including Arkansas, Georgia, Indiana, Michigan, Mississippi, Nevada, North Carolina, Ohio, West Virginia and Wisconsin.

CareSource will provide operational support and services including claims processing and appeals, all member and provider services and managing the provider network. By being a CareSource provider, you will interact with CareSource services when verifying member eligibility, submitting requests for prior authorization, using our Find-a-Doctor provider directory tool and our CareSource Provider Portal, or interacting with some of our member services like our Nurse Advice Line. CareSource is a trusted partner and is here to support you whenever needed.

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, The CareSource Foundation was launched in 2006 to add another component to our professional services: community response. Since its inception, the CareSource Foundation has responded at significant levels and made some great friends, including non-profit organizations and other charitable funders who were equally committed to better health for all communities. We are addressing tough issues and growing together.

To date, the CareSource Foundation has awarded grants totaling over $16.4 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.

Our Services

- Provider relations
- Provider services
- Member eligibility/enrollment information
- Claims processing
- Credentialing/recredentialing
- 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 our benefit managers:
    - Pharmacy: Express Scripts, Inc.
    - Vision: EyeMed
    - Hearing: Nations Hearing

In addition to the functions above, our Care Management programs include the following:

- High-risk care management
- Lower risk care coordination
- High emergency department (ED) utilization focus (targeted at members with frequent utilization)
- 24-Hour Nurse Advice Line
- Transition of Care – Our team works with providers, members and their families to coordinate care needs and make the transition to home or a lower level of care as successful as possible
- Maternal and child health:
    - Dedicated neonatal intensive care unit (NICU) care management nurses
    - Outreach programs in partnership with community agencies to target members at greatest risk for pre-term birth or complications
- Disease management
- Behavioral health and substance use disorder (SUD)

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 standards we must all follow.

CareSource complies with applicable state and federal civil rights laws. We do not discriminate, exclude people, or treat them differently because of race, color, national origin, disability, age, religion, or sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes), marital status, health status, or public assistance status.

Our CareSource Corporate Compliance Plan is an affirmation of CareSource's ongoing commitment to conduct business in a legal and ethical 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 company 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 must conduct himself or herself. 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. All providers are required to review and comply with CareSource's corporate compliance plan, located at **CareSource.com** > About Us > Legal > Corporate Compliance.

General Compliance and Ethics Expectations of Providers

- Act according to the standards of our compliance plan.
- Notify us about suspected violations or misconduct.
- Contact us if you have questions.

For questions about provider expectations, please call Provider Services at **1-833-230-2112**.

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

- Ethics and Compliance Hotline: 844-784-9583 or CareSource.ethicspoint.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.

Personally Identifiable Information

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 that PII be appropriately protected wherever it is stored, processed and transferred in the course of 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 this content when it is 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.

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 HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located at **CareSource.com** > Provider > Forms.

The 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.

Communicating with CareSource

CareSource communicates with our provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSource.com** and network notifications. We encourage you to reach out to your assigned Health Partner Engagement Specialist with any questions.

CareSource Hours of Operation

Provider Services 1-833-230-2112	
Monday to Friday	8 a.m. to 6 p.m. Pacific Time (PT)
Member Services 1-833-230-2058	
Monday to Friday	8 a.m. to 6 p.m. PT

Provider Services staff are available to provide assistance through the toll-free call center at all times during the hours of 8 a.m. to 6 p.m. PT, except for the following holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- President's Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Nevada Day
- Veteran's Day
- Thanksgiving Day
- Family Day
- Christmas Day

Please visit **CareSource.com** > About Us > 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.

Provider Services	1-833-230-2112
Prior Authorizations	1-833-230-2112
Claim Inquiries	1-833-230-2112
Credentialing	1-833-230-2112
Member Services	1-833-230-2058
Care Management	1-844-206-5948
24-Hour Nurse Advice Line	1-833-687-7365
Fraud, Waste and Abuse Hotline	1-833-230-2112
TTY for the Hearing Impaired	711
EyeMed Member Services	1-833-337-3129
Nations Hearing Member Services	1-866-202-2561

Active&Fit® Member Services	1-877-771-2746

Fax

Credentialing	866-573-0018
Fraud, Waste and Abuse	1-800-418-0248
Medical Prior Authorization	844-824-5592
Prescription Drug Prior Authorization	866-930-0019
Outpatient Drugs Covered Under Medical Benefit Prior Authorization Request	888-399-0271
Provider Appeals	937-531-2398
Provider Maintenance	937-396-3076

Health Partner Engagement Specialist Information

Our goal is to build collaborative and mutually supportive relationships with our network. CareSource's Health Partner Engagement Specialist are dedicated to helping your practice.

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

Website

Accessing our website, **CareSource.com**, is quick and easy. On the Provider section of the site, you will find commonly used forms, newsletters, updates and announcements, our Provider Manual, claims information, frequently asked questions, clinical and preventive guidelines and much more.

Provider Portal

URL: Providerportal.CareSource.com/NV/

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.

In accordance with federal and state regulations concerning HIV/AIDS/SUD consent requirements, member data on the CareSource Provider Portal may be incomplete unless a consent is on file. Please contact Provider Services at **1-833-230-2112** if additional information is needed.

Provider Portal Benefits

- Easy access to a secure online (encrypted) tool with time-saving services and critical information
- Availability 24 hours a day, seven days a week
- Secure, convenient access to time-saving services and critical information
- Accessibility on any web browser 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**
    - Submit Claims – Submit claims using online forms or upload a completed claim. Claim submission through the portal is available to traditional providers, community partners, delegates, and health homes. For more information about submitting claims online, please visit the "Claims Submissions" chapter of this manual.
    - Claim Status – Search for status of claims.
    - Claims Attachments – Submit documentation needed for claims processing.
    - Rejected Claims – Find claims that have rejected so you can correct and resubmit.
    - Claim Dispute and Appeals – Submit and search for claim appeals and disputes.
- **Coordination of Benefits (COB)** – Confirm COB for patients.
- **Prior authorization** – Request authorization for medical and behavioral inpatient/outpatient services, as well as prescription drug authorizations.
- **Eligibility termination dates** – View the member's termination date (if applicable) under the eligibility tab.
- **Benefit limits** – Track benefit limits electronically in real time before services are rendered for chiropractic, occupational therapy, physical therapy, speech therapy, and more.
- **Care treatment plans** – View care treatment plans for patients on our Provider Portal.
- **Clinical Practice Registry (CPR)** – Review member gaps in care. View and sort CareSource members into actionable groups for improved focus on preventive care (e.g., well-baby visits, diabetes, asthma and more). Look on the "Member Eligibility" page for alerts to notify you what tests a patient needs.
- **Recovery Letters** – View and download letters.
- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **Monthly membership lists** – View and download current monthly membership lists.
- **Care management referrals** – Submit automated care management forms on our Provider Portal to efficiently enroll members.
- **Information exchange** – Share relevant member information to facilitate better integration of behavioral health and medical care.
- **File Grievance**

Portal Registration

If you are not registered with our Provider Portal, please follow these easy steps:

- Visit the Provider Portal. Click "Sign Up" to establish your account by creating your username and password*
- For added security, set up multifactor authentication
- To connect your account, you will need information provided in this letter including your Provider Name, Tax ID, CareSource Provider ID and your Zip Code
- Review and accept the agreement

*Please note that your first registered account will become the account Administrator and may add additional users.

View the Provider Education Series: Provider Portal Overview training to learn about the portal's functionality and how to work with us through our portal's many self-service features.

For more information, see our Provider Portal Key Features Overview on the Quick Reference Materials page.

Once registered, access our Provider Portal by clicking the Login button at the top of any page.

Dental Providers

The state of Nevada partners with Liberty Dental plan to offer Medicaid dental benefits in Clark and Washoe counties. Providers can contact Liberty Dental at 1-888-700-0643 or check Liberty Dental's website for additional information.

Routine Vision Providers

CareSource has partnered with EyeMed to provide routine vision services to our members. Other than Accidental/Medical Vision Services, vision services are to be performed by a EyeMed contracted provider.

Forms

Providers may access plan forms at **CareSource.com** > Providers > Tools & Resources > Forms.

Mailing Addresses

General Mailing Address	CareSource P.O. Box 8738 Dayton, OH 45401-8738
Medical Prior Authorization Submission Address	CareSource P.O. Box 1307 Dayton, OH 45401
Behavioral Health Prior Authorization Submission Address	CareSource P.O. Box 1307 Dayton, OH 45401
Medical Claims Submission Mailing Address	CareSource Attn: Nevada Claims P.O. Box 36 Dayton, OH 45420-0036
Provider Claims Dispute Mailing Address	CareSource Attn: Nevada Medicaid Provider Grievance & Appeals P.O. Box 2008 Dayton, OH 45401

Provider Appeals Mailing Address	CareSource Attn: Nevada Medicaid Provider Grievance & Appeals P.O. Box 2008 Dayton, OH 45401
Provider Clinical Appeals Mailing Address	CareSource Attn: Nevada Medicaid Provider Grievance & Appeals P.O. Box 2008 Dayton, OH 45401 Please visit our website at **CareSource.com** for more information on how to submit appeals online.
Member Appeals and Grievances Mailing Address	CareSource Attn: Nevada Medicaid Member Grievance & Appeals P.O. Box 1947 Dayton, OH 45401
Fraud, Waste and Abuse Address **Please Note:** Provider appeals can only be mailed if supporting documentation is above 100 MBs where the Provider Portal will not allow submission.	CareSource Attn: Program Integrity P.O. Box 1940 Dayton, OH 45401-1940 Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.

Provider Communications

Newsletters

Our provider newsletter contains operational updates, clinical articles, and new initiatives underway at CareSource. We will also share updates to adopted Evidence Based Guidelines through our newsletters. Newsletters are published quarterly and are mailed or emailed directly to providers based on the provider's contact information. Newsletters are also available online by visiting our website at **CareSource.com** > Providers and click the link for **Newsletters & Communications** under the Education heading.

Network Notifications

We regularly communicate policy and procedure updates to CareSource providers via network notifications. Network notifications are found on our website at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements.

Provider Demographic Changes and Updates

Advance written notice of status changes, such as a change in address, phone or adding or deleting a physician to your practice helps us keep our records current. Your current information is critical for efficient claims processing.

Please Note: Where applicable, changes should be made with the state Medicaid agency in addition to CareSource. Claim information submitted for Medicaid reimbursement must meet Nevada Medicaid requirements for reimbursement.

The CareSource Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Provider Portal, entering your login credentials and selecting "Provider Maintenance" from the left-hand navigation.

Demographic Change Submission Options	
Online/Provider Portal* *Preferred Method	**CareSource.com** > Providers > Provider Portal Log-In
Email	ProviderMaintenance@CareSource.com
Mail	CareSource Attn: Provider Maintenance P.O. Box 8738 Dayton, OH 45401-8738
Questions?	Email ProviderMaintenance@CareSource.com

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 encourages our providers to access our on-demand and scheduled virtual trainings on topics related to your practice. These trainings provide key information for you to do business with us. Providers may access CareSource's trainings and events information by visiting **CareSource.com** > Providers > Education > Training & Events.

Providers may also contact their assigned Health Partner Engagement Specialist for additional live training support. You can find your assigned specialist by visiting **CareSource.com** > Providers > Provider Overview > Contact Us.

Providers are required to complete any mandatory training as directed by Nevada Medicaid.

Credentialing and Recredentialing

CareSource credentials and recredentials all licensed independent practitioners, including physicians, facilities, and non-physicians with whom it contracts and who fall within its scope of authority and action. Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners.

Credentialing Process

CareSource has partnered with Verisys to complete Primary Source Verification (PSV) credentialing requirements. Verisys may contact you on behalf of CareSource if additional information is required for credentialing to be completed.

Verisys offers a web-based credentialing application tool that streamlines the credentialing process for health care professionals. Updates in the Council for Affordable Quality Healthcare's (CAQH) web platform allow for the information to be shared directly with Verisys and CareSource for primary source verification.

Who Is Credentialed?

Contracted providers listed in the Provider Directory and the following are credentialed:

- Providers who have an independent relationship with CareSource. This independent relationship is defined through contracting agreements between CareSource and a provider or group of providers and is defined when CareSource selects and directs its enrollees to a specific provider or group of providers.
- Providers who see members outside the inpatient hospital setting or outside ambulatory free- standing facilities.
- Providers who are hospital-based but see the organization's members as a result of their independent relationship with the organization.
- Dentists who provide care under the organization's medical benefits.
- Non-physician providers who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.
- Covering providers (locum tenens).
- Medical directors of urgent care centers and ambulatory surgical centers.

The following providers listed in the Provider Directory do not need to be credentialed:

- Providers who practice exclusively within the inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting.
- Providers who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the CareSource Provider Directory.
- Pharmacists who work for a pharmacy benefit management (PBM) organization.
- Providers who do not provide care for members in a treatment setting (e.g., board-certified consultants).

Nevada Health Coverage Programs Enrollment

In partnership with the Nevada Health Authority, CareSource must certify that all of its network providers are eligible and enrolled with Nevada Medicaid. To ensure our providers receive proper reimbursement, we encourage all our providers to enroll with Nevada Medicaid via the State's website. For more information on Nevada Medicaid enrollment, please visit the Nevada Medicaid website.

Providers involuntarily disenrolled from CareSource will be reported to Nevada Medicaid and may subsequently be disenrolled as a Nevada Medicaid provider. Nevada Medicaid is required to report involuntarily disenrolled providers to the Centers for Medicare & Medicaid Services (CMS).

Council for Affordable Quality Healthcare (CAQH) Application

CareSource is a participating organization with the CAQH. Please make sure that we have access to your provider application prior to submitting your CAQH number.

- Log on to the CAQH website at www.CAQH.org, utilizing your account information.
- Select the "Authorization" tab and ensure CareSource is listed as an authorized health plan (if not, please check the "Authorized" box to add).
- Ensure choosing Nevada as the primary location if located in the state of Nevada.

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current) or Controlled Substance Registration (CSR)
- Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable
- Standard collaborative care arrangement (if an advanced practice nurse or a physician assistant)

It is essential that all documents are complete and current, or CareSource will discontinue the contracting and credentialing process.

Debarred and Criminal Conviction Attestation

CareSource verifies that its providers and the providers' employees have not been debarred or suspended by any state or federal agency. CareSource also requires that its providers and the providers' employees disclose any criminal convictions related to federal health care programs. "Provider employee" is defined as directors, officers, partners, managing employees, or persons with beneficial ownership of more than five percent of the entity's equity.

Providers must offer a list that identifies all of the provider employees, as defined above, along with the employee's tax identification or social security numbers. Providers and their employees must execute the attestation titled, "CareSource Debarment/Criminal Conviction Attestation" (in addition to being subject to and cooperating with CareSource verification activities) as a part of the credentialing and recredentialing process.

CareSource conducts credentialing and recredentialing activities utilizing the CMS, NCQA and credentialing as defined in the Nevada Code and Nevada Department of Insurance.

Provider Selection Criteria

CareSource is committed to providing the highest level of quality of care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we have developed the following provider selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our providers.

The Institute of Medicine defines quality of care delivery as: *"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."*

CareSource has developed comprehensive care management and quality improvement programs to facilitate this level of quality-of-care delivery, as well as a comprehensive credentialing program to ensure that our providers have the appropriate training and expertise to serve our members from a care delivery and service perspective. CareSource bases selection on quality of care and service aspects, in addition to business and geographic needs for specific provider types. CareSource does not make credentialing or recredentialing decisions based on race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The following selection criteria have been put in place and are assessed during the credentialing and recredentialing process in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

Selection Criteria:

- Active and unrestricted license in the state issued by the appropriate licensing board.
- Current DEA or CSR certificate (if applicable).
- Successful completion of all required education.
- Successful completion of all training programs pertinent to one's practice.
- For MDs and DOs, successful completion of residency training pertinent to the requested practice type.
- For providers where special training is required or expected for services being requested, successful completion of training.
- Board certification is not required for primary care specialties. Primary Care Provider (PCP) who are approved by the CareSource Credentialing Committee will appear in CareSource Provider Directories.
- Providers approved by the CareSource Credentialing Committee in non-primary care specialties will be listed in the Provider Directory as specialists if certified by a specialty board, which is recognized by the CareSource Credentialing Committee.
- An advanced practice registered nurse (APRN) and Physician Assistances (PA-Cs) may be credentialed as a primary care provider if that APRN maintains compliance with the rules set forth by the Nevada Board of Nursing and Nevada specific codes. The APRN is expected to be familiar with these rules.
- Education, training, work history and experience are current and appropriate to the scope of practice requested.
- Malpractice insurance at specified limits ($1m/$3m) established for all practitioners by the credentialing policy.

- Good standing with Medicaid and Medicare.
- Quality of care and practice history as judged by:
    - Medical malpractice history.
    - Hospital medical staff performance.
    - Licensure or specialty board actions or other disciplinary actions, medical or civil.
    - Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction.
    - Other quality of care measurements/activities.
    - Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing.
    - Lack of issues on HHS-OIG, SAM/ EPLS, or state site for sanctions or terminations (fraud and abuse).
- Signed, accurate credentialing application and contractual documents.
- Participation with Care Management, Quality Improvement and Credentialing programs.
- Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
- Agreement to comply with plan preferred drug list (PDL) requirements or acceptance of PDL as administered through the pharmacy benefit manager.
- Agreement to access and availability standards established by the health plan.
- Compliance with service requirements outlined in the provider agreement and Provider Manual.
- A site visit survey in good standing, which includes the following:
    - The care provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities and proper fire and safety procedures are in place;
    - The care provider's enrollee record keeping practices at each site to ensure conformity with the Managed Care Plan's organizational standards

Please Note: Any pending and/or suspected fraud, waste and abuse investigation(s) or case(s) against the provider may affect the provider's credentialing application.

Organizational Credentialing and Recredentialing

The following organizational providers are credentialed and recredentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Behavioral health facilities providing mental health or substance use services in an inpatient, residential, or ambulatory setting (i.e., Opioid Treatment Facility)
- Free-standing Rural Health Center
- Free-standing Inpatient Psychiatry Health Facility
- Outpatient Infusion Center

Additional organizational providers are also credentialed:

- Hospice providers
- Urgent care facilities, free-standing and not part of a hospital campus
- Dialysis centers
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Free-standing facilities that provide outpatient, non-emergent advanced radiology services (including MRI/MRA, CT and PET scans)

In addition to the Ambulatory Surgical Facilities, Opioid Treatment Facilities, Rural Health Centers, Free standing Inpatient Psychiatry Health Facilities and Outpatient infusion Center being credentialed the Medical Director or senior provider responsible for medical services will be credentialed using the standard, provisional credentialing or recredentialing process. If Medical Director or Senior Physician is denied credentialing the facility will also not be credentialed.

The following elements are assessed for organizational providers:

- Provider is in good standing with state and federal regulatory bodies.
- Provider has been reviewed and approved by an accrediting body.
- Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body.
- Malpractice/Liability insurance coverage is maintained and meets contract minimums
- Clinical Laboratory Improvement Amendments (CLIA) certificates are current (if applicable).
- Completion of a signed and dated application.
- If not approved by an accrediting body must have a CMS Site survey or agree to a site visit.

Providers will be informed of the credentialing committee decision within 60 business days of the committee meeting. Providers will be considered recredentialed unless otherwise notified.

Long Term Care Home and Community Based Providers

Requirements include the following:

- Credentialing/recredentialing application along with the following:
    - W-9
    - current business/ occupational license
    - active Medicaid ID number (limited or full enrollment with the state)
    - active NPI number
- Complete applicable training and include some additional information as required for Long Term Care providers per the State of Nevada, AHCA and SMMC LTC

If you have a valid limited enrolled or fully enrolled agreement with AHCA, you must meet the following requirements for credentialing and recredentialing:

- A copy of your current license for medical care providers, or occupational or facility license as applicable to care provider type or authority to do business
- No revocation, moratorium or suspension of your state license by AHCA or the Department of Health

    - No sanctions imposed by Medicare or Medicaid (validated through AHCA, DHHS OIG and SAM database)
1. A satisfactory Level 2 background check for all treating care providers not currently enrolled in the Medicaid program
2. Disclosure related to ownership and management, business transactions and conviction of crimes

Providers will be informed of the credentialing committee decision within 60 business days of the committee meeting. Providers will be considered recredentialed unless otherwise notified.

Provider Credentialing Rights

- Providers have the right to review information submitted from outside sources (e.g. malpractice insurance carriers and state licensing boards) to support their credentialing application upon request to the CareSource Credentialing department. CareSource keeps all submitted information locked and confidential. This could include information from outside sources like malpractice insurance carriers, state licensing boards, etc. CareSource is not required to provide information such as references, recommendations and peer-review protected information.
- Providers have the right to correct incomplete, inaccurate, or conflicting information that was submitted to support their application prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, CareSource will request that the provider submit written clarification to the Credentialing department electronically, by e-mail, fax or by certified mail, return receipt requested and the provider will be given five business days to respond. Nonresponse within that time frame will result in discontinuance on the sixth day.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department. An automated email is sent to providers once their application is submitted via the CareSource Provider Portal. This email directs them to contact Provider Services at **1-833-230-2112** to obtain application status updates. Provider Service Representatives are able to inform providers if their application is completed and they are showing as participating in the CareSource network, or if their application is still in process while referencing the state-specific time frames. Practitioners also have the ability to check the status of their application by visiting the **CareSource.com** website, signing into the provider portal, and entering their application and NPI numbers. CareSource is not required to provide status information such as references, recommendations and peer-review protected information.

Provider Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. CareSource will initiate immediate action in the event that the participation criteria are no longer met. Providers are required to inform CareSource of changes in status or adverse actions, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification Medicare or Medicaid sanctions and/or exclusions in addition to any event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

Providers are recredentialed a minimum of every three years. As part of the recredentialing process, CareSource considers information regarding ongoing performance to include investigation of all practitioner-specific member complains and in addition to monthly reviews of safety and quality issues collected from the NPDC, Medicare and Medicaid Sanctions, Exclusions and Reinstatement Report, Medicare Opt-Out and the HHS/OIG. Providers will be considered recredentialed unless otherwise notified.

Delegation of Credentialing/Recredentialing

CareSource will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is NCQA-accredited for these functions, utilizes an NCQA-accredited Credentials Verification Organization (CVO) and successfully passes a pre-delegation audit demonstrating compliance with NCQA, federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing provider file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

CareSource may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited CVO. Providers will be notified of this and must adhere to the requests from the chosen CVO.

Reconsideration and Appeals of Credentialing/Recredentialing Decisions

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. Reconsideration and appeal opportunities are available unless an exception applies. Exceptions are set forth in the CareSource Provider Participation Plan.

For reconsideration for denied participation, following the steps below:

> A request for a Fair Hearing must be received by the Division of Health Care Financing and Policy Hearings Unit within 90 calendar days from the date of this notice. Requests are submitted to:
>
> > Nevada Medicaid Hearings Unit
> > 9850 Double R Blvd.
> > Suite 200
> > Reno, Nevada 89521

To submit a request, the following steps apply:

Step 1

The Participating Provider must request such a hearing, in writing, within fourteen (14) days of receipt of the Notice of Action. The request must be addressed to the Chair of the Credentialing Committee or his or her designee as referenced in the Notice of Action and must be sent via certified mail, return receipt requested. Failure to file such a request within the required time period shall constitute the Participating Provider's complete and final waiver of any right to a hearing, any appellate review, and/or any other procedural due process rights associated with the Action at issue.

Step 2

Upon receipt of a Participating Provider's request for a hearing, the Chair of the Credentialing Committee or his or her designee will promptly arrange for and schedule the hearing. Promptly after the hearing is scheduled, the Chair of the Credentialing Committee or his or her designee will send a notice to the Participating Provider, via certified mail, return receipt requested, of the date, time and place of the hearing, which may be held virtually or in-person.

Step 3

Within seven business days of the conclusion of the hearing, the Provider Hearing Plan (PHP) shall render its decision which shall be deemed full and final and not subject to appeal. A three-business day extension may be granted by the PHP Chairperson. The PHP Decision will be sent to the Chair of the Credentialing Committee. The Chairperson of the Credentialing Committee will, within five business days of receipt of the PHP Decision, send notice via certified mail, return receipt requested, to the Participating Provider, of the PHP Decision.

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 Provider Participation 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
P.O. Box 8738
Dayton, OH 45401

Summary Suspensions

CareSource reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating provider who 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 appeal the action and request a hearing through the CareSource Provider Participation Plan unless an exception applies. Exceptions are set forth in the CareSource Provider Participation Plan.

Claims Submission

In general, CareSource follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. These can be found at **CareSource.com** > Providers > Provider Policies. For expedited claims processing and payment delivery, please ensure addresses and phone numbers on file with CareSource are up to date. You can update this information on the Provider Portal at **CareSource.com** > Login > Provider Portal or email ProviderMaintenance@CareSource.com.

Provider demographic updates must first be submitted to Nevada Health Coverage Programs (Nevada Medicaid) as CareSource will not make any changes to provider demographics until updated with Nevada Medicaid. Nevada Medicaid approved provider demographic changes must then be submitted to CareSource via the Provider Portal.

Claims must be submitted within 180 calendar days of the date of service. Out-of-state providers have 365 calendar days from the last day of service. We will not pay a claim with incomplete, incorrect or unclear information. If this happens, providers have 180 calendar days from the date of service or discharge to submit a corrected claim.

Out-of-network providers are required to coordinate with CareSource for payment to ensure the cost to the member is no greater than it would be if the services were furnished within the network.

Billing Methods

CareSource accepts claims in a variety of formats, including paper and electronic claims. We encourage providers to submit claims electronically to take advantage of the following benefits:

- Faster claims processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claims status
- Minimal staff training or cost

Submit Claims Online Through Provider Portal

Providers may submit claims through the secure, online Provider Portal. Online submission saves you money by eliminating the costs associated with printing and mailing paper claims. Using the portal for claims submission also provides additional benefits:

- Improves accuracy by decreasing the opportunities for transcription errors and missing or incorrect data
- Allows tracking and monitoring of claims through a convenient online search tool
- Includes attachments up to 100 MB that may be necessary for claim processing
- Allows uploading of a completed claim form up to 50 MB
- Allows corrections and re-submissions

Who Can Submit Claims Via the Portal?

CareSource's providers, community partners and delegates, and health homes – specifically health care providers using the UB-04 or CMS-1500 claim form – can submit claims through the Provider Portal.

What Types of Claims Can Be Submitted?

- Professional medical office claims (CMS 1500 and 837P)
- Institutional claims (UB-04 and 8371)

Electronic Claim Submission

Electronic Data Interchange (EDI) is the computer-to-computer exchange of business data in ANSI ASC X12 standard formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). CareSource has invested in an EDI system to enhance our service to participating providers. Our EDI system complies with HIPAA standards for electronic claims submission.

Clearinghouse

CareSource prefers electronic claim submission. To submit claims electronically, providers must work with an electronic claims clearinghouse. CareSource currently accepts electronic claims from Nevada providers through the clearinghouse listed below. Please contact the clearinghouse to begin electronic claims submission.

Clearinghouse	Phone	Website
Availity	1-800-282-4548	www.availity.com

Please provide the clearinghouse with the CareSource payer ID number: **ID NVCS1**.

File Format

CareSource accepts electronic claims in the 837 ANSI ASC X12N (005010X ERRATA version) file format for professional and hospital claims.

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This was in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format. All trading partners and payers should be 5010 compliant.

Transactions Covered Under the 5010 Requirements

- 837 Health Care Claim/Encounter
- 276/277 Health Care Claim Status Request and Response
- 270/271 Health Care Eligibility Benefit Inquiry and Response

Please include the full physical address for billing 5010 transactions. P.O. boxes are no longer accepted for the billing address. However, a P.O. Box or lock box can be used for the pay-to address (Loop 2010AB).

National Provider Identifier and Tax ID Numbers

Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Professional Claims

On 837P professional claims (005010X222A1), the provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
    - Identification Code Qualifier – NM108 = XX
    - Identification Code – NM109 = Billing provider NPI
- 2310B Loop – Rendering provider name
    - Identification Code Qualifier – NM108 = XX
    - Identification Code – NM109 = Rendering provider NPI

The Billing Provider TIN (Tax Identification Number) must be submitted as the secondary Provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

Institutional Claims

On 837I institutional claims (005010223A2), the billing provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
    - Identification Code Qualifier – NM108 = XX
    - Identification Code – NM109 = Billing provider NPI

The Billing Provider TIN (Tax Identification Number) must be submitted as the secondary Provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

On all electronic claims, the Member Medicaid ID number should go on:

- 2010BA Loop – Subscriber name
- NM109 = Subscriber Primary Identifier

Electronic Payment Processing

CareSource has partnered with ECHO Health, Inc. To offer electronic funds transfer (EFT) as a payment option. 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 Electronic Data Interchange (EDI) 835 (Electronic Remittance Advice), the 835 file can will be sent to the preferred clearinghouse. Providers can also download their Explanation of Payment (EOP) from the Provider Portal or request a hard copy via the mail.

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 health partners.
- Reliable – Claim payments electronically deposited into your bank account.
- Secure – Access your account through our secure Provider Portal to view (and print if needed) remittances and transaction details.

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. If you prefer to receive Virtual Card Payment or Paper Check payments, call ECHO Health support at 1-888-834-3511. *Payment processing fees are what you pay your bank and credit card processor for use of payment via credit card.

Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. For more information on electronic claims, please reference the “Electronic Claims Submission” section of this manual.

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare and Medicaid Services (CMS) and the National Uniform Claim Committee (NUCC).

We cannot accept handwritten claims or SuperBills. Detailed instructions for completing each form type are available at the websites below:

- CMS 1500 Form Instructions: www.nucc.org
- UB-04 (CMS 1450) Form Instructions: www.nucc.org

Please Note: On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering provider’s NPI and (if applicable) Box 33A for the group NPI
- UB-04 (CMS 1450): Box 56 for the billing provider’s NPI (if applicable) or Box 76 for the attending physician’s NPI

All claims (EDI and paper) must include:

- Patient (member) name

- Patient address
- Insured's ID number – Be sure to provide the complete CareSource member ID number of the patient. For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.
- Patient's birth date – Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name
- Place of service – Use standard CMS (HCFA) location codes
- ICD-10 diagnosis code(s)
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable
- Units, where applicable (anesthesia claims require minutes)
- Date of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain from/to formats. Please enter each date individually
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization
- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information
- Federal tax ID number or physician Social Security Number – Every provider practice (e.g., legal business entity) has a different tax ID number
- Signature of physician or supplier – The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field

Please Note: Claims must be submitted in alignment with Nevada Medicaid's requirements. CareSource must match claim data to the enrollment data received by the state Medicaid agency.

The NPI and taxonomy submitted on the claim must crosswalk to one Nevada Medicaid provider ID, or the claim will be rejected/denied. Three data elements are used for the standard CPI crosswalk to establish a one-to-one match:

- Billing NPI
- Billing taxonomy code
- Billing provider service location zip code +4

Claims submitted without this information may not meet the state's matching logic, which could result in claim rejection or recoupment of paid claims. Additional information about the state's matching logic and submission requirements can be found in the Nevada Medicaid SMMC provider master list tip sheet for Claims Submission and Processing.

Prenatal or Delivery Services Claims

For prenatal or delivery services, the last menstrual period date* is required on professional claims (HCFA 1500). For delivery services, the birth weight is required.

*Last menstrual period may be calculated – For Medicaid providers, CareSource must include the last menstrual period (LMP) date for the mother when we submit encounter data (paid claims information) to regulatory entities. We understand that this information may not always be available to the provider who delivers the baby, especially if the member received prenatal care from another provider or facility. Please remember that participating providers may estimate the LMP on delivery claims based on the gestational age of the child at birth.

This will help ensure that your delivery claims do not go unpaid because of missing claim information.

National Drug Code (NDC)

What to include on claims that require National Drug Code:

- NDC and unit of measure (i.e., pill, milliliter - cc, international unit or gram)
- Quantity administered – number of NDC units
- NDC unit price – detail charge divided by quantity administered
- HCPCS codes that will require NDCs on professional claims (submitted on the 837P format)

Instructions for National Drug Code on Paper Claims

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code – F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC, or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

Tips for Submitting Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.

CareSource uses an optical/intelligent character recognition (OCR/ICR) system to capture claims information, which increases efficiency, improves accuracy and results in faster turnaround time.

To Ensure Optimal Claims Processing Timelines:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.
- When submitting paper claims, know we require the most current form version as designated by CMS and NUCC.
- Do not submit handwritten (including printed claims with any handwritten information) claims or SuperBills. They will not be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.

- Ensure fonts are 10 to 14 point (capital letters preferred) with printing in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels, or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- NPI, GNPI (is applicable) and federal TIN or physician SSN is required for all claim submissions.

Please send all paper claim forms to CareSource at the following address:

Nevada Medicaid
CareSource Attn: Claims Department P.O. Box 36 Dayton, OH 45420-0036

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

CareSource has chosen to establish relationships with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as critical safety net providers. CareSource will reimburse FQHCs and RHCs at no less than the reimbursement level CareSource would make to a non-FQHC or non-RHC for the same services. The state requires CareSource to identify and report any performance incentives it offers to the FQHC or RHC in relation to the cost of providing FQHC covered or RHC covered services to its members. Given the state makes supplemental payments to FQHCs and RHCs that contract with CareSource, the payments are meant to represent the difference, if applicable, between the payment an FQHC or RHC would be entitled to under the Benefits Improvement and Protection Act of 2000 (BIPA).

CareSource will perform claim reconciliations with each of the FQHCs or RHCs it contracts with in an effort to determine billing issues and resolve discrepancies that may affect the clinic's annual reconciliation with the State of Nevada. To that end, CareSource will provide separate reports for Nevada Medicaid around utilization and reimbursement to the State annually. To ensure accurate documentation of encounters, we encourage our partners to properly capture the National Provider Identifier (NPI) for all practitioners rendering service on their claims. Capitated FQHCs and RHCs must also submit encounter data (i.e. shadow claims) to CareSource on a monthly basis.

Claim Submission Timely Filing

For in-network providers, claims must be submitted within 180 days from the date of service or the date of eligibility decision, whichever is later. For out-of-state providers, the timely filing period is 365 days. We will not be able to pay a claim if there is incomplete, incorrect, or unclear information on the claim, as the claim will be denied. If this happens a corrected claim may be submitted with corrected information, but this is still considered an initial claim and will be subject to 180 days of the date of service or date of eligibility decision, whichever is later. Claims submitted by out-of-state providers must be received within 365 days of the date of service or date of eligibility decision, whichever is later.

Claim Processing Guidelines

If an initial claim is **filed timely** and is **denied**, the provider has the following options:

- If a claim denial is due to a provider's incorrect or inaccurate claim information, the provider may resubmit the claim with corrections.
- For adjudication purposes, a denied claim that is resubmitted with corrected information is considered to be an initial claim and, as such, is subject to the 180 days of the date of service or date of eligibility decision timely filing limit.
- For adjudication purposes, a denied claim resubmitted without corrected information is considered to be a duplicate claim and will continue to deny for the same reasons. Resubmitted claims with no correction will be subject to the 180 days of the date of service or date of eligibility decision timely filing limit and will not be accepted as "reasonable and continuous attempts to resolve a claim problem" for consideration to waive or extend the timely filing limit.
- If a claim denial is not due to a provider's incorrect or inaccurate claim information, but the provider disagrees with the denial, the provider should refer to the provider appeal section of this manual for further information.
- If a line item on a claim is denied that line item should be resubmitted separately, unless the claim details are dependent on one another for payment. For example, all surgical services for the same member, same date and same provider must be submitted on one claim form and cannot be separately processed. To rebill a surgical procedure, a claim adjustment must be requested.

If an initial claim is **filed timely** and is **paid**, including claims **partially paid**, or **paid at zero**, the provider has the following options:

- If a claim paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider may submit a corrected claim. The corrected claim must be filed within 180 days of the date of service or date of eligibility decision, also referred to as the explanation of payment (EOP).
- If a claim payment disagreement is not due to a provider's error, refer to the provider appeal section of this manual.
- If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment within 365 days of the date of service or date of eligibility decision, whichever is later.
- 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 60 days from the date the provider was reimbursed or notified of non-coverage/denied services by the vendor. The provider must attach the EOB and/or documentation from the primary insurance carrier. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing. When the patient is discharged, the provider will be required to submit a final bill, which includes the entire bill from date admitted to date discharged. CareSource is not able to determine correct

payment unless the full, final bill is submitted. The provider will have six months from the date of discharge to submit the complete bill. If this information is not submitted within the timely filing guidelines, the claim will be denied, and previous payments will be recouped.

All claims for newborns must be submitted using the newborn's MID. Do not submit newborn claims using the mother's MID; the claim will deny. Claims for newborns must include the birth weight. The same timely filing guidelines apply for newborns. Newborns receiving **retroactive** eligibility are not subject to timely filing requirements.

Claims that Require Completed Consent Forms

Abortion – Provider must submit the State of Nevada Abortion Certification Form, AHCA-Med Serv Form 011, with the claim, as applicable. Abortions that are the result of rape, incest or to save the life of the mother must have a claims attachment with the appropriate form (FA-54 for rape, form FA-55 for incest, and FA-57 for life endangerment).

All spaces on the form must be completed according to the instructions for the form.

The documentation must contain the name and address of the member, Medicaid identification number, physician's name, and physician's signature. Providers must attach this documentation to the paper claim form or send it separately as an attachment to the electronic claim transaction.

Hysterectomy – The Nevada Medicaid Hysterectomy Acknowledgement Form (FA-50) must be attached to the first claim submitted for the procedure, regardless of which provider submits it.

- All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement may be made.

Sterilization – This type of service requires a completed Consent for Sterilization Form - HHS-687 or HHS-687-1, or Sterilization Consent Form (FA-56).

Providers must specify Essure® method of sterilization on the consent form, if appropriate, and submit the form with the claim.

For additional information please see the "Covered Services and Exclusions" section of this manual. The forms referenced above are available on our provider website at **CareSource.com** > Provider Overview > Tools & Resources > Forms.

Claims Status

Go to the Provider Portal at **CareSource.com** > Login > Provider, selecting your state.

Claim status is updated daily on our Provider Portal, and you can check claims that were submitted for the previous 36 months from the data of service (DOS). You can search by Medicaid ID, CareSource Member ID, member name and date of birth, claim number, check number, or patient number.

You can find the following claim information on the Provider Portal:

- Claim history available up to 36 months from the date of service

- Submit claim appeal and disputes
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date

Adverse Benefit Decision (ABD)
CareSource defines ABD as:

a. The denial or limited authorization of a requested service, including determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
b. The reduction, suspension or termination of a previously authorized service.
c. The denial, in whole or in part, of payment for a service. A denial of a payment for a service solely because the claim doesn't meet the definition of a "clean claim" is not an ABD.
d. The failure to provider services in a timely manner.
e. The failure of CareSource to act within the time frames regarding the standard resolution of grievances and appeals.
f. For a resident of a rural area, the denial of a member's request to exercise his or her right, to obtain services outside the network.
g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities.

Procedure and Diagnosis Codes

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 www.ama-assn.org
- HCFA Common Procedure Coding System (HCPCS). Available at cms.gov
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org
- National Drug Codes (NDC). Available at fda.gov

Procedures That Do Not Have a Corresponding Code

- If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
    - A full, detailed description of the service provided.
    - A report, such as an operative report or a plan of treatment.

    - Any information that would assist in determining the service rendered. For example, 84999 is an unlisted lab code that would require additional explanation.
- Provider administered drugs that do not have specific HCPCS code (J3490 through J3999) and any assigned HCPCS code that is not listed on the Medicaid fee schedule requires the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.
- Sterilization and Hysterectomy procedures – Consent forms must be attached.
    - Nevada Medicaid Forms
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report.
- Coordination of Benefits (COB) claims require a copy of the Explanation of Payment (EOP) from the primary carrier or required dollar amounts billed via the HIPAA 837 claim transaction. If you have questions on how to bill COB claims electronically, please contact your EDI vendor.
- Any amount of drug discarded from a single dose vial.

Code Editing

CareSource uses clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately, and efficiently.

CareSource's code editing software finds any coding conflict or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need for additional information from the provider.

CareSource's code editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Corrected Claims Submissions

Accepted standards for corrected claim submissions require that the original claim number is populated on both EDI 837 transactions and paper forms. Including the original claim number allows your corrected claim to auto adjudicate, resulting in the fastest payment.

CareSource will reject both EDI and paper form corrected claims that are received without the original claim number.

Electronic Data Interchange Billing Instructions:

We strongly encourage use of electronic claim submission for all standard claim transactions, including corrected claims.

- Submit the corrected claim in the nationally recognized Electronic Data Interchange (EDI) 837 file format.
- Use an EDI 837 Loop 2300 CLM 05-3 value of "7" (Replacement).
- Carry over the Original Reference No. /Claim No. (12-character data) on the REF 02 data element with a Qualifier "F8" on Loop 2300.

Paper Form Billing Instructions:

Professional Claims:
For professional claims (CMS 1500 claim form), the provider must include the original CareSource claim number and a frequency code of "7" per industry standards. When submitting a corrected claim, enter a "7" in the left-hand side of Box 22 and the original claim number in the right-hand side of that box.

Institutional Claims:
For institutional claims (UB-04 claim form), the provider must include the original CareSource claim number in Box 64 and a valid bill frequency code in Box 4 per industry standards.

Please Note: If a corrected claim is submitted without this information, the claim will be processed as an original claim and rejected or denied as a duplicate. Additionally, this process is for correcting denied claims only, not for resubmission of rejected claims (rejected claims are defined as EDI claims not accepted by CareSource).

Provider Coding and Reimbursement Guidelines

CareSource strives to be consistent with all Nevada Medicaid and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code or code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims.

Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, ICD-10 and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored as would be any aspect of a provider contract. Generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the listed links for details:

- Medicare: cms.gov
- Nevada Medicaid: https://www.medicaid.nv.gov/

CareSource uses coding industry standards, such as the American Medical Association (AMA) Current Procedural Terminology (CPT) manual, CCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPCS code or modifier usage

CareSource seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that will review, upon request, any claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review will take into consideration all the previously mentioned OMPP, Medicare, CCI, and

national commercial standards when considering the appeal. In order to ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the CareSource appeals team to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Emergency Department Reimbursement Guidelines

CareSource covers emergency department visits, once per day, per member.

CareSource covers emergency services, as defined in Rule 59G-1.010, F.A.C., provided by a hospital that is not enrolled as a Nevada Medicaid provider until the recipient can be moved to a participating hospital.

Providers must include the following on the claim form:

- Revenue code 045X for ED services
- The date the recipient entered the ED as the date of service for the ED visit
- The date the provider rendered any service related to the ED visit as the date of service for that line item

Notification

If a CareSource member presents to the emergency department for services, the provider may notify CareSource to allow for care management services, preparation for admission, or discharge planning. Calls to CareSource with the notification should be made to Provider Services at **1-833-230-2112** If the call occurs after hours, CareSource will return the call within 24 hours. If an inpatient admission is expected, a prior authorization may be needed. Additional information along with instructions to submit a request can found at **CareSource.com**.

Explanation of Payment

An Explanation of Payments (EOPs) is statements of the status of your claims that have been submitted to CareSource and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated, depending on your claim submission activity. Providers who receive EFT payments will receive an Electronic Remittance Advice (ERA) and can access it on the Provider Portal.

Information Included on EOPs

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

Check Claim Status Online

Please remember that you can track the progress of your submitted claims at any time through our Provider Portal.

Providers and their support staff can also track the status of claims using our Clearinghouse Availity. A search can be completed using the website or through a connection in the providers Electronic Health Records (EHR) system. This connection can be established if the EHR system is configured for X12 5010 276 Claim Status Inquiry output and able to receive a 277 Claim Status Response.

CareSource is responsible for resolving any pended claims, not the provider. The report may be sent to you merely to acknowledge receipt. Please do not resubmit pended claims; this may further delay processing. A Pended Claim Explanation report may be sent on the first and third check write of the month.

Coordination of Benefits

CareSource collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately, and in general we are required to comply with the federal regulations that Medicaid programs serve as the payer of last resort.

While we try to maintain information as accurately as possible, we rely on numerous sources of information that are updated periodically, and some information may not always be fully reflected on our Provider Portal. Please ask CareSource members for all health care insurance information at the time of service.

Search Coordination of Benefits on the Provider Portal By:

- CareSource member ID number
- CareSource case number
- Medicaid number/MMIS number
- Member name and date of birth

You can check COB information for members who have been active with CareSource within the last 12 months.

Claims involving COB will not be paid until an Explanation of Benefits/Payment or EDI payment information has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (zero balance) must still be submitted to CareSource for processing. This is due to regulatory requirements.

Coordination of Benefits Overpayment

If a provider receives a payment from another carrier after receiving payment from CareSource for the same items or services, this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the provider, or the provider can issue refund checks to CareSource for any overpayments. Providers should not refund any money received from a third party to a member.

Workers' Compensation

Claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The provider will be advised to submit the charges to workers' compensation for reimbursement.

Third-Party Liability/Subrogation

Claims indicating the provided services were the result of an injury will be considered as a case of possible subrogation. Any third-party liability will be determined. CareSource will pay the provider for all covered services. Then, we will pursue recovery from any third parties involved.

Member Billing Policy

In order to charge the member for non-covered services, Providers must inform member of his or her responsibility to pay for services that are not covered by Nevada Medicaid, and document in the recipient's file that the recipient was informed of his or her liability, prior to rendering each service. The provider must disclose the following in writing:

- That the service to be rendered is not covered by Medicaid.
- Whether there are procedures or treatments covered by the Department that are available to the member in lieu of the non-covered procedure or treatment. If there are covered procedures or treatments available to the member, the member must indicate on the disclosure form his or her willingness to accept the non-covered service.

The requirements and documentation must be signed prior to providing any service. Members in emergent situations cannot be billed for services. For example, a member who uses a transportation provider who is not enrolled in Nevada Medicaid for an ambulance ride to an emergency room may not be billed. Members cannot be billed for missed appointments or if the provider fails to bill CareSource correctly and in a timely manner.

Generally, providers enrolled in the Nevada Medicaid can bill members only under the following conditions:

- The service is not covered under the Nevada Medicaid (for example, cosmetic procedures).
- The member has exceeded the program limitation for a particular service.
- The member understands that the Nevada Medicaid does not cover the service and accepts financial responsibility before receiving a service that is not covered by the program.
- The services provided are covered or non-covered embellishments or enhancements to covered services. These services can be considered and billed separately from the basic service only if a separate procedure, revenue or National Drug Code (NDC) exists for the enhancement. Otherwise, a service in its entirety is considered covered or non-covered.
    - The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the Nevada Medicaid did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service.

- The provider has taken appropriate action to identify a responsible payer, and the enrollee has failed to inform the provider of Nevada Medicaid eligibility before the one-year claim-filing limitation.

It is never appropriate to balance bill a Medicaid member for a Medicaid covered service. A member must be given an option, with the ability, to leave and find an alternative option prior to rendering consent for direct billing.

Referrals and Prior Authorizations

CareSource uses a select network of hospitals, physicians and ancillary providers. Typically, CareSource does not pay for non-network, non-emergent services; however, these may be provided in limited situations with prior authorization from CareSource's Utilization Management (UM) team. Any participating facility/provider requesting prior authorization for an elective admission must obtain prior authorization for the use of any out-of-network Radiologist, Anesthesiologist, Pathology, Hospitalist and Laboratory (RAPHL). Please visit the Provider Portal at **CareSource.com** for the most current information on prior authorization and referral requirements.

Referral Information

Generally, CareSource does not require referrals or prior authorization before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, prior authorizations are needed before CareSource will pay for services from out-of-network providers, except in cases of emergency and other scenarios as defined in the Evidence of Coverage (EOC). If you have questions about referrals, please call our Utilization Management department at **1-833-230-2112**.

Referral Procedures

Any treating provider can refer CareSource members to specialists. Please refer to our website for more information. Simply put a note about the referral in the patient's chart. Please remember, nonparticipating specialists must request prior authorization for any services rendered to CareSource patients and must be enrolled as an Nevada Medicaid provider.

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

You can request a prior authorization through our provider portal or by faxing a request to 844-824-5592.

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: **1-833-230-2112**.

Services That Do Not Require a Referral

Health care services provided by specialists do not require a referral from a PCP. 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, the specific services rendered may still require prior authorization from CareSource. In addition, all services rendered are still subject to benefit

limits. PCPs do not need to arrange or approve these services for members as long as any applicable benefit limits have not been exhausted. These include the following:

- Certified Nurse Practitioner (CNP) services
- Chiropractic care
- Services to treat an emergency
- Family planning services
- Laboratory services (must be ordered by a participating provider)
- Podiatric care
- Psychiatric care, including mental health and SUD as applicable
- Psychological care (from private practitioners or at Community Mental Health Centers)
- 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)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours
- Services for children with medical handicaps
- Behavioral health providers. Members may also self-refer to any Nevada Medicaid-enrolled psychiatrist. The mental health providers to which the member may self-refer within network include:
    - Outpatient mental health clinics
    - Community Mental Health Centers
    - Psychologists
    - Certified psychologists
    - Health services providers in psychology (HSPPs)
    - Certified social workers
    - Psychiatric nurses
    - Independent practice school psychologists
    - Advanced practice nurses under NRS 632.237, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
    - Persons holding a master's degree in social work, marital and family therapy or mental health counseling

Members May Go to Non-Participating Providers for:

- Emergency care
- Care at Community Mental Health Centers
- Psychiatric care
- Family planning services provided at qualified family planning providers
- Care at FQHCs and RHCs
- Necessary covered medical services if CareSource does not have in-network providers within 60 miles of the member's residence

Members are not limited to network providers; however prior authorization is required for any out of network providers.

Please Note: Non-participating providers must be Nevada Medicaid enrolled to receive reimbursement and claims must be submitted within the filing limit for non-participating providers.

How to Make a Referral to a Specialist

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. CareSource expects specialists to collaborate on the member's care and inform the member of treatment plan updates.

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 of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care. The period of time must be at least one year to be considered a standing referral. Treating providers must get prior authorization from our health plan before sending a member to an out-of-network provider.

Referrals to an out-of-plan provider – A member may be referred to out-of-plan provider 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 prior authorization 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.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be an Nevada Medicaid enrolled provider
- The provider must be a participating provider. If not, prior authorization 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.

Prior Authorization Information

Services that Require Prior Authorization

CareSource members have the right to request a second opinion. The second opinion does not require a prior authorization unless you are being seen by an out of network provider. All out of network services require a prior authorization.

Please visit **CareSource.com** > Providers > Provider Portal > Prior Authorization for the most up-to-date information of services that require prior authorization.

Services are provided within the benefit limits of the member's enrollment. Prior authorization requirements by service type may be found at **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization or on the searchable authorization lookup tool.

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

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

Providers can obtain prior authorization from Evolent for an imaging procedure in the following ways:

- Online – www.radmd.com
- By phone – 1-800-424-4906 (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 5 p.m. PT.

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

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

CareSource as Secondary Payor

If CareSource requires prior authorization for a service, and the member has additional insurance coverage that is primary, the provider must follow the primary insurance requirements for obtaining prior authorization.

Prior Authorization Procedures

The Provider Portal is the preferred method to request prior authorization for health care services. You can get immediate approval or pend status and can check pending claim status. Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone, fax or mail. If submitted by mail or fax, the prior authorization form used should be the Nevada Medicaid prior authorization request form.

Request Prior Authorization	
Online/Provider Portal* *preferred method	Visit **CareSource.com** > Login > Provider
Phone	Please call **1-833-230-2112** and tell our IVR that you need to submit an authorization request.
Fax	Please fax the prior authorization form to 844-824-5592. The prior authorization form can be found on **CareSource.com** > Providers > Tools & Resources > Forms. NICU Fax: 937-396-3499
Mail – Prior Authorizations	CareSource Attn: Nevada Utilization Management Department P.O. Box 1307 Dayton, OH 45401-1307
Mail – Behavior Health Prior Authorizations	CareSource Attn: Nevada Behavioral Health Utilization Management Department P.O. Box 1307 Dayton, OH 45401-1307

Copies of prior authorization forms can be found on **CareSource.com** > Providers > Forms.

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource Member ID number
- Provider name and NPI/TIN
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity for the service

Prior Authorization

Please Note: Below is not a comprehensive listing and other criteria may be associated to other items requiring prior authorization.

- **If the provider fails to obtain prior authorization for non-emergency services, neither the plan nor a covered person will be required to pay for those non-emergency services.**
- If the request is for **inpatient admission** (whether it is elective, urgent or emergent), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

- If **inpatient surgery** is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, any appropriate clinical and anticipated discharge needs prior to the planned surgery.
- If the request is for **outpatient surgery**, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs prior to the planned surgery.
- Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and coverage/benefit limitations.
- When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service and adherence to other terms and conditions of the Evidence of Coverage, such as benefit limits. Providers must verify eligibility on the date of service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.
- All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the provider. CareSource will notify you of prior authorization determinations via fax to the provider's address on file.
- For standard prior authorization decisions, CareSource provides notice to the provider and member as expeditiously as the member's health condition requires, but no later than seven calendar days following receipt of the request for service.
- Urgent prior authorization decisions are made within two business days or 72 hours, whichever is sooner. Please specify if you believe the request is urgent.
- Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. If an authorization is being appealed for medical necessity, a member consent form must also be submitted.

Determination Time Frames

CareSource 's time frames to make authorization determinations vary depending upon the member's health condition, completeness of submission of information and state requirements. Please reference the appropriate table below to find determination time frames:

Authorization Type	Decision	Extension

Concurrent	3 calendar days	No extensions available on Concurrent.
Urgent Preservice	2 business days or 72 hours, whichever is sooner	May extend the timeframe once, by up to 14 calendar days. If an urgent pre-service request is incomplete and requires additional information, CareSource must request the additional information within 48 hours. Health care providers then have 48 hours to respond to the request.
Standard Preservice	7 calendar days	CareSource may extend the time frame once, by up to 14 calendar days if a member requests the extension or CareSource needs additional information, provided it documents at least one attempt to obtain the necessary information.
Retro (Post service)	30 calendar days	None

Prior Authorization of Unlisted Services

Required Content: Procedures to obtain authorization of any medically necessary service to enrollees under the age of 21 years when the service is not listed in the service-specific Nevada Medicaid Coverage and Limitations Handbook, Nevada Medicaid Coverage Policy, or the associated Nevada Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Medically necessary services are constituted as:

a. Not more restrictive than that used by the State Medicaid program as indicated in state statutes and regulations, the Medicaid and Nevada Check Up State Plans, and other state policy and procedures, including the Medicaid Services Manual (MSM), including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and
b. Addresses the extent to which CareSource is responsible for covering services that address:
    a. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.
    b. The ability for a member to achieve age-appropriate growth and development.
    c. The ability for a member to attain, maintain or regain functional capacity.
    d. The opportunity for a member receiving LTSS to have access to the benefits of the community living, to achieve person-centered goals, and live and work in the setting of their choice.

Billing for Services Denied Prior Authorization

CareSource may permit billing members for services that require authorization, but for which authorization is denied, if certain safeguards are in place and are followed by the provider:

- The provider must establish that authorization has been requested and denied before rendering the service.
- The provider can request CareSource review of the authorization decision. CareSource must inform providers of the contact person, the means for contact, the information required to complete the review and procedures for expedited review, if necessary.
- If CareSource maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that the authorization has been denied.
- The member must be informed of the right to contact CareSource to file an appeal if the member disagrees with the decision to deny authorization.
- The provider must inform members of member responsibility for payment if the member chooses to or insists on receiving the service without authorization.

If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:

- The waiver is signed only after the member receives the appropriate notification stated in requirements three and four.
- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
- Providers must not use nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.
- The waiver must identify the specific procedure to be performed, and the member must sign the consent before receiving the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that CareSource did not authorize the service.

The waiver must include the right to appeal any denial of payment by CareSource for denial of authorization.

Utilization Management (UM)

Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The UM department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate 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. Referrals to the CareSource care management team are made, if needed. CareSource makes its UM criteria available in writing by mail, fax, and via the website.

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

Fax
937-396-3081
NICU Fax: 937-396-3499

On an annual basis, CareSource completes an assessment of satisfaction with the UM process and identifies any areas for improvement opportunities.

Continuity of Care
For members new to CareSource, authorizations that were obtained with the previous managed care company or fee-for-service will be honored for a minimum of 90 calendar days from the date of enrollment. These services are approved regardless of the provider's network status with CareSource. For dates of service beyond the approval on file with the previous carrier, please contact CareSource's Utilization Management department for authorization. Authorization requirements can be found on the Prior Authorization Look-Up Tool.

Criteria

CareSource utilizes state and federal, as well as nationally recognized criteria to determine medical necessity and appropriateness of services. The 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 also has medical policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource Clinical Peer Reviewer for further discussion. Clinical Peer Reviewers from CareSource are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request.

Providers can access CareSource's medical policies online at **CareSource.com** > Provider > Provider Policies.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health care 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 when an adverse decision has been rendered. You may request the information by calling or faxing the UM department. If you would like to discuss an adverse decision with a CareSource Clinical Peer Reviewer, please call the Utilization Management Department at **1-833-230-2112** then state "extension" once the automated phone system completes the introduction. Please then ask for extension 1283. This request for the discussion with the Clinical Peer Reviewer needs to

occur within five business days of the determination. After this deadline, you must follow the appeals process.

Emergency Medical Conditions & Services

CareSource defines “emergency medical condition” as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

CareSource defines “emergency services” as covered inpatient and outpatient services that are as follows:

a. Furnished by a provider that is qualified to furnish these services under Title 42.
b. Needed to evaluate or stabilize an emergency medical condition.

Post-Stabilization Services

Please call **1-833-230-2112** for any questions related to post-stabilization services. The definition of “Post-Stabilization Care Services” is 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.

Prior authorization 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.. CareSource covers and pays for emergency services regardless of whether the provider that furnishes the services is in network. CareSource will not deny payment for treatment obtained under either of the following circumstances:

a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of “emergency medical condition.”
b. A representative of the MCO instructs the member to seek emergency services.

Additional Rules for Emergency Services

a. CareSource does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
b. CareSource does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s PCP, the MCO, or the State of the member’s screening and treatment within 10 calendar days of presentation for emergency services.
c. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

d. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding.
e. CareSource is financially responsible for post-stabilization care services obtained within or outside the network that are pre-approved by a plan provider or other CareSource representative.
f. CareSource is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other CareSource representative, but administered to maintain the member's stabilized condition within one hour of a request for pre-approval of further post-stabilization care services.
g. CareSource is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or CareSource representative, but administered to maintain, improve, or resolve the member's stabilized condition if:
    a. CareSource does not respond to a request for pre-approval within one hour.
    b. CareSource cannot be contacted.
    c. CareSource representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, CareSource must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached.
h. CareSource's financial responsibility for post-stabilization care services it has not pre-approved ends when:
    a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
    b. A plan physician assumes responsibility for the member's care through transfer.
    c. A CareSource representative and the treating physician reach an agreement concerning the member's care.
    d. The member is discharged. To request prior authorization for observation services as a nonparticipating provider or to request authorization for an inpatient admission please visit our provider portal to request a prior authorization.

You can also request a prior authorization by calling our Provider Services, follow the prompt for post-stabilization. During regular business hours, your call will be answered by our Utilization Management department. If calling after regular business hours, the 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 the Provider Services.

Access to UM Staff

Providers may call our UM department at **1-833-230-2112** with any questions.

Staff Availability

- Staff members are available from 8 a.m. to 6 p.m. PT during normal business hours 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.

Retrospective Review

Upon written request, CareSource shall not permit retrospective authorization submission after the date of service or admission where a prior authorization was required but not obtained (Retro Authorization) except in some circumstances.

Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria will need to be met to qualify for a retro authorization review.

Claims not meeting the necessary criteria as described above will be administratively denied. Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal. If the request is received within these time frames and a medical necessity denial is issued, you may submit a request for an appeal within 180 days from the date of the service, date of discharge, or date of denial if service was not yet rendered.

A request for retrospective review can be made by contacting the Utilization Management department at 1-833-230-2112 and following the appropriate menu prompts, or by faxing the request to 844-432-8924. Clinical information supporting the request for services must accompany the request.

Pharmacy

CareSource covers all medically necessary Medicaid-covered prescription drugs and medical supplies. This applies to all CareSource members who get health care through a Nevada Medicaid managed care plan.

CareSource works with Express Scripts, our pharmacy innovation partner, to manage our prescription drug costs and to develop and implement state uniform preferred drug list (SUPDL).

Prescription Drug Coverage

- **Other medical supplies and durable medical equipment (DME)** – To support member access and convenience, other select medical supplies, such as wound care

supplies and enteral feeds, may be filled through the retail pharmacy for a limited period of time (up to 30 days) until you coordinate delivery with a DME provider.

- **Medications administered in the provider setting** – Physician administered drugs/medications that are administered in a provider setting (such as a physician office, hospital, outpatient department, clinic, dialysis center, or infusion center) will be billed to CareSource with the exception of drugs carved out and covered by Nevada's Fee for Service Medicaid program.
  Please Note: prior authorization requirements exist for many provider administered drugs.
- **Transition period** – A 90-day transition period applies for members new to the plan who are on pre-existing drug regimens. Some medications are excluded from the transition period. After the 90-day transition period has ended, prior authorization may be applicable, depending on the member's medication. Check **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization to find out medications require prior authorization.

Preferred Drug List

CareSource uses evidence-based guidelines to ensure health care services and medications meet the standards of excellent medical practice and are the lowest cost-effective alternative for the member.

CareSource follows Nevada's Statewide Uniform Preferred Drug List (SUPDL). Drugs and drug categories not on the SUPDL are termed neutral and are managed by CareSource. Both preferred SUPDL and preferred neutral products are found within CareSource 's posted Preferred Drug Lists (PDLs). CareSource also maintains an online drug formulary search tool. These and additional resources can be found online at **CareSource.com** > Providers > Drug Formulary.

CareSource provides advance notification for PDL changes here **CareSource.com** > Providers > Tools & Resources > Drug Formulary > Drug Formulary Changes.

Step Therapy and Quantity Limits

Certain medications on and off of the PDL require utilization criteria to be met. Step therapy is a utilization technique that requires use of preferred medication(s) before a non-preferred or higher cost medication would be approved for use.

Quantity limits are also placed on many medications based on FDA-recommended dosing frequencies and safety considerations.

Generic Substitution

Generic substitution occurs when a pharmacy dispenses a generic version rather than a prescribed brand-name product.

Generic drugs are usually priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. 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.

When a generic drug is substituted for a brand-name drug, you can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic interchange).

Prior Authorization

CareSource will process prior authorization requests in accordance with Nevada Medicaid regulations. Prior authorization requires that a drug be pre-approved in order for it to be covered under a health benefit.

The prior authorization staff will adhere to the Nevada Medicaid regulations and determine medical necessity for SUDPL exception requests that will be reviewed based on drug-specific prior authorization criteria or non-SUDPL prescription request criteria.

Prior authorization requests for medications covered under outpatient medical benefit for Medicaid may be submitted electronically through the Provider Portal or by fax.

Medical Benefit Fax: 888-399-0271

Prior authorization requests for medications covered under the pharmacy benefit may be submitted electronically via the CoverMyMeds or SureScripts prior authorization portals or by fax.

Pharmacy Benefit Fax: 866-930-0019

You may submit requests via fax with pharmacy prior authorization forms linked on the Forms webpage.

In emergent situations, requests may be accepted via phone.

Phone: 1-833-230-2112 (Phone requests are not for routine prior authorization requests.)

Note: All oncology medication treatment regimen requests must be submitted and reviewed through the EVITI Connect Portal.

For all prior authorization decisions (standard or expedited), CareSource provides notice to the provider and member as expeditiously as the member's health condition requires. Please specify if you believe the request is urgent.

Specialty Pharmacy Program

In order to improve medication compliance, disease state and side effect management, our preferred specialty provider is Accredo. Accredo will provide specialty medications directly to the member or the prescribing physician and coordinates nursing care if required. Please visit our Pharmacy webpage at **CareSource.com** > Providers > Education > Pharmacy, selecting

Nevada Medicaid from the dropdown menu, to see more details about the Specialty Pharmacy program.

Medication Therapy Management Program

CareSource offers a medication therapy management (MTM) program for all members. MTM services allow local pharmacists to work collaboratively with other physicians and prescribers to enhance quality of care, improve medication compliance, address medication needs and provide health care to patients in a cost-effective manner. You may be contacted by a pharmacist to discuss your patients' medications, as we want to make sure they are getting the best results from the medications they are taking.

Behavioral Health

Behavioral Health Overview

Behavioral health is critical to each member's overall health, and CareSource provides behavioral health benefits to our Medicaid members. CareSource ensures that all members have access to behavioral health resources and that behavioral health is integrated across all interventions. Behavioral health providers (BHPs) are expected to assist members in accessing emergent, urgent and routine behavioral services as expeditiously as the member's condition requires.

Members may self-refer to behavioral health services within our provider network without a referral from their PCP.

Screening & Evaluation

CareSource requires that PCPs and specialists have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs and specialists may provide clinically appropriate behavioral health services within the scope of their practice.

CareSource provides training to network PCPs on how to screen for and identify behavioral health disorders as well as our referral process and clinical coordination requirements for behavioral health services. The PHQ9 and Edinburgh Postnatal Depression screening can be located on provider website. Training includes coordination, quality of care and new models of behavioral health interventions appropriate in a primary care setting. Training may be found at **CareSource.com** > Providers > Education > Patient Care, then going to the Behavioral Health page.

BHPs may provide physical health care services within their scope of practice. Behavioral health providers are required to use DSM-5 multi-axial classification when assessing the member for behavioral health services. Behavioral health providers are required to document the DSM-5 diagnosis and outcome of assessment information in the member's medical record.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an evidence-based approach to identify, reduce, and prevent problematic substance use disorders.

There are three major components to SBIRT:

- **Screening:** Assessing a patient for risky substance use behaviors using standardized screening tools.
- **Brief Intervention:** A short conversation to provide feedback and advise while exploring and supporting changes in risky substance use behaviors.
- **Referral to Treatment:** Providing a referral for brief therapy or additional treatment to patients whose screening indicates the need for additional services.

This screening should occur annually. However, more frequent screening may be warranted for:

- Adolescents
- Patients who are pregnant or considering becoming pregnant
- Individuals experiencing significant increases in psychological stressors
- Patients with substance use problems who demonstrate recent changes in behavior

SBIRT Coding and Reimbursement

SBIRT coding and reimbursement can vary by plan and by state.

For Medicaid plans, the following licensed providers can independently bill for SBIRT:

- Physician (MD, DO) and Physician Assistant (PA)
- Psychologist endorsed as a health service provider (PhD, PsyD, HSPP)
- Behavioral Health Professional (LCSW, LMFT, LMHC, LCAC)
- Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)

SBIRT sessions must last at least 15 minutes to be eligible for billing. This can be documented by either:

- Documenting the start and stop time or
- documenting total face-to-face time involved in the SBIRT session.

For up-to-date information, refer to the Nevada Medicaid Professional Fee Schedule.

Reference: Screening, Brief Intervention and Referral to Treatment
https://www.samhsa.gov/sbirt

Care Management

CareSource members have access to specialty behavioral health Care Managers for assistance in obtaining both routine and higher complexity health care services.

PCPs can contact CareSource for assistance in facilitating specialty behavioral health services for our members. We can assist members and PCPs with provider referrals and with making appointments for members in need of therapy and/or psychiatric services.

Coordination of Care

CareSource requires that behavioral health providers refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so.

CareSource encourages communication and care coordination between PCPs and behavioral health providers to achieve optimal health for our members. Where appropriate and allowed, providers may deliver same-day, co-located primary and behavioral health care. Communication is necessary to ensure continuity of care and member safety.

CareSource encourages behavioral health providers to send initial and at least quarterly status reports to PCPs, with the member's or the member's legal guardian's consent.

CareSource requires every provider to ask and encourage members to sign a consent permitting release of substance use disorder information to CareSource and to the PCP or BHP. The consent form can be found on **CareSource.com** > Providers > Tools & Resources > Forms.

Prior Member Consent

Prior member consent is required to disclose sensitive health information, a subset of protected health information. Impacted conditions includes Substance Use Disorder (SUD). Consent requirements are based on federal and state requirements.

For SUD, federal rule 42 CFR PART 2 exists to encourage people to engage in substance use treatment without fear of legal prosecution. This rule:

- Is commonly called "Part 2"; Is part of the Code of Federal Regulations
- Pertains only to drug and alcohol treatment
- Restricts disclosure of records by a Part 2 provider (any entity that "provides alcohol or drug abuse diagnosis, treatment or referral for treatment") and redisclosure of records received from a Part 2 provide
- Is more stringent than HIPAA privacy rules

To secure appropriate consent, members are encouraged to complete the Member Consent/HIPAA Authorization Form, which allows their providers to effectively communicate and coordinate care. Find this form at **CareSource.com** > Member Overview > Tools & Resources > Forms.

Your CareSource members' current consent status can be found on the Provider Portal. Search for the patient using the "Member Eligibility" option.

If you have questions, contact Provider Services at **1-833-230-2112**.

Community of Innovation™

The Community of Innovation™ (COI) is a strategically organized coalition of complex health industry leaders focused on innovations and support to transform the provider experience. The outcome of the COI is improved health access and opportunities and health outcomes of complex health populations. The COI identifies and creates solutions for complex health providers related to the environmental, social and technological factors that may be impeding their ability to deliver the best possible person-centered quality of care. Supported by Project ECHO® CareSource, the COI will ensure all complex health providers can benefit from the solutions developed to advance health access and opportunities and outcomes for all complex health populations.

Project ECHO®

A key feature of the COI is the inclusion of CareSource Project ECHO as not all solutions will be innovations. Project ECHO allows CareSource to disseminate existing specialty knowledge (i.e., evidence-based practices and complex health related trainings) and practice experience in a proven tele-mentoring model mode. The model leverages the enhanced provider partnerships cultivated within the COI. Project ECHO transforms the way education and knowledge are delivered to reach more people in rural and underserved communities.

The focus areas and specific solutions developed through the COI are critically important to all who provide services and supports to members with complex health needs. Project ECHO is a means by which the COI disseminates information and training to anyone serving these populations.

Interested providers should email CareSource at: Community.Innovation@CareSource.com. Please provide the following information in your email:

- Your name
- Your organization
- Best point of contact via email

Access and Availability Standards | Behavioral Health Providers

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care	Not to exceed 48 hours (no prior authorization required services); Not to exceed 96 hours (prior authorization required services)
Initial visit for routine care	Not to exceed 14 days
Follow-up after discharge	Within 7 days from the date of discharge
Follow-up visit for routine care	Not to exceed 30 calendar days
Non-life-threatening emergency	Within6 hours, or direct members with non-life-threatening emergencies to the emergency department (ED)

Scope of Practice

BHPs may provide physical health care services within their scope of practice. PCPs and specialists may provide clinically appropriate behavioral health services within the scope of their practice. Behavioral health providers are required to use DSM-5 when assessing the member for behavioral health services. Behavioral health providers are required to document the DSM-5 diagnosis and outcome of assessment information in the member's medical record.

Member Enrollment and Eligibility

The Nevada Health Authority (NHA) is solely responsible for member enrollment, including auto-assignment to a managed care organization (MCO), disenrollment, education on enrollment options and outreach activities to those eligible to enroll in an MCO. NHA has implemented

potential open enrollment and auto-assignment processes in order to enroll all Medicaid members with selected MCOs.

Once eligible to participate in Medicaid, members may select CareSource as their MCO health plan. The Division of Welfare and Supportive Services is responsible for determining eligibility in Nevada Health Coverage Programs (Medicaid), which includes Medicaid.

Medicaid Eligibility

Medicaid is a risk-based managed care program that covers those most in need. To be eligible for Nevada Medicaid, a person must be:

- A resident of the state of Nevada, a U.S. national, citizen, permanent resident, or legal alien
- In need of health care/insurance assistance, with a financial situation that would be characterized as low income or very low income.

Members must also be one of the following:

1. Pregnant, or
2. Be responsible for a child 18 years of age or younger, or
3. Blind, or
4. Have a disability or a family member in your household with a disability, or
5. Be 65 years of age or older.

Nevada Medicaid Enrollment Categories

Enrollment in a managed care plan is mandatory for members in the following groups:

- **Nevada Medicaid:** The mission of the Nevada Health Authority also known as Nevada Medicaid, is to provide access to health coverage for eligible low-income individual and families in Nevada, including children, pregnant women, seniors, and people with disabilities, helping them to pay for medical bills and access health care services they may not otherwise afford.
- **Nevada Check Up (CHIP):** The mission of the Nevada Check Up program is to program is to provide low-cost, comprehensive health care coverage to low income, uninsured children (birth through 18) who are not covered by private insurance or Medicaid; while (1) promoting health care coverage for children; (2) encouraging individual responsibility; and (3) working with public and private health care providers and community advocates for children.

Presumptive Eligibility

The Affordable Care Act (ACA) gives qualified hospitals the opportunity to determine presumptive eligibility (PE) for certain Medicaid- eligible populations. PE enables hospitals to temporarily enroll individuals in the Medicaid program for immediate access to medical care and a pathway to longer-term Medicaid coverage. Enrollment ensures provider compensation for all covered services, including hospital-based services, while a final Medicaid eligibility determination is made. Review requirements by visiting NV.gov > Providers > Hospital Presumptive Eligibility.

Member Eligibility Verification

Providers are expected to verify member eligibility each time a service is rendered.

Providers may use the Provider Portal to verify member eligibility. Upon logging in to the Provider Portal, providers will be able to view member eligibility with:

- 24 months of history
- Member span information
- Multiple member look-up (up to 500)

You can also verify eligibility directly with the state by calling the Nevada Medicaid Automated Voice Response System (GABBY) by calling 1-800-842-6511 or verify eligibility with CareSource by calling our Provider Services at **1-833-230-2112**.

Member ID Cards

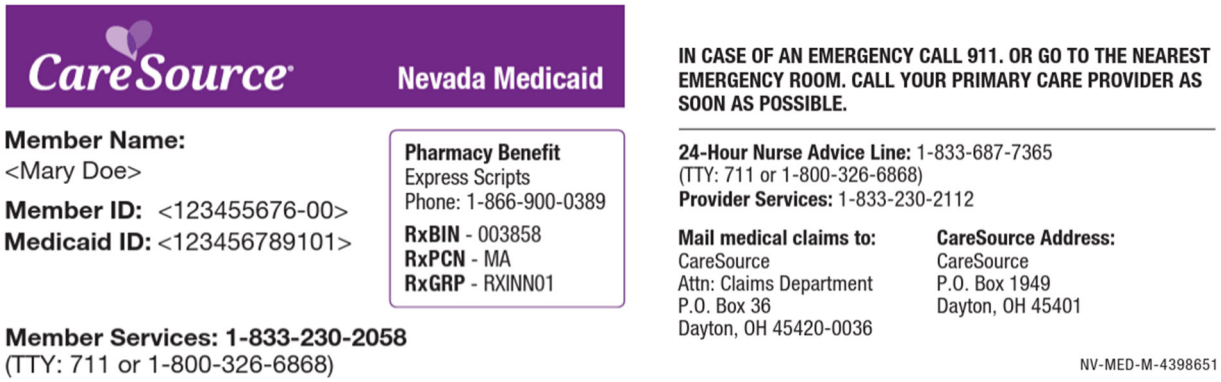
The member ID card is used to identify a CareSource member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their ID card. Therefore, it is important to verify member eligibility prior to each service rendered.

Providers may use our secure Provider Portal or call Provider Services at **1-833-230-2112** to check member eligibility:

- Click on “Member Eligibility” on the left, which is the first tab. Make sure to enter the full 11-digit member ID number for the person, and if a dependent, include the dependent suffix.

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.

Sample Nevada Medicaid Member ID Card



ID Card Elements

- Member Name
- Member ID
- Medicaid ID

New Member Welcome Kits

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

New Member Kit Elements

- Quick Start Guide
- Member Handbook Request Card
- Provider Directory Request Card
- ID Card

Finding a Doctor

Members are generally referred to our online **Find-a-Doctor** directory tool. The online Provider Directory, which lists participating CareSource providers and facilities within a certain radius of the member's residence, provides the latest information on our provider network. A current list of providers can be found at any time on CareSource's website, **CareSource.com** > Members > Tools & Resources > Find a Doctor.

Members will only receive a printed copy of our Provider Directory if they requested one at the time of enrollment or by returning a request postcard included in their new member kits. As the contents of the printed directory are subject to change, we encourage members to call CareSource or to use the online provider directly to confirm they are in network.

Newborn Enrollment

When a mother gives birth, the newborn child will automatically be enrolled into the mother's health plan starting on the baby's date of birth.

The mother will have the choice up to 90 days from the baby's date of birth to make a one-time change. If no change is made, the baby will stay on the mother's health plan until the next year.

The birth of a baby is a qualifying event for the mother to request disenrollment and to be assigned to a different health plan.

Member Disenrollment

We understand that members may choose to select a different health plan from the MCO to which they were assigned by the Division of Welfare and Supportive Services (DWSS). For various reasons, including reenrolling with a previous MCO with which the member has a historical relationship, a member may choose to change MCO. We support this decision by our members and provide judgement-free disenrollment assistance and referral to DWSS.

If we choose to disenroll a member based on DWSS-approved criteria, CareSource will provide DWSS with documentation of at least three interventions made over a period of 90 days that occurred through treatment, care management and care coordination to resolve the issue.

Reasons for Disenrollment

The DSS or its agent will process all MCO disenrollment requests. This includes:

1. Check Up members have quarterly premiums they pay to the state
2. Loss of eligibility for Medicaid due to other reasons
3. All disenrollment requests members, participants or CareSource submits via telephone, surface mail, internet, facsimile and in person

Disenrollment Initiated by the Member

Any member may request to switch contractors for cause at any time pursuant to 42 CFR 438.56(c)(1). These members may contact their current contractor verbally or in writing for permission to disenroll. The contractor must make a disenrollment determination as expeditiously as the member's health requires and within a time frame that does not exceed 14 calendar days following receipt of the request for disenrollment. If the contractor determines that there is sufficient cause to disenroll, the member may choose from the remaining contractors. The contractor must provide the member with information on how to do so in accordance with Section 10.10.4.J and must notify the State of the member's disenrollment using the Good Cause Disenrollment Form as specified in the Reporting Requirements exhibit. Nevada Medicaid will notify the State's Fiscal Agent to affect the disenrollment at the first of the next administrative month pursuant to 42 CFR 438.56(e)(1)-(2), 42 CFR 438.56(d)(3)(iii), and 42 CFR 457.1201(m).

A member may request disenrollment or a change in MCO enrollment for cause at any time. The following constitutes cause for requesting disenrollment:

- The member moves out of CareSource's service region.
- CareSource does not, because of moral or religious objections, provide the covered service the member seeks.
- The member needs related services to be performed and not all related services are available within the network. The member's or participant's provider or another provider has determined that receiving related services from in-network and out-of-network providers would subject the member to unnecessary risk.
- The member requests to be assigned to the same MCO as family member(s).

Other reasons for disenrollment initiated by the member, pursuant to 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the contract or lack of providers experienced in addressing the member's health care needs. DSS or its agent will make the determination of these reasons.

Disenrollment Initiated by CareSource

Pursuant to 42 CFR 438.56(b), 42 CFR 457.1201(m), and 42 CFR 457.1212, CareSource may request disenrollment of a member if the continued enrollment of the member seriously impairs our ability to furnish services to either the particular member or other members or the member relocated their residence outside the contractor's geographic service area. In addition, the contractor must confirm the member has been referred to the contractor's Member Services department and has either refused to comply with the referral or refused to act in good faith to attempt to resolve the problem. CareSource must provide all disenrollment requests to the State in writing for review and approval. The State will make a determination on such requests within 10 business days. If approval is granted, the member will be given notice by the Contractor that disenrollment will occur effective the next administratively possible month, after the member is given State Fair Hearing rights to appeal the decision.

Provider-Initiated Requests for Member Reassignment

The Medicaid programs encourage positive and continuous relationships between members and PCPs. In rare instances, a PCP may request reassignment of a member to another PCP within CareSource. CareSource must approve and document these situations. The reasons for these situations include the following:

- Missed appointments (with appropriate documentation and criteria).
- Member fraud (upper-level review required).
- Uncooperative or disruptive behavior on the part of the member or member's family (upper-level review required).
- Medical needs that could be better met by a different PCP (upper-level review required).
- Breakdown in physician and patient relationship (upper-level review required).
- The member accesses care from providers other than the selected or assigned PCP (upper-level review required).
- Previously approved termination.
- Member insists on medically unnecessary medication.

CareSource 's medical director or a committee appointed by the medical director performs an upper-level review – a thorough review of the individual case – to determine whether the cause and documentation are sufficient to approve a reassignment. The upper-level review includes monitoring to improve the overall quality of the program and to ensure that CareSource 's guidelines and policies are consistent with those of the program.

The following, developed and finalized by the Medicaid Quality Improvement Committee (QIC), provides guidelines for situations outlined previously:

- **Missed appointments** – A member may miss at least three scheduled appointments without defensible reasons before a PCP may request member reassignment. The PCP or staff is responsible for educating the member, on the first occurrence, about the

problems and consequences associated with missed appointments. Medicaid members are not penalized for an inability to leave work, for lack of transportation, or for other defensible reasons. Missed appointments must be documented in the member's chart that is accessible to the PCP and staff. On documentation of the third missed appointment for non-defensible reasons, CareSource may approve the PCP's request for the member's reassignment within CareSource. CareSource has procedures in place to assist members and PCPs with missed appointments and may intervene to resolve issues, while supporting the overall goals of the Medicaid program.

- **Member fraud** – This reason for member reassignment must be restricted to cases referred to the Nevada Bureau of Investigation or the Office of the Inspector General (OIG).
- **Threatening, abusive or hostile actions by members** – The PCP can request a member's reassignment when the member or the member's family becomes threatening, abusive or hostile to the PCP or to the office staff after attempts at conflict resolution have failed. The request must be consistent with the PCP's office policies and with criteria used to request reassignment of commercial patients.
- **Member's medical needs may be better met by another PCP** – A PCP may request member reassignment because the PCP believes a member's medical needs would be better met by a different PCP. This request must be documented as to the severity of the condition and must be reviewed by the CareSource's medical director. CareSource's medical director must review the request based on the specific condition or severity of the condition as a PCP scope-of-practice matter, not based on a bias against an individual member.
- **Breakdown of physician and patient relationship** – CareSource must conduct an upper-level review, as defined previously, to ensure that the breakdown in the relationship between the PCP and the member is mutual.
- **Member accessing care from other than the selected or assigned PCP** – CareSource must conduct member education about the health plan and the PCP selection process. If the member does not initiate a PCP change and continues to access primary care services from a provider other than the PCP, the PCP may request the member's reassignment. Misuse of the emergency room is not a valid reason for requesting a member's reassignment.

Most of these situations can be resolved by facilitating the member's selection of another PCP within the health plan. Members who require services of providers not available within the health plan generally are not disenrolled but remain in CareSource, with CareSource managing and reimbursing for out-of-network services.

Unacceptable reasons for PCP-initiated member reassignment requests:

- **For good cause** – This term is used for member-initiated PCP change requests.
- **Noncompliance with mutually agreed-to treatment** – Members are not reassigned for being noncompliant or refusing treatment. A patient has the right to refuse treatment.
- **Demand for unnecessary care** – A PCP-initiated request for member reassignment is not approved for this reason unless there is documentation of threatening, abusive or hostile behavior, as described.

- **Language and cultural barriers** – PCPs who have difficulty with a member's language or other cultural barriers must request assistance from CareSource to address the problem.
- **Unpaid bills incurred before Medicaid enrollment** – PCPs may not initiate member transfer requests because of unpaid medical bills incurred before Medicaid enrollment. PCPs can pursue charges outstanding before Medicaid enrollment through the normal collection process.

Covered Services and Exclusions

Please visit **CareSource.com** for information on services, the member's coverage status and other information about obtaining services for Medicaid. Please refer to our website and the "Referrals and Prior Authorizations" section in this manual for more information about referral and prior authorization procedures.

For the most comprehensive and up-to-date list of CareSource Nevada's Medicaid covered benefits, please see the CareSource Covered Benefits grid at **CareSource.com** > Nevada > Plans > Medicaid > Benefits and Services > Medicaid Benefits & Services.

Medicaid Benefit Summary

Below is a list of common services under each Medicaid package. Services provided by out-of-network health care providers need prior authorization.

Office Visits/Hospital	
Type of Service	**Covered?**
Doctor Visits	Yes
Checkups	Yes
Chiropractors – services limited to Medicaid eligible children under the age of 21	Yes
Family Planning Services	Yes
Clinic Services	Yes
Nurse Practitioner Services	Yes
Urgent Care Services	Yes. Urgent Care services are covered if they are medically necessary. Urgent care is needed for non-life- threatening emergencies that cannot wait for a normal scheduled office visit.
Hospital Care (Non-Emergency)	Yes

Pharmacy & Medicine		
Type of Service	**Covered?**	**Prior Authorization Needed?**
Preferred Drug Lists	Yes	Prior authorization, step therapy, quantity limit, and/or other medical

		necessity review will be required for some drugs.

Emergencies, Tests & Transportation		
Type of Service	**Covered?**	**Prior Authorization Needed?**
Emergency Services	Yes	No
Lab and X-ray Services	Yes	No
Emergency Transportation	Yes	No Prior authorization needed for airline or air ambulance (can get after services are rendered). Please see Nevada Medicaid rules for medical necessity, special circumstances and hospital-to-hospital transfers.

Special Services		
Type of Service	**Covered?**	**Prior Authorization Needed?**
Anesthesia	Yes	Yes
Nursing Facility Services (Long Term)	Transition of Care up to 60 days	N/A
Skilled Nursing Facility Services (Short Term)	Yes, less than 30 days	Yes
Hospice Care	No*	No
Nurse Midwife Services	Yes	No
Foot Care	Laboratory services, x-ray services, hospital stays and surgical procedures involving the foot are covered when medically necessary.	Yes
CareSource Life Services® and CareSource WorkConnect™, support programs for non-medical barriers	Yes	No
Home Health Services	Yes	Yes
Non-Emergency Transportation	Yes	No
DME/Orthotics/	Yes	Yes

Prosthetics		
Stop Tobacco Use *Nevada Tobacco Quitline* ***1-800-784-8669***	Yes	No
Education/Training Services	Yes	No
***Members requiring long-term care may qualify for Hospice benefits under Traditional Medicaid. For more information, please call Member Services at 1-833-230-2058.**		

Mental Health & Addiction Services		
Type of Service	**Covered?**	**Prior Authorization Needed?**
Assessments, Screenings, & Evaluations	Yes	No Assessments and screenings do not require prior authorization. Diagnostic evaluations prior authorization is needed after one per benefit year.
Counseling	Yes	Yes, prior authorization is needed after 20 sessions (individual, family and group) per provider per 12-month period.
Psychiatry	Yes	No
Intensive Outpatient Treatment (IOT)	Yes	Yes
Partial Hospitalization Program (PHP)	Yes	Yes
Medication Assisted Treatment (MAT)	Yes	Prior authorization is not needed for preferred drug. Yes, prior authorization is needed for non-preferred drug.
Withdrawal Management	Yes	Y es
Substance Use Disorder Residential Treatment	Yes	Yes
Inpatient Mental Health and Substance Use Disorder Treatment	Yes	Yes

Therapies/Habilitative Services		
Type of Service	**Covered?**	**Prior Authorization Needed?**
Applied Behavioral	Yes	Yes

Analysis (for Autism Spectrum Disorder)		
Speech Therapy	Yes	Yes
Respiratory Therapy	Yes	Yes
Occupational Therapy	Yes	Yes
Physical Therapy	Yes	Yes

For the most comprehensive and up-to-date list of CareSource Nevada's HIP covered benefits, please see the CareSource Covered Benefits grid at **CareSource.com** > Nevada > Plans > Medicaid > Benefits and Services > Plan Benefits & Services.

Well-Child Care

High-quality well-child visits can improve children's health, support caregivers' behaviors to promote their children's health, and prevent injury and harm. It is recommended that children have nine well-care visits by the time the child turns 15 months of age. These visits should include:

- Family-centered health history
- Physical examination
- Immunizations
- Vision and hearing screening
- Developmental and behavioral assessment
- Oral health needs assessment
- Social assessment
- Maternal depression screening
- Education for parents
- Care coordination as needed

When children receive the recommended number of high-quality visits, they are more likely to be up-to-date on immunizations, have developmental concerns recognized early, and are less likely to visit the emergency department.

Early Periodic Screening, Diagnosis and Treatment Program (EPSDT)

EPSDT is a federally mandated child health program developed for Medicaid beneficiaries under the age of 21. All CareSource members between 0 – 21 years must receive well-child/EPSDT exams and other age-appropriate screenings. EPSDT program periodicity is based on Bright Futures program informed and supported by the American Academy of Pediatrics (AAP). This program supports two goals:

- to ensure access to necessary health resources and
- to assist parents and guardians in appropriately using those resources.

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 Medicaid.

EPSDT Exam Components

The exam is a general health assessment and is composed of the following required screening components:

- Medical history
- Complete unclothed exam (with parent approval)
- Developmental screening (to assess if a child's physical and mental abilities are age appropriate)
- Vision screening
- Hearing assessment
- Immunization assessment (making sure child received them on time)
- Lead screening
- Other services or screenings, as needed

Providers can access a list of eligible CareSource members who have been chosen or assigned to the provider via the Provider Portal. The list also includes indicators for patients who are due for a health check exam. If there is a "Y" in the Exam Due column, that member is due to receive an EPSDT exam in the following month. You can find this list on our website at **CareSource.com** > Medicaid > Benefits and Services > EPSDT.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit includes a comprehensive array of preventive, diagnostic and treatment services for Medicaid eligible infants, children, and adolescents under age 21.

EPSDT Reimbursement

The program provides reimbursement for preventive health services, interperiodic visits, developmental screenings, brief emotional/behavioral assessments, hearing and vision screenings, and immunizations under the EPSDT benefit.

Use appropriate preventive medicine CPT codes, diagnosis codes and EPSDT referral indicators to ensure proper payment. Coding guide is available in the Provider Manual.

EPSDT Recommendations

The American Academy of Pediatrics (AAP) Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule is the periodicity schedule used for EPSDT visits and services. For a complete listing of the American Academy of Pediatrics Preventive Health Guidelines go to www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule.

High-Risk Children

Children at high risk should be tested according to the AAP guidelines. Problems found or suspected during a well-child visit must be diagnosed and treated as appropriate. Referrals must be made based on standards of good practice and AAP's recommendations for preventive pediatric health care or presenting need.

Immunizations

All members less than 21 years of age shall be provided with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

CareSource pays for the administration of the vaccine only when billed with an appropriate immunization and administration CPT code. Immunizations, flu vaccines and pneumococcal vaccines can be obtained at the retail pharmacy for those members ages 19 and older.

CareSource will not reimburse costs for vaccines obtained outside the Vaccines for Children (VFC) program when provided to children under age 19.

Immunization Schedule

Immunizations are an important part of preventive care for children and adolescents and should be administered during exams as needed. CareSource endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). The recommended schedule is included in this section of the manual. This schedule is updated annually, and the most current updates are located on www.aap.org.

Vaccines for Children Program

The federal Vaccines for Children (VFC) program makes designated vaccines available at no cost to VFC participating health care providers to administer to children under the age of 19 who are eligible for Medicaid, uninsured, underinsured, or American Indian/Alaskan native.

CareSource encourages providers to participate with the VFC program. Vaccines administered to children under the age of 19 must be obtained through the VFC program, which supplies vaccines to program participating providers at no cost. CareSource will not reimburse costs for vaccines obtained outside the VFC program. CareSource will pay for the administration of the vaccine only.

Immunization Codes

Please bill CareSource with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. Please refer to the code tables located on the CMS website at https://www.cms.gov/Medicare/Coding/ ICD10/2016-ICD-10-CM-and-GEMs.html. You can also get CMS coding guidelines at https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

Statewide Web-Based Immunization Registry

Participating providers must report all immunizations to the statewide web-based immunization registry called The Nevada WebIZ found at https://webiz.nv.gov/webiznet_nv/Login.aspx.

The Nevada WebIZ is a secure web-based application that is administered by the Nevada Health Immunization Section of the Nevada Division of Public and Behavioral Health (DPBH) and is supported by the Center for Disease Control and Prevention. Providers can use the registry to both review vaccination records for their patients and to record all newly administered vaccinations. The State of Nevada mandates use of the registry for certain providers.

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. Members may receive an annual wellness exam consisting of the following:

- Routine physical exam by the PCP or OB/GYN.
- Screening which consists of the following, as appropriate:
    - Abdominal aortic aneurysm ultrasound (AAA) for men ages 65-75
    - Alcohol misuse
    - Blood pressure for adults
    - Bone mass measurements
    - Cardiovascular disease
    - Cholesterol for adults
    - Depression for adults
    - Diabetes
    - Hepatitis B
    - Human immunodeficiency virus (HIV)
    - Obesity
    - Colorectal
    - Electrocardiogram (ECG or EKG)
    - Lung
    - Mammogram
    - Pap smear
    - Prostate
    - Sexually transmitted infections (STIs)
    - Tobacco/smoking
    - Vision exam for members aged 21 and over

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

Opioid Treatment Program (OTP) Coverage

CareSource provides coverage for the daily Opioid Treatment Program (OTP). A daily opioid treatment program includes administration and coverage of methadone, routine drug testing, group therapy, individual therapy, pharmacological management, HIV testing, Hepatitis A, B, and C testing, pregnancy tests, Tuberculosis testing, Syphilis testing, follow-up examinations, care management and one evaluation and management office visit every 90 days for the management of patient activities identified in the individualized treatment plan that assist in patient goal attainment, including referrals to other service providers and linking patients to recovery support groups.

Providers rendering OTP treatment must be enrolled with Nevada Health Coverage Programs (Nevada Medicaid) with the provider specialty of OTP as defined in the Nevada Medicaid Provider Enrollment Type and Specialty Matrix.

Eligible members include:

- Members 18 years and older who have become addicted at least one year prior to admission and are placed in the Opioid Treatment Services (OTS) Level of Care according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.
- Members under 18 years of age and have had two documented unsuccessful attempts at short-term withdrawal management or drug free treatment within a 12-month period.

- All members released from penal institution (within six months of release).
- Pregnant members.
- Previously treated members (up to two years after discharge).

Prior authorization is not required for OTP services. Providers must maintain documentation demonstrating medical necessity and that the coverage criteria are met, as well as the individual's length of treatment, in the member's records.

Residential Substance Use Disorder (SUD) Services

CareSource providers coverage for short-term low-intensity and high-intensity residential treatment for opioid use disorder (OUD) and other substance use disorder (SUD) in settings of all sizes, including facilities that qualify as institutes of mental disease (IMDs).

Prior authorization is required for all residential SUD stays. When residential services are determined medically necessary for a member, the contractor will approve a minimum of 14 days for residential treatment, unless the facility requests fewer than 14 days. If a facility determines that a member requires more time than the initial 14 days, the facility should submit a prior authorization update request showing that the member has made progress but can be expected to show more progress given more treatment time.

An additional length of stay can be approved based on documentation of medical necessity. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria:

- ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services
- ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

Facilities need to include all necessary documentation to demonstrate medical necessity for the SUD level of care being requested. This documentation should include diagnoses, clinical presentation, treatment history, treatment goals, prescriber contact following admission and weekly thereafter, and other relevant information to provide a complete picture of an individual's needs. Providers should incorporate documentation supporting the ASAM six dimensions of multidimensional assessment. When submitting an initial PA request, it is helpful to include documentation of the psychosocial assessment.

Facilities must be appropriately enrolled with Nevada Health Coverage Programs (Nevada Medicaid) as an SUD Residential Additional Treatment Facility in addition to being certified by the Division of Mental Health and Addiction (DMHA). Residential substance use disorder treatment facilities are not eligible for hospital assessment fee (HAF) adjustments. The service must be billed appropriately on a CMS-1500/professional claim and codes must match the authorization in order to be eligible for reimbursement.

In Lieu of Services

CareSource is currently collaborating with the state and other MCOs to develop policies for In Lieu of Services (ILOS).

Enhanced Benefits

This list is not all inclusive. For more information on all enhanced benefits, go to **CareSource.com**.

Benefit Name	Eligible Members	Urban/Rural	Description
MyResources powered by FindHelp	All members	Urban/Rural	On-demand access to local community resources like food banks/pantries.
Devices and Connectivity	Members 18 and older	Urban/Rural	Members are eligible for the Federal Lifeline Program with free Android phone, and the CareSource partnership with Pulsewrx supplies assistance to help with enrollment.
MyLife Digital Wellness Manager with Smartphone App	All members	Urban/Rural	A mobile app and digital platform that offers a unique person-centered, relational experience.
Enhanced Transportation (SafeRide)	Members who reside in designated rural areas	Rural	Non-emergent transportation (5 round trips per month)
CareSource Member Assistance Fund	All members	Urban/Rural	Access to up to $500 per member per year to meet necessary needs not covered by insurance or provided by another governmental or social service organization.
CareSource Education Employment Fund	All members ages 17 and older, and members who have aged out of foster care.	Urban/Rural	Access to $125 per member per year for necessary needs associated with education-related supplies and/or obtaining employment not covered by

			insurance or provided by another governmental or social service organization.
myStrength	All members 20 years and older	Urban/Rural	Tool designed to support member's emotional health and strengthen their mind, body and spirit.
CareSource WorkConnect	All members ages 16 and older	Urban/Rural	Reduces the dependency on governmental services by providing members with life coaching for up to two years, free Nevada ID card or birth certificate assistance, facilitating access to community-based resources, and help members reach their professional and educational goals.
Home Delivered Meals	Limited to pregnant and postpartum members	Urban/Rural	Home-delivered meals for pregnancy support to moms with high risk pregnancy, and postpartum after child birth. Qualifying moms will get 14 meals (2 meals a day for 7 days) delivered to their home.
Transition Box	Transitioned aged youth in rural areas	Rural	CareSource will provide a transition box once per lifetime to individuals transitioning from foster care. This box will include essential

			household items, such as basic cooking seasonings, hygiene products and fundamental cleaning supplies.
Over-the-counter (OTC) Benefit through Nations	All members	Urban/Rural	Receive a quarterly benefit of $30 for items. Money will not rollover quarter to quarter.
Tutoring	All members in grades K-12	Urban/Rural	Virtual tutoring up to 12 hours per year
Retail Memberships/Subscriptions	All members who inquire and complete an HNA. One per household	Urban/Rural	CareSource will provide Sam's Club membership to Sam's warehouse for one year for daily necessities (clothing, gas, etc.).
Interactive Health Library	All members	Urban/Rural	Trusted source of health information for the whole family – parents, children and teens. Provides easy-to-read articles, videos, interactive health tools and advice on health topics.
Healthy Homes Asthma Remediation Program	Members diagnosed with asthma and enrolled in Care Management	Urban/Rural	CareSource provides education on the disease process, environmental triggers and the importance of medication adherence. A Case Manager will assist members to get the recommended asthma remediation item.
Non-Medication Pain Management	Members 21 and over who have chronic pain diagnosis and	Urban/Rural	CareSource will offer a TENS unit or massage gun once per lifetime to help

	enrolled in Care Management		with pain management.
Expungement Fund – Through Re-entry Program	Members recently released from incarceration	Urban/Rural	One-time monetary assistance fund to help cover expungement fees through the CareSource Re-Entry Program. CareSource will cover the cost of expungement up to $500 for eligible individuals.
Transition Assistance Fund	Transitioned aged youth	Urban/Rural	Provides services to help youth transitioning into adulthood with stable and safe living accommodations. CareSource will offer up to $2,000 (amount may vary per market) to support youth as they age out of foster care and enter adulthood. Limited to once per lifetime.

Abortion and Sterilization

CareSource covers abortions, hysterectomy, and sterilizations in very limited circumstances. Please review the information below for specific information.

Abortion

Nevada Medicaid uses the word abortion to describe the early termination of pregnancy. Nevada Medicaid does not consider termination of an ectopic pregnancy to be an abortion. Abortions and abortifacients are not covered services except as allowable under the federal Hyde Amendment. Abortions are covered only if the pregnancy is the result of an act of rape or incest or a case where a 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, which would, as certified by a physician, place the individual in danger of death unless an abortion is performed and in compliance with 42 CFR 441.202.

For spontaneous abortions, the Nevada Medicaid requires no documentation from providers billing with the appropriate treatment code. For elective abortions, the physician must specify in writing the physical condition of the patient leading to the professional judgment that the abortion was one of the following:

- Necessary to preserve the life of the pregnant woman
- Due to rape or incest

The documentation must contain the name and address of the member, dates of service, physician's name, and physician's signature. Providers must attach this documentation to the paper claim form or send it separately as an attachment to the electronic claim transaction.

Sterilization

Sterilization procedures are covered if the following requirements are met:

- The member is at least 21 years of age at the time of the informed consent.
- The member is mentally competent and not institutionalized in a correctional facility, mental hospital, or other rehabilitative facility.
- Sterilization is the result of a voluntary request for services by a member legally capable of consenting to such a procedure.
- For a female member, a hysterectomy is only rendered for medical necessity and not for the purpose of family planning, sterilization, hygiene, or mental retardation; the individual must be informed prior to the hysterectomy that she will be permanently incapable of reproducing.
- 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 calendar days before, but not more than 180 calendar days, after the consent is signed, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form).

These requirements are applicable to all sterilizations when the primary intent of the sterilizing procedure is fertility control.

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 that the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Provider Services at **1-833-230-2112**.

Any services rendered in excess of the benefit limits will be denied.

Covered services may require prior authorization. Please visit **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization or the Procedure Code Lookup Tool for the most up-to-date list of services that require prior authorization.

Prior authorization requirements for members enrolled with CareSource are determined and enforced by CareSource.

Medical Necessity Standards and Practice Guidelines

"Medically reasonable and necessary service" is a covered service that is required for the care or well-being of the member and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable, it must:

- Be medically reasonable and necessary, as determined by CareSource, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
- Not be listed as a non-covered service, or otherwise excluded from coverage.

Some services require prior authorization. If a request for authorization is submitted, CareSource will notify the provider and member in writing of the determination. Authorizations can also be requested retroactively in emergencies. For more information about our authorization procedures, see the "Referrals and Prior Authorizations" section in this manual.

If a service cannot be covered, providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Grievances and Appeals" section on page 116 for information on how to file an appeal.

Covered Services Excluded from Medicaid

Broad categories of service, covered by the Nevada Health Coverage Programs (Nevada Medicaid), LTSS and CHIP, but excluded from managed care, are payable as fee-for-service (FFS) claims by the State fiscal agent. If a CareSource member becomes eligible for any of these services, the member is disenrolled from Medicaid managed care. Excluded services include the following:

- **Long-term institutional care:** Members requiring long-term care in a nursing facility or intermediate care facility (ICF) for members with intellectual and developmental disabilities must be disenrolled from the Medicaid programs and converted to fee- for-service eligibility in the Nevada Medicaid. Before the nursing facility can be reimbursed by the Nevada Medicaid for the care provided, the nursing facility must request a Pre-

Admission Screening Resident Review (PASRR) for nursing facility placement. The State must then approve the PASRR request, designate the appropriate level of care in CoreMMIS, and disenroll the member from Medicaid. CareSource coordinates care for its members who are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR. CareSource is responsible for payment for up to 60 calendar days for its members placed in long-term care facilities while the level of care determinations are pending. However, CareSource may obtain services for its members in a nursing-facility setting on a short-term basis, such as for fewer than 30 calendar days. This may occur if this setting is more cost-effective than other options, and the member can obtain the care and services needed in the nursing facility. CareSource may negotiate rates for reimbursing the nursing facilities for these short-term stays. Providers are encouraged to immediately contact CareSource for care management and to arrange care for a member needing services outside of their covered benefits.

- **Hospice care:** Medicaid members must be disenrolled from managed care in order to receive hospice care.
- **Home and community-based waiver services:** Home and community-based waiver services are also excluded from the Medicaid. Similar to the situations described previously, members who have been approved for these waiver services must be disenrolled from managed care, and CareSource will coordinate care for its members who are transitioning into a HCBS waiver program until the disenrollment from Medicaid is effective.
- **Psychiatric treatment in a state hospital:** Medicaid members receiving psychiatric treatment in a State hospital are disenrolled from Medicaid.
- **Psychiatric Residential Treatment Facility (PRTF) Services:** Members receiving treatment in a PRTF are not CareSource 's responsibility and will be disenrolled from Medicaid. When the prior authorization vendor enters a PRTF level of care for a Medicaid member, the managed care assignment is automatically end-dated as of the date the PRTF level of care is entered in CoreMMIS. Once the member is discharged from the PRTF and the LOC is end-dated, the auto- assignment process immediately reassigns the member to his or her previous managed care entity (MCE) with an effective date of the 15th of the month for discharges occurring on day one through day 14 of the month; or effective the first day of the following month for discharges that occur on day 15 through the last day of the month.

CareSource members who qualify for long-term institutional care, hospice care or waiver services are disenrolled from their Medicaid managed care plans. CareSource must note that it is possible for a member's IPAS/PASRR process to be under way (but not complete) when the member is linked to an MCE. In this situation, the financial responsibility lies with CareSource for no more than 60 days. Care management at CareSource will facilitate coverage and treatment for the member until the change is made to ensure continuity of coverage.

Member Support Services and Benefits

CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive

health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

CareSource Member Services

Representatives are available by telephone Monday through Friday, except on certain holidays.

Please visit **CareSource.com** > About Us > Contact Us for the holiday schedule or contact Provider Services for more information.

Members access Member Services by calling our toll-free number at 1-833-230-2058, 8 a.m. to 6 p.m. PT, and telling our interactive voice response system (IVR) what their question is regarding.

24-Hour Nurse Advice Line

For Physical and Behavioral Health Services

Members can call our nurse advice line 24-hours a day, seven days a week. With our 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 gave.

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 anytime night or day. The phone number is on the member's ID card.

Behavioral Health Crisis and 988 Suicide & Crisis Lifeline

CareSource contracts with the State of Nevada's designated behavioral health crisis line which provides members with a service that is available 24 hours a day, seven days a week, every day of the year. Members may dial 988 from any phone to obtain immediate access to trained, skilled and licensed behavioral health professionals who provide assistance for any type of behavioral health distress the member may be experiencing.

MyHealth Rewards

CareSource offers MyHealth Rewards for members over the age of 18 who actively participate in healthy behaviors. The program encourages the member to complete healthy activities, including: cervical cancer screening, breast cancer screening, colorectal screening, annual flu shot, prenatal and post-partum visits and more.

Members can redeem their rewards through the MyHealth website for a variety of gift cards to national retailers such as iTunes, Google Play, TJ Maxx, Sephora, Old Navy, Panera Bread and more. Members can access MyHealth via our website at MyLife.CareSource Health.com.

Members are automatically enrolled in MyHealth Rewards.

Rewardable Program Activity	Frequency/Period	Amount Earned Per Completion	Maximum Earning Per Reward	Population
Cervical Cancer Screening	1 time/calendar year	$20	$20	Females (18-64 years old)
Breast Cancer Screening	1 time/calendar year	$25	$25	Females (40-64 years old)
Colorectal Screening	1 time/calendar year	$15	$15	All adult members (18-125 years old)
Annual Flu Shot	1 time/calendar year	$25	$25	All adult members (18-125 years old)
Diabetes – Kidney Health Evaluation	1 time/calendar year	$10	$10	All adults diagnosed with diabetes (18-125 years old)
Diabetes – Retinal Exam	1 time/calendar year	$25	$25	All adults diagnosed with diabetes (18-125 years old)
Tobacco Cessation Incentive	1 time/calendar year	$25	$25	All adults (18-125 years old)
Early Prenatal Care Initiative	1 time/pregnancy	$30	$30	Pregnant families (18-54 years old)

Postpartum	1 time/pregnancy	$50	$50	New mothers (18-54 years old)
Syphilis Screening	1 time/calendar year	$20	$20	Pregnant females (18-54 years old)
Health Needs Assessment (HNA)	1 time/calendar year	$25	$25	All adults (18-125 years old)

Rewards are subject to change. Rewards vary by age, gender and health needs. If someone is no longer a CareSource member, they lose access to their rewards. Rewards that aren't redeemed will expire in mid-December following the year the reward was issued.

MyResources

The MyResources search engine is a social service and community resource search tool. The MyResources Tool connects members with local low-cost and no cost community-based programs and social services. The tool is easy to use and allows our staff and members to search for a wide category of resources like food, housing, transportation and job training programs by simply entering a zip code from anywhere in the United States.

The search information is provided in real time, including 8 a.m. to 7 p.m. Monday through Friday, distance from the zip code entered, and other locations nearby. More than 100 languages are supported, and resources can be updated and new resources suggested directly from the site. Other features include the ability to send a resource to a friend via email or text.

Members can log into their MyLife account to learn more or call CareSource Member Services at 1-833-230-2058 (TTY: 711).

Health Needs Assessment

CareSource asks that all members complete the risk assessment tool, Health Needs Assessment (HNA). Through a few questions about their health and well-being CareSource can help identify health, housing, education and employment concerns where we may be able to help.

CareSource wants members to take a HNA when they join CareSource and each year after. Members answer questions about their health and habits. This tool helps identify members' health needs. It shows CareSource how they can help members get and stay healthier.

Completing the HNA is simple! Members can complete the HNA in one of the following ways:

- Call our Member Assessment Team at **1-833-230-2011 (TTY: 711)** Monday through Friday, 8 a.m. to 5 p.m. PT.
- Visit MyLife.CareSource.com/Assess.

Members 18 and older can earn a $25 reward when they complete the HNA through the CareSourceMyLife App.

Care Management/Outreach

CareSource provides care management services utilizing medical and behavioral health nurses, social workers, and community health workers 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 treatment adherence, 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.

You can refer a member to Care Management by calling Provider Services at **1-833-230-2112**. Providers can also make referrals to care management on behalf of the member by submitting the request in the Provider Portal.

Role of the Care Manager

Each one of our members is assigned a Care Manager. Members can call member services at 1-833-230-2058 to find out more information and to get the contact information for their Care Manager. The role of the Care Manager includes:

- Licensed health care professional
- Coordinates member's health care needs
- Coordinates development of member's care plan
- Ensures care plan is using member's available benefits and resources
- Connect member with community support services
- Assist members in accessing support to address health-related social needs (HRSN)
- Assist member in completing Health Needs Assessment
- Assist member in closing gaps in care
- Assist with transitions of member's care
- Remove barriers

Care Management Services

CareSource's Care Management program is designed to support the care and treatment you provide and recommend to your patient. We stress the importance of establishment of the medical home, identification of barriers and keeping appointments. We can assist in arranging transportation to the provider's office. One-on-one personal interaction with community health workers and professional case managers helps provide a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote self-management and healthy lifestyle decisions.

In addition, we help connect your patient with additional needed community resources, such as assistance with housing and food. CareSource encourages you to take an active role in your patient's care management program through the Patient Profile feature on the Provider Portal. This profile provides member-specific information on pharmacy, inpatient 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.

We invite and encourage you to direct and provide input into patient assessment activity and participate in the development and monitoring of a care treatment plan individualized to the needs of your patient. We believe communication, coordination, and collaboration are integral to ensure the best care for your patients.

We offer individualized education and support for many conditions and needs, including:

- High risk pregnancy and complex newborns
- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Depression
- Special health care needs
- Serious mental illness (SMI)

Care Management of High-Risk Members

CareSource applies a particular community-based management model for our high-risk members. Utilizing nurses, social workers and community health workers, this multi-disciplinary approach integrates the Case Management Society of America (CMSA) Standards of Practice into key processes to help ensure implementation of a best-practice program. Community health workers help patients overcome health care access barriers and strengthen our provider and community resource partnerships through collaboration.

Our services include meetings with our most at-risk members. Typical high-risk members served by this model may have multiple medical issues, socioeconomic challenges and behavioral health care needs. Care coordination efforts may include:

- Care transition planning
- Identifying gaps in care and collaborating with the care team to close gaps
- Facilitating member access to appropriate care and services
- Providing referrals to appropriate medical, behavioral, social and community resources to address identified member needs
- Coordinating planned interventions, driven by a care coordination plan, consistent with evidence-based clinical guidelines

CareSource encourages you to take an active role in your patients' care management programs and participate in assessment activities and development of individualized care plans to help meet their needs. Together, we can make a difference.

Transitions of Care (TOC) Planning

When care transitions occur, CareSource identifies members who require assistance as they transition from an inpatient stay. Our team works with members and their families to coordinate care needs and make the transition to home or a lower level of care as successful as possible.

Our Transitions of Care (TOC) program has focused outreach and discharge planning activities based on the Coleman Model, utilizing a team approach to coordinate post-discharge care needs for members at risk for readmission. Through these efforts, we strive to empower and educate members to help ensure all components of the member's discharge plan are in place.

When an at-risk member is discharged from an inpatient stay, our TOC team reaches out to ensure the member has a clear path to recovery, free from barriers to care. We can coordinate home care and medical equipment needs, assist with obtaining prescribed medications and coordinate other medical care and services as needed.

We believe in the importance of partnership. That is why we collaborate with PCPs to provide our members with the services they need along the continuum of care.

Mom and Baby Beginnings and NICU Care Management

CareSource's maternity and neonatal care management program employs a multi-disciplinary team with extensive expertise in obstetrics and neonatal intensive care (OB/NICU). Our dedicated team includes nurses, nurse practitioners, social workers, behavioral health specialists, and lactation consultants, al specializing in maternity and NICU care.

Specialized nurses are available to support pregnant members and medically complex newborns by collaborating closely with both providers and families. Our staff's expertise emphasizes patient education and care coordination, ensuring direct communication with members and health care providers.

All pregnant members receive educational materials and ongoing support throughout their pregnancy and the fourth trimester. For those with high-risk pregnancies, we offer enhanced support that addresses physical health, behavioral health and health related social needs (HRSN). Members in care management benefit from personalized perinatal education throughout their pregnancy and postpartum period.

Notification of Pregnancy

We encourage our prenatal care providers to notify our Care Management department by phone at 1-833-230-2067 or by fax at 844-839-6395 when a pregnant member has been identified. Prenatal care providers are encouraged to electronically complete the Notification of Pregnancy (NOP) risk assessment. The submitted information will be used by CareSource to determine the member's health risk during her pregnancy and the level of care coordination needed.

Disease Management Program

Our free Disease Management Program helps our members find a path to better health through information, resources, and support.

We help our members through:

- The MyHealth online platform to provide members 18+ with health education and self-management tools (called Journeys) to help manage chronic conditions and improve their overall health.
- Educational materials with helpful tips and information to manage their disease, promote self-management skills, and provide additional resources.
- Coordination with outreach teams such as wellness advocates and health coaches
- One-to-one care management (if qualify)

Members with specific disease conditions are identified by criteria or triggers such as emergency room visits, hospital admissions, and the health assessment. All ages (children, teens, and adults) are eligible. These members are automatically enrolled in the program and sent reminders to encourage them to access the health and wellness platforms and education content available in the MyLife App. Any member may self-refer or be referred into the disease management program to receive condition-specific information or outreach. If a member does not wish to receive reminder notifications or outreach, they can contact CareSource to update their contact preferences.

Disease Management Benefits to Members and Providers

Members identified in the 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. The program improves the percentage of CareSource members who receive their recommended screenings.

If you have a patient with a chronic condition who you believe would benefit from this program and are not currently enrolled, please call Care Management at 1-844-206-5948.

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 department (ED) if they feel they have an emergency. CareSource covers all emergency services for our members.

We instruct members to call their PCP or the Nurse Advice Line if they are unsure if they need to go to an ED. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access.

Member ED utilization is tracked closely. If there is frequent ED 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.

Tobacco Cessation

CareSource would like to remind providers of resources available for tobacco cessation to help members maintain a healthy lifestyle. This includes not using tobacco products as well as prevention. The tobacco cessation program includes:

- Referrals and member participation in the Nevada Tobacco Quitline.
- Promoting the availability of behavioral counseling.
- CareSource does not limit tobacco dependence counseling.
- Informing members on how to obtain prescribed medications from their providers for assistance with quitting. There are no coverage limits for pharmacotherapy for Medicaid members.
- Member incentive rewards annually for participating in tobacco cessation activities.

Links to resources to assist members are available for providers at: **CareSource.com** > Provider Overview > Tools and Resources > Quick Reference Materials.

CareSource offers providers enhanced reimbursement when rendering tobacco dependence counseling to members identified as using tobacco or tobacco related products. As a reminder, providers may prescribe one or more treatment modalities. Any combination of treatment must include counseling.

Weight Loss

CareSource believes that physical fitness and exercise benefits the overall well-being of its members. Members who complete an annual physical can obtain access to Fitness on Demand (FOD), an online world-class digital fitness solution that matches every lifestyle and space. This benefit is available to members 18 and older who have completed an annual well visit.

Interpreter Services

Non-Hospital Providers

CareSource offers sign and other language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. We can also provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. 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 patients and offer assistance to them appropriately. Providers who have 24-hour access to health care-related services in their service area or via telephone must provide members with 24-hour language interpreter services, either through in-person or telephone interpreter services. To arrange services, please contact our Provider Services department at **1-833-230-2112**. To request a sign language interpreter, five business days' notice is needed before the scheduled appointment while any other language interpreter services require four business days' notice before the scheduled appointment. 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.

Hospital Providers

CareSource requires hospitals, at their own expense, to offer sign and other language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. We can provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services should be available at no cost to the member. You are also required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. If you do not have access to interpreter services, contact Provider Services at **1-833-230-2112**. 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.

School-Based Clinics Providing Care

CareSource is committed to helping providers manage the complex needs of our members who receive Nevada Health Coverage Program (Nevada Medicaid)-covered services as part of an individualized education plan (IEP). All claims for services provided to Medicaid members as part of an IEP that are billed by provider specialty (Provider Type – PT 60-School Based) 120-school corporation should be submitted as a fee-for-service claim to the State of Nevada.

CareSource is also committed to supporting care coordination efforts between school-based clinics and our members' PCPs. CareSource will coordinate health care services with schools to ensure continuity of care and avoid duplication of services for clients with individualized education plan (IEP) services. We will work collaboratively with the school-based clinic or in partnership with the school nurse to ensure that the member can access needed services. We will participate in the planning and the evaluation of services as appropriate and necessary. CareSource has a strong history of working with schools and school-based providers, and we will use this experience to assure proper coordination of services for our members with an IEP as well.

We ask school-based clinics to complete the risk assessment form found on the Provider Portal to communicate critical information to us about our members. In turn, participating providers receive payment for submission of each risk assessment form. Payment is made according to the Medicaid fee schedule and your provider agreement with CareSource.

Medicaid Transportation

Members in our Medicaid programs have ride benefits, including an option for mileage reimbursement. All Medicaid members can access an unlimited number of non-emergency rides for covered health care visits throughout the year, without the need for prior authorizations. Additionally, Medicaid members have access to non-emergency transportation with respect to the following:

- Unlimited rides to the pharmacy after their visit with the doctor and five additional trips to the pharmacy per month when they have not just visited with their doctor
- Unlimited rides to the local Women, Infants and Children (WIC) office
- Unlimited rides to Medicaid Enrollment events
- Unlimited rides to CareSource events
- Must be enrolled in CareSource Life Services Program which provides 12 round trips a year
- Rides to pick up food from the food pantry or curb-side food pick up from a grocery store (five round trips/month)
- Free five round trip transportation monthly for members and caregivers to grocery, community events, WIC, CareSource-sponsored events and religious events.

Members are directed to please call **1-833-230-2058** (TTY: 711) for a ride at least three days before their visit. Our ride benefit is provided through a transportation vendor. They also support the mileage reimbursement option. Members can call us if they have a ride concern or issue. Members are directed to please call 911 or go directly to the nearest ED if they have an emergency.

CareSource will serve the rural populations with SafeRide and providing the non-emergency medical transportation (NEMT) and value-added benefits. Members who live in urban zip codes (i.e., Las Vegas or Reno) will be using MTM for their transportation benefits which is supported by the state.

Transportation Policy

Please look carefully at the list below to understand member responsibilities. These rules will help make rides safer and quicker.

Rides should be easy and enjoyable. Drivers are trained to treat riders with respect and to think of their needs. Members are expected to treat the driver in the way they wish to be treated. Members are asked to follow these steps:

- Call to arrange non-emergency ride three business days in advance. (Saturday, Sunday, and holidays are not business days).
- Be able to provide the complete address, phone number, and who they will be seeing at the doctor’s office.

- Be at the pick-up address. Be there at the earliest time given to the member by the transportation service.
- To cancel their ride, they should call at least 24 hours before their pick-up time.
- When their visit is finished, they should call the transportation company for their return trip.

No Show

Members need to be ready for their pickup. They should be there at the beginning of their pick-up time. The transportation company can only wait 15 minutes before a member will be marked as a no show. If a member cannot keep their appointment, they must call the transportation company as soon as possible.

What is a No Show?

- A member is not at the pick-up location
- A member cannot be seen at the pick-up location
- A member is not on-time at the pick-up location

The driver will wait 15 minutes, then will leave. If members have any questions, they are asked to call Member Services.

Telehealth/Telemedicine

Telehealth technology makes health care more accessible, cost-effective, and can increase patient engagement. CareSource wants to support your telehealth program by covering select telehealth services you provide to our members. If you do not have a telehealth program or if you need help servicing your patients during busy times, CareSource has partnered with Teladoc® to offer the convenience of telehealth to our Nevada Medicaid members. General medical services are available to all Nevada Medicaid members, and mental health services are available for members 18 years and older.

How Providers Access Services

- Providers will notify their CareSource Market Health Partner that they would like to offer telehealth services via Teladoc's Core Platform.
- CareSource will use basic provider information to update a roster file with necessary data that will be shared with Teladoc.
- Once the required provider information is populated on the roster, the roster file will be sent to Teladoc.
- The roster file will be ingested by Teladoc, who will then set up the requested provider account.
- Teladoc's training team will send training details to the provider via email with information on how to access and utilize the platform.
- Once the provider has completed the required trainings, Teladoc will then send the provider their unique log in credentials and enable access to the Core Platform.
- Provider will log-in using the credentials sent by Teladoc (*user will be required to change the password at first log-in).
- Provider will then have access to the Teladoc Core Platform to begin completing scheduled telehealth consultations.

Telemedicine Requirements for Providers

Telehealth technology makes health care more accessible, cost-effective and can increase patient engagement. CareSource wants to support your telehealth program by covering select telehealth services you provide to our members. If you do not have a telehealth program or if you need help servicing your patients during busy times, CareSource has partnered with Teladoc® to provide the convenience of telemedicine to all of our members over the age of two.

Teladoc physicians can consult, diagnose and also prescribe medications when appropriate (DEA-controlled substances excluded) and provide treatment for non-emergency conditions like allergies, asthma, sore throat, cold and flu, ear infection, pink eye, UTI, skin inflammation, join aches and pains and sinus infections.

CareSource will continue to encourage our members to engage with their PCP first, but much like using retail clinics or urgent care as a way to meet medical needs, we are providing another access point through Teladoc.

Members can connect to Teladoc by:

- Downloading the Teladoc app to a smart phone
- Visiting http://www.teladoc.com/CareSource
- Calling 1-800-Teladoc (1-800-835-2362)

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 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 interactive guides

All of the tools are accessible via web or mobile.

Consent Form Requirements

Per Nevada requirements, information about SUD treatment and HIV/AIDS should only be released if you have obtained member consent.

Advanced Directives

An advance directive is a written instruction, such as a living will or durable power of attorney for health care including mental health, recognized under Nevada law, relating to the provision of health care when a member is incapacitated.

Providers delivering medical care to CareSource members must ensure all adult CareSource members 18 years of age and older receive information on advance directives and are informed of their rights to execute advance directives. Information regarding advance directives should be made available in provider's offices and discussed with CareSource members or provider's staff when questions arise.

Providers should discuss advance directives with adult CareSource members during the member's initial office visit and document in the member's medical record whether or not the member has executed an advance directive.

Providers delivering medical care to CareSource members shall not, as a condition of treatment, require a member to execute or waive an advance directive. In addition, providers shall not discriminate against CareSource members based on whether or not the member has executed an advance directive.

Member Grievance and Appeals

The grievance process allows the member, or the member's authorized representative acting on behalf of the member (or provider acting on the member's behalf with the member's written consent) to file a grievance either orally or in writing. A grievance is defined as an expression of dissatisfaction about any matter other than an "adverse action."

Grievances may be filed at any time. Grievances are acknowledged within three business days and resolved within45 calendar days. Grievances can be submitted in writing or via the Provider Portal.

If you have any questions or concerns, please contact Provider Services at **1-833-230-2112** speak with your Provider Engagement Representative.

Member Grievances

Members have the right to file a grievance or appeal and request a State Hearing or a review by an Independent Review Organization of a decision made by CareSource. As a CareSource provider, we may contact you to obtain documentation when a member has filed a request for one of these reviews. CareSource does not retaliate or discriminate against any member or provider for utilizing the grievance and appeals process.

Members are encouraged to call or write to CareSource to let us know of any complaints regarding CareSource or the health care services they receive. Members or providers, when designated as the authorized representative by the member and with member consent, may file a grievance or appeal with CareSource. Detailed grievance and appeal procedures are explained in the Member Handbook. Members can contact CareSource at **1-833-230-2058** (TTY: 711) to learn more about these procedures. Members must exhaust CareSource 's

internal appeals process before requesting an external review by an independent review organization or a State Fair Hearing. Grievances are not eligible for a State Fair Hearing.

Time Frames and Requirements

The member can file a grievance at any time CareSource responds to member grievances within 45 calendar days of the receipt of the request and provider grievances within 90 calendar days of the receipt with notice of extension every 30 days. This period may be extended up to 14 calendar days if resolution of the matter requires additional time. A letter notifying the member of this extension is required.

Member Appeals

CareSource notifies members in writing when we:

- Deny or limit authorization of a requested service, including the type or level of service.
- Reduce, suspend or terminate services prior to the member receiving the services previously authorized.
- Deny, in whole or part, of payment for a service.
- Fail to provide services in a timely manner.
- Fail to act within the resolution time frame.

Members have the right to appeal the actions listed in the letter if they contact CareSource within 60 calendar days from the date of the denial letter. CareSource will respond to the appeal in writing within three calendar days and resolve the appeal within 30 calendar days of when it was received. This period may be extended up to 14 calendar days if resolution of the matter requires additional time. CareSource must give the member written notice of the reason for the extension.

If the amount of time necessary to resolve a standard appeal could jeopardize the member's life, health or ability to attain, maintain or regain maximum function, the member may request an expedited appeal. If the request meets the expedited criteria, CareSource will resolve the appeal as quickly as possible, not exceeding 72 hours after receipt of the request. CareSource will review the request and determine if the request meets the expedited criteria, if the expedited request is denied, CareSource must:

- Transfer the request to a standard appeal for resolution of 30 calendar days.
- Make a reasonable effort (one (1) outreach attempt) to give the member prompt oral notice and follow up within two calendar days with a written notice of the decision.

State External Review by Independent Review Organization and State Hearings

CareSource members can request an external review and/or State Fair Hearing after they have exhausted all CareSource 's internal appeals process. The member or a member's representative must submit the request, with member consent, in writing within four months from the date of the appeal decision for a State External Review. The member or a member's representative must submit the request, with member consent, in writing within 90 calendar days from the date of the appeal decision for a State Fair Hearing. To request an external review the member can write to the Office of Consumer Health Assistance at:

Office of Consumer Health Assistance
3320 W. Sahara Avenue
Suite 100
Las Vegas, NV 89102
Phone: 1-702-486-3587 or 1-888-333-1597
Fax: 702-486-3586
Web: http://dhhs.nv.gov/Programs/CHA/

You can ask for a Fair Hearing in writing by:

Nevada Medicaid Hearings Unit
4070 Silver Sage Drive
Carson City, NV 89701
Phone: 1-877-638-3472 or 1-775-684-3600
Fax: 775-684-3610
Email: dhcfphearings@dhcfp.nv.gov

Continuation of benefits while the appeal and the State Fair Hearing are pending:

In certain member appeals, CareSource is required to continue the member's benefits pending the appeal, in accordance with 42 CFR 438.420. Members may be required to pay the cost of services provided while the appeal or state hearing is pending.

Provider Appeals Procedure

If you are dissatisfied with a determination made by our Utilization Management department regarding a member's health care services or benefits, you may appeal the decision. Please see the "Appeal Procedures" section in this manual for information on how to file a clinical appeal.

Please Note: If you are appealing on our member's behalf with their written consent, you have 60 calendar days from the date of the action notice.

Provider Claim Disputes

Providers may file grievances related to members, other providers, or operational issues of the plan. CareSource will thoroughly investigate each provider complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying the CareSource written policies and procedures.

Claim Dispute Process for Participating and Non-Participating Providers:

If you believe the claim was processed incorrectly due to incomplete, incorrect, or unclear information on the claim, you should submit a corrected claim. You do not need to file a dispute.

Process for claim disputes for participating and nonparticipating providers:

- Claim disputes must be submitted using one of the methods below:
    - Provider Portal: The Provider Portal is the preferred method of submission to ensure timely receipt and resolution of the dispute. Under the portal, click "Claims" tab on the left, select "Dispute".

    - In writing, by submitting the claim dispute form by mail:
        - Mail:
            Claim Disputes Department
            P.O. Box
            2008 Dayton, OH 45401
- The dispute must be submitted within 60 calendar days of the explanation of payment (EOP).

If CareSource fails to decision a claim within 30 days after receipt, an appeal may be submitted.

Appeals for Participating and Non-Participating Providers:

Pre-service authorization denials, based on medical necessity review, can be appealed with member written consent from the date of the action notice. Pre-authorization denials must be within 60 days from the date of the action notice.

If you are submitting a timely filing dispute, you must send proof of original receipt of the claim by fax or Electronic Data Information (EDI) for reconsideration.

For additional information, contact Provider Services at **1-833-230-2112**.

CareSource Member Rights and 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 list of our 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, as stated in the Member Handbook, are as follows:

- To receive information about CareSource, its services, its practitioners and providers, providing care, and member rights and responsibilities.
- To receive all services that CareSource must provide.
- To be treated with respect and with regard for their dignity and privacy.
- To ensure medical records and personal information will be kept private.
- To be given information about their health. This information may also be available to someone who the member has legally authorized to have the information or whom the member has said should be reached in an emergency when it is not in the best interest of the member's health to give it to him/her.
- To discuss any appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- To participate in decisions regarding his or her health care, including the right to refuse treatment.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- To be sure that others cannot hear or see the member when he/she is 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 request and receive a copy of his or her medical records and request to amend or correct the record.
- To be able to say “yes” or “no” to having any information about himself/herself given out unless CareSource has to by law.
- To be able to say “no” to treatment or therapy. If the member says “no”, the doctor or CareSource must talk to him/her about what could happen, and a note must be placed in the member’s medical record about the treatment refusal.
- To be able to file an appeal, a grievance (complaint) or state hearing about CareSource or the care it provides.
- To be able to get all CareSource written member information from CareSource:
    - At no cost to the member
    - In the prevalent non-English languages of members in CareSource ’s service area
    - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from CareSource and its providers if the member does not speak English or needs help in understanding information.
- To be able to get help with sign language if the member is 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 freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated.
- To know that CareSource must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives the member care whenever possible and appropriate with the ability to seek care from an out of network provider when the necessary covered medical services are not available within 60-miles of the member’s residence.
- To be able to choose primary care practitioners, including specialists as their PCP if the member has a chronic condition, within the limits of the network, including the right to refuse care from specific practitioners.
- To be able to get a second opinion from a qualified provider on CareSource’s panel. If a qualified provider is not able to see the member, CareSource must set up a visit with a provider not on its panel.
- To pursue resolution of grievances and appeals about the contractor or care providers.
- To formulate advance directives.
- To not be held liable for the supplier’s debts in the event of insolvency.
- To not be held liable for the covered services provided to the member for which Nevada Medicaid does not pay the supplier.
- To not be held liable for covered services provided to the member for which Nevada Medicaid or CareSource does not pay the health care provider that furnishes the services.

- To not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the supplier provided the services directly.
- To be responsible for cost sharing.
- To not be billed for any service covered by Medicaid.
- To make recommendations regarding CareSource's member rights and responsibility policy.
- To contact the United States Department of Health and Human Services Office of Civil Rights using the information below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services:

  Office of Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  Phone: 1-800-368-1019

Members of CareSource are also informed of the following responsibilities:

- Use only approved providers.
- Keep scheduled doctor appointments, be on time and call 24 hours in advance of a cancellation.
- Follow the advice and instructions for care they have agreed upon with his/her doctors and other health care providers.
- Always carry his/her ID card and present it when receiving services.
- Never let anyone else use his/her ID card.
- Notify his/her county Department of Family Resources (DFR) and CareSource of a change in phone number or address.
- Contact his/her PCP (Primary Care Provider) after going to an urgent care center or after getting medical care outside of CareSource's covered counties or service area.
- Let CareSource and the county DFR know if he/she has other health insurance coverage.
- Provide the information that CareSource and his/her providers need in order to provide care.
- Understand as much as possible about his/her health issues and take part in reaching goals that the member and his/her providers agree upon.
- Let us know if he/she suspects fraud, waste or abuse.

HIPAA Notice of Privacy Practices

Members are notified of CareSource 's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (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 how they may obtain a statement of disclosures or request their medical claim information. CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members.

As a provider/covered entity, please remember that you are obligated to follow the same HIPAA regulations as CareSource and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations. Thank you for your assistance in providing requested information to CareSource in a timely manner.

Please remember that 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 care management and care coordination, among others. Thank you for your assistance in providing requested information to CareSource in a timely manner.

When a patient has a sensitive health diagnosis (e.g., treatment for drug/alcohol use, genetic testing, HIV/AIDS, 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 of 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.

Americans with Disabilities Act

The Americans with Disabilities Act (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.

Quality Improvement Program

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 Program is comprehensive, inclusive of both clinical and non-clinical services, and health, safety, and/or welfare concerns. CareSource objectively and systematically monitors and evaluates the quality and safety of the care and service delivered to our members emphasizing:

- Accessibility and availability to medical, behavioral health and other care

- Equitable delivery of service
- Quality of care and member safety
- Internal monitoring, review, and evaluation of program areas, including but not limited to, Utilization Management, Care Management and Pharmacy

Member and provider satisfaction and health outcomes are monitored through:

- Quality improvement activities
- Routine health plan reporting
- Annual Health Effectiveness Data and Information Set (HEDIS®)—data collection and reporting
- Annual administration and analysis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)—measures patient experience with the health care system
- Member feedback captured via surveys, inclusion in surveys and advisory workgroups
- Review of accessibility and availability standards
- Utilization trends
- EPSDT utilization
- In lieu of services utilization

CareSource assesses our performance against goals and objectives that are in keeping with industry standards and State of Nevada Quality Strategy targets. Annually, we complete an evaluation of our QI Program. We submit the evaluation which includes identified priority areas for improvement and the degree to which improvement was achieved for each priority.

Accreditation
CareSource will be pursuing Health Plan Accreditation and Health Equity Accreditation by the National Committee for Quality Assurance (NCQA) for our Medicaid plan. NCQA is a private, nonprofit organization dedicated to improving health care quality and health equity through measurement, transparency and accountability. Achieving accreditation indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection, quality improvement and health equity. Visit www.NCQA.org for more information.

Program Purpose

The purpose of the QI Program, which is documented in CareSource's Quality Improvement Plan, is to ensure that CareSource Nevada has the necessary infrastructure to:

- Coordinate member care and services to improve health outcomes
- Promote the use of evidence-based best practices for the treatment of member health conditions
- Ensure high performing and efficient systems for delivery of care
- Address the health, safety, and welfare concerns of CareSource members and implement appropriate interventions

The Quality Improvement Plan is revised as needed:

- To remain responsive to member needs
- Based on feedback received from our providers and other health partners

- In response to changes in nationally recognized practice standards and evidence-based research
- To meet CareSource business needs

Program Scope

CareSource supports an active, ongoing and comprehensive quality improvement program across the organization. Performance goals are developed to measure the components of our program, including performance against national benchmarks.

CareSource uses HEDIS as one method to determine the quality of care delivered to members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS data collection and reporting is developed and maintained by NCQA. HEDIS 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 research and address significant health priorities in the United States.

CareSource uses the annual member survey, Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS), to capture how a member views the quality of health care received. CAHPS is a survey overseen by the United States Department of Health and Human Services–Agency for Healthcare Research and Quality (AHRQ). Potential CAHPS measures include:

- Helpful and courteous customer service
- Getting care quickly, for example, getting timely care for an illness or an injury
- Ease of access in obtaining needed care
- Providers' ability to communicate and show respect to member
- Ratings of all health care, health plan, personal, doctor, and specialists

The CareSource Quality Improvement Program oversees quality assessment and performance improvement activities for our Nevada Medicaid and Check Up members to maintain a robust QI Program, our scope includes:

- Advance health access and opportunity related issue including reduction of barriers to care and health related social needs
- Ensure regulatory and accrediting agency compliance, including:
    - All federal requirements as outlined by CMS and in 42 CFR Part 438, Managed Care
    - Perform HEDIS® compliance audit and performance measurement.
    - Ensure compliance with NCQA accreditation standards.
- Establish safe clinical practices throughout our network of providers.
- Provide quality oversight of all clinical services, including addressing all quality-of-care concerns.
- Advocate for members across settings, including review and resolution of quality-of-care concerns.
- Meet member access and availability needs for physical and behavioral health care.

- Using interventions for HEDIS® overall rate improvement to increase preventive care rates and facilitate support of member acute and chronic health conditions and other complex health, safety, or welfare needs.
- CareSource uses the annual member CAHPS® survey and other enrollee experience surveys to assess member perspectives on health care quality and establishes interventions based on results to enrich member and provider experience and satisfaction.
- The use the Institute for Healthcare Improvement (IHI) model for improvement methodologies and Six Sigma, where appropriate, to evaluate initiatives and effect change.
- Ensure CareSource is effectively serving our members with cultural and linguistic needs, as well as identified risks related to health-related social needs that may impact member receipt of health care services and achieving positive member outcomes.
- Monitor important aspects of care to ensure the health, safety and welfare of members across health care settings and ensure that CareSource is effectively serving members with complex health needs.
- Ongoing assessment of member population health characteristics.
- Regularly assess the geographic availability and accessibility of primary and specialty care providers.
- Partner collaboratively with network providers, practitioners, regulatory agencies and community agencies.
- Conduct regular Provider Satisfaction Survey with results driving improvement initiatives and education development.

Our commitment to the Quality Improvement Program is aligned with the Nevada Health Improvement Plan which sets goals for Nevada's public health system.

Medicaid Initiatives

CareSource performs detailed population assessments when analyzing our members' needs. We aggregate both internal and external data sources including HEDIS, census, access data, and utilization data points to develop a robust understanding. We further segment our member populations to tailor our initiatives to address specific subpopulation needs.

Sample initiatives include addressing these are of need:

Healthy Children & Adults:

- Improvements in children and adolescents' well-care
- Improvements in childhood immunization status – Combination 10
- Completion of health needs screen (> 70%)
- Lead screening in children
- Asthma medication ratio

Women and Infant Health:

- Prenatal and postpartum depression screening in pregnant members
- Pregnancy Coordination

Behavioral Health:

- Follow-up after Emergency Department (ED) Visit for Substance Use
- Antidepressant Medication Management

Chronic Physical & Developmental Conditions:

- Eye Exam for Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes

Quality Strategy

CareSource seeks to advance a culture of quality and safety that begins with our executive and 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 State of Nevada DHCFP Quality Strategy 2025-2027, which provides a framework for implementing a coordinated and comprehensive system to drive improvements in access to care, health outcomes and member satisfaction.

The Institute for Healthcare Improvement Quintuple Aim for Populations

CareSource aligns with the IHI framework to:

- Enhance the experience and outcomes of the member
- Improve the health of populations
- Reduce the per capita cost of health care
- Improve provider satisfaction
- Advance health access and opportunities

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

Centers for Medicaid & Medicare Services National Quality Strategy

CareSource aligns with the CMS National Quality Strategy to optimize health outcomes by leading clinical quality improvement and health system transformation. The CMS Quality Strategy vision for improving health care delivery can be summed up in three words: better, smarter, healthier.

The strategy corresponds to the six priorities of the Agency for Healthcare Research & Quality's National Quality Strategy. Each of these priorities is a goal in the CMS Quality Strategy:

- Make care safer by reducing harm caused while care is delivered
    - Improve support for a culture of safety
    - Reduce inappropriate and unnecessary care
    - Prevent or minimize harm in all settings
- Help patients and their families be involved as partners in their care
- Promote effective communication and coordination of care
- Promote effective prevention and treatment of chronic disease
- Work with communities to help people live healthily
- Make care affordable

Quality Measures

CareSource adheres to the following quality measures as part of our QI Program:

- Achieve and maintain National Committee for Quality Assurance (NCQA) accreditation
- Ensure compliance with NCQA accreditation standards
- Receive scores on Healthcare Effectiveness Data and Information Set (HEDIS) that reflect a high level of performance
- Receive scores on Consumer Assessment of Healthcare Providers and Systems (CAHPS) that reflect a high level of performance
- Develop and maintain a comprehensive population health management program
- Develop and maintain a comprehensive provider engagement program
- Ensure CareSource is meeting all state requirements for a quality improvement and management program

CareSource continually assesses and analyzes the quality of care and services provided to our members, through the use of objective and systematic monitoring and implementation of quality improvement initiatives.

Member Health, Safety & Welfare

CareSource recognizes that patient safety is the cornerstone of high-quality health care, contributing to the overall health and welfare of our members. Our Patient Safety Program evaluates patient safety trends with the goal of reducing avoidable harm. The 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 risks can be identified in a timely manner, reviewed and mitigated by a proactive corrective action, or performance improvement steps.

Quality of Care Reviews

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

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

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 time frame 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.

Clinical Practice Guidelines & Preventive Guidelines

CareSource approves and adopts evidence-based nationally recognized standards and guidelines and promotes them to practitioners 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 needed 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 and Quality Enterprise Committee (QEC) are 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)
- Chronic health (e.g., hypertension and diabetes)
- Population health (e.g., obesity and tobacco cessation)

Guidelines may be promoted to providers through one or more of the following: 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 is made available to members via member newsletters, the CareSource member website, or upon request.

If you would like more information on our Quality Management and Improvement Program, please visit **CareSource.com** > Provider Overview > Education > Quality Improvement or call Provider Services at **1-833-230-2112**.

Access 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 have procedures in place to see patients within these time frames and to offer 8 a.m. to 7 p.m. Monday through Friday to their CareSource patients that are no less (in number or scope) than the 8 a.m. to 7 p.m. Monday through Friday offered to non-CareSource members. If a provider serves only Medicaid recipients, hours offered to Medicaid members must be comparable to those offered to Medicaid fee-for-service members. In addition, a member's waiting time at a PCP's or specialist's office is no more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency.

Please keep in mind the following access standards for differing levels of care.

Primary Care Providers

Type of Visit	Should be seen…		
	Urban	Rural	Frontier
Emergency needs	Immediately upon presentation		
Urgent Care	Within 48 hours		
Primary Care (adult)	10 business days	15 business days	15 business days
Primary Care (pediatric)	10 business days	15 business days	15 business days

For Primary Care Providers (PCPs) only: Provide 24-hour availability to your CareSource 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.**

Non-Primary Care Providers (Specialists)

Type of Visit	Should be seen…		
	Urban	Rural	Frontier
Emergency needs	Immediately upon presentation		
Urgent Care	Within 48 hours		
Physical, Occupational, or Speech Therapy	15 business days	20 business days	20 business days
Obstetrics/Gynecology, other than prenatal care	10 business days	15 business days	15 business days

Prenatal Care in 1st and 2nd trimester	7 calendar days	10 calendar days	10 calendar days
Prenatal Care in 3rd trimester or for high-risk pregnancies	3 calendar days	5 calendar days	5 calendar days
Home Health, Private Duty Nursing, or Personal Care Services	14 calendar days		

Behavioral Health Providers

Type of Visit	Should be seen…		
	Urban	**Rural**	**Frontier**
Emergency needs	Immediately upon presentation		
Non-life-threatening emergency	Within 6 hours		
Urgent care*	Within 48 hours		
Initial visit for routine care	10 business days		
Follow-up routine care	30 calendar days		
Outpatient Mental Health and SUD Treatment (adult)	10 business days		
Outpatient Mental Health and SUD Treatment (pediatric)	10 business days		

*A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms.

Availability of Services

CareSource is required to provide female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

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. It is expected that a member's waiting time at a PCP's or specialist's office is no more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency.

Services included in the CareSource Medicaid contract must be available 24 hours a day, seven days a week, when medically necessary. Providers may find information about medically necessary services that must be available 24/7 by visiting **CareSource.com** > Tools & Resources > Provider Policies and selecting Nevada Medicaid.

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 medical care providers and behavioral health providers.

Advance written notice of status changes, such as a change in address, phone, or adding or deleting 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.

How to Submit Changes to CareSource

The CareSource Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Provider Portal, entering your login credentials, and selecting Provider Maintenance from the left-hand navigation. You may also use the methods below. If submitting updates by email, mail. Or fax, providers must utilize the HIE form to submit the updates.

Please note any demographic changes must first be updated with Nevada Health Coverages Program (Nevada Medicaid) before submission to CareSource.

Provider Information Change Submission Options	
Provider Portal/Online* **Preferred*	**CareSource.com** > Login > Provider Portal, entering your login credentials, and selecting Provider Maintenance from the left-hand navigation
Email	ProviderMaintenance@CareSource.com
Fax	937-396-3076
Mail	CareSource Attn: Provider Maintenance P.O. Box 8738 Dayton, OH 45401-8738

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 Health and Social Partnerships Commitment

CareSource is dedicated to the communities in which we serve and making a positive impact in the lives of our members by improving members health, removing barriers to care, supporting our organization's health access initiatives, and partnering with community stakeholders to carry out this much needed work.

We recognize language and cultural differences have a significant impact on member health care experience and outcomes. Consistent with federal mandate 42 CFR 438.206 (c) (2), Access and Cultural Considerations, CareSource Network Partners, LLC and its Affiliates, including 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 prohibit our providers or partners from refusing to treat, serve or otherwise discriminate against an individual because of race, color, national origin, disability, age, religion, or sex (which includes discrimination on the basis of sex characteristics, including intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes) marital status, health status, or public assistance status.

In consideration of cultural differences, including religious beliefs and ethical principles, we will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the United States Department of Health and Human Services (HHS).

Cultural Competency

Cultural competency within CareSource is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population.” It is the use of a system’s perspective which values differences and is responsive to diversity at all levels in an organization.

Cultural competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Participating providers are expected to deliver services in a culturally competent manner, which includes removing all language barriers to service and accommodating the unique ethnic, cultural and social needs of the member. 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.

Providers can address racial and ethnic gaps in health care with an awareness of cultural needs and improving communication with their growing numbers of diverse patients. CareSource recognizes cultural differences, including religious beliefs and ethical principles. In accordance with this, providers are not required to perform any treatment or procedure that is contrary to their religious or ethical principles.

We provide links to cultural competency training, as well as to our full Cultural Competency Plan for Nevada, online at **CareSource.com** > Providers > Education > Patient Care > Primary Care Provider Roles and Responsibilities, selecting Nevada Medicaid from the drop-down menu.

CLAS Standards: National Standards for Culturally & Linguistically Appropriate Standards

The Office of Minority Health (United States Department of Health & Human Services, 2018), created National Culturally and Linguistically Appropriate Standards (CLAS) to provide a blueprint for implementing culturally and linguistically appropriate services for health and health care organizations to:

- Advance health access and opportunities
- Improve quality
- Help eliminate risks related to health-related social needs

CareSource recognizes language and cultural differences have the potential to negatively impact interactions between providers, members, and employees.

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, and 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.

CareSource encourages our participating providers to visit the U.S. Department of Health

and Human Services Office of Minority Health website. Their Cultural Competency Resources website found at: https://thinkculturalhealth.hhs.gov/ provides toolkits and educational resources. Included on the site is a free, nine credit Continuing Medical Education (CME) course, *A Physician's Practical Guide to Culturally Competent Care*. This self-directed e-learning program equips providers to better understand and treat diverse populations.

CareSource educates its contracted providers, including behavioral health providers, regarding provider requirements and responsibilities. CareSource educates the provider on prior authorization policies and procedures, clinical protocols, member rights and responsibilities, claims submission process, claims dispute resolution process, program integrity, identifying potential fraud, waste and abuse, pay for outcomes programs, and any other information relevant to improving the services provided to Medicaid members.

CareSource Life Services®

This program is our health-related social needs (HRSN) model designed to address and eliminate the socioeconomic barriers that CareSource members often experience, such as access to nutrition, affordable housing, transportation, education, legal assistance and employment. Additionally, our WorkConnect program under Life Services provides members with life coaching for up to two years, facilitating access to community-based resources, and helping members reach their employment and educational goals.

CareSource Life Coaches assist members in their journey out of poverty by addressing member barriers on an individual basis. These barriers include, but are not limited to, housing, food, transportation, childcare, education, training and job placement. Once members have an established foundation of support for HRSN needs, they will work with their Life Coach to create resumes, submit applications to viable employment opportunities, work on interviewing skills, and/or work towards any education goal the member may have such as obtaining their GED, enrolling in post-secondary education or training programs.

To connect a member to our Life Services team, call **1-833-230-2033** or email NVLifeServices@CareSource.com.

Critical Incident Reporting

A critical incident is an event or occurrence that causes harm to a member or that indicate a risk to a member's health or welfare. Nevada State Medicaid requires CareSource Nevada Medicaid to report ALL actual or suspected critical incidents involving members to the NHA within 24 hours or one business day of becoming aware of the incident.

All providers contracted with CareSource must report an actual or alleged critical incident to CareSource Nevada Medicaid by submitting a critical incident form. This form is located in Providers > Forms on the CareSource website. NHA considers the following as critical incidents that must be reported:

- Major injury or major trauma that has the potential to cause prolonged disability or death of a member that occurs at a facility licensed by the State to provide publicly funded Behavioral Health Services.

- An unexpected death of a member that occurs in a facility licensed by the State to provide publicly funded Behavioral Health Services.
- Abuse, neglect, exploitation, or unexpected death of a member (not to include child abuse).
- Homicide or attempted homicide by a member.
- Any event involving a member that has attracted or is likely to attract media attention.
- Unauthorized leave of mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e., Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions.

Identifying Member Abuse, Neglect and Human Trafficking

Given the diverse populations we serve, as an CareSource provider, there is great potential for victims of abuse, neglect and/or human trafficking to encounter you or your facility. It is important to recognize the signs of abuse, neglect, and human trafficking and to know what to do when you suspect an issue.

Required Training

The state of Nevada requires all providers to receive and attest to receiving abuse, neglect, and exploitation training, including training to identify victims of human trafficking. To attest to receiving this training please visit **CareSource.com** > Provider > Forms > Provider Education Attestation Form and provide the required information.

Human Trafficking Education: The Nevada Court System has developed training on identifying and stopping human trafficking. Training can be found on their website https://www.flcourts.gov/Resources-Services/Office-of-Family-Courts/Human-Trafficking.

Nevada Health has also developed a catalog of resource to identify and support victims of human trafficking. Resources can be found on their website.

Abuse and Neglect Education: The National Children's Advocacy Center provides helpful information for providers caring for children. Resources can be found on their website at https://www.nationalcac.org/online-training-catalog/. The U.S. Department of Justice offers information for providers caring for elderly patients. Resources can be found on their website at https://www.ojp.gov/feature/elder-abuse/training.

Reporting

CareSource requires all staff and providers to report adverse incidents to the Nevada Abuse Hotline or to contact Member Services at 1-833-230-2058. Reporting should occur immediately but not more than 24 hours after the incident in known. Reporting should include:

- Member's identity
- Description of the incident
- Status of the member

For members who present with an immediate health and/or safety concern, our case managers will arrange to move or transition to a provider of the member's choice to ensure the member's safety and well-being.

All information related to the suspected abuse, neglect, or harm, including the reporting of such, must be kept separately and confidentially from the member's case file. Such file shall be made available to the Agency upon request. Any quality-of-care (QOC) issues should be reported to our Quality Management Department.

Mandated Reporters

Nevada law requires certain professionals to report abuse or evidence of abuse. These professionals may also be referred to as "mandatory reporters." The below list provides descriptions of mandatory reporters for Nevada:

- Physicians, osteopaths, medical examiners, chiropractors, nurses, or hospital personnel
- Other healthcare or mental health professionals
- Practitioners who rely solely on spiritual means for healing
- Teachers or other school officials or personnel
- Social workers, daycare center workers, or other professional childcare, foster care, residential, or institutional workers
- Law enforcement officers or judges
- Animal control officers

Primary Care Providers

Primary Care Provider Concept

All CareSource members may choose a 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. Medicaid members must choose a PCP within 30 days, otherwise a PCP will be assigned to the member.

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 or by completing the PCP Change Request Form on **CareSource.com** > Provider > Tools & Resources > Forms.

Primary Care Provider Roles and Responsibilities

PCP 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 care management care treatment plans and notifying CareSource of members who may benefit from care management. Please see the

"Member Support Services and Benefits" section of this manual to learn how to refer members for care management.

PCPs are responsible for:

- Treating CareSource 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 plan(s) and Nevada Medicaid.
- Providing 30 days of emergency coverage to any CareSource patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by CareSource patients for emergency or urgent care if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use.
- Reporting suspected fraud and/or abuse.
- PCPs disenrolling from Medicaid that remain an Nevada Medicaid provider must provide continuation of care for Medicaid members for a minimum of thirty (30) calendar days or until the member's link to another PCP becomes effective.

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

Primary Care Provider Selection

CareSource allows for PCPs to include not only traditional provider types that have historically served as PCPs but also alternative provider types such as specialists with documented physician oversight and meaningful physician engagement. A member who has a primary diagnosis of a severe persistent mental illness may be permitted to have any physician, including a psychiatrist, as his or her PCP.

A member may select a PCP as a medical home from the following types of providers:

- Family practice physicians
- General practice physicians
- Pediatricians – for members up to age 19
- Internal medicine

- Obstetricians and gynecologists – optional
- Nurse practitioners certified (NP-C) specializing in:
    - Family practice
    - Pediatrics

Note: NP-Cs in independent practice must also have a current collaborative agreement with a licensed physician who is a network provider, who has hospital admitting privileges and who oversees the provision of services furnished by NP-Cs.

- Psychiatrists who agree to serve as PCPs for members who have a primary diagnosis of Severe Persistent Mental Illness
- Physicians who provide medical services at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Providers who practice at Public Health Department clinics and hospital outpatient clinics when the majority of their practice is devoted to providing continuing comprehensive and coordinated medical care
- Physician assistants (physician will be listed as member's PCP)
- Retail Health Clinics, such as Walmart, Little Clinics, CVS and Walgreens
- Specialists treating a member's chronic condition(s) who agrees to act as his or her PCP

If a member does not select a PCP, CareSource will assign them one.

Dental Providers

CareSource recognizes the importance of regular dental care to our member's overall health. The state of Nevada partners with Liberty Dental plan to offer Medicaid dental benefits in Clark and Washoe counties. Providers can contact Liberty Dental at 1-888-700-0643 or check Liberty Dental's website for additional information.

Provider Rights

CareSource complies with 42 CFR 438.102, which relates to provider-enrollee communications. CareSource shall not prohibit or otherwise restrict a health care professional, acting within his or her lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding the following:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under the Medicaid programs;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Medical Records

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.

Providers are required to maintain member records on paper or in an electronic format. Member medical records shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review.

Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records and other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the contract. Medical records shall be signed by the provider of service.

The PCP also must maintain a primary medical record for each member that contains sufficient medical information from all providers involved in order to ensure quality of care.

The medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information, on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school name and telephone numbers (if no phone, contact name and number) of emergency contacts, consent forms, identification of language spoken and guardianship information
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions and known allergies noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses (for children, past medical history includes prenatal care and birth information, operations and childhood illnesses [i.e., documentation of chickenpox])
- Identification of current problems
- The consultation, laboratory and radiology reports in the medical record shall contain the ordering provider's initials or other documentation indicating review
- Documentation of immunizations
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or the Department for Public Health
- Follow-up visits provided and (secondary) reports of emergency room care
- Hospital discharge summaries
- Advance medical directives, for adults
- All written denials of service and the reason for the denial
- Record legibility to at least a peer of the writer (records judged illegible by one reviewer shall be evaluated by another reviewer)

A member's medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's physical/behavioral health, including mental health and substance abuse status
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (e.g., EPSDT) addressed from previous visits
- Plan of treatment including:
    - Medication history, medications prescribed, including the strength, amount, directions for use and refills
    - Therapies and other prescribed regimen
    - Follow-up plans including consultation and referrals and directions, including time to return
- A member's medical record shall include the following minimal detail for hospitals and mental hospitals:
    - Identification of the member
    - Physician name
    - Date of admission and dates of application for and authorization of Medicaid benefits, if application is made after admission; the plan of care (as required under 42 CFR 456.172 (mental hospitals) or 42 CFR 456.70 (hospitals)
    - Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)
    - Reasons and plan for continued stay, if applicable
    - Other supporting material the committee believes appropriate to include
- For non-mental hospitals only:
    - Date of operating room reservation
    - Justification of emergency admission, if applicable

Nevada Health Information Network

Providers are encouraged to participate in the HealtHIE Nevada. HealtHIE Nevada provides access to a more complete view of patient health information directly from electronic health record (EHR) systems. This exchange of information can save time, improve care, reduce costs and enhance privacy for your patients. This improves care coordination for our members.

The HealtHIE Nevada supports the following types of providers:

- Physicians
- Mid-level practitioners (physician assistants, nurse practitioners, certified nurse midwives)
- Doctors of dentistry, optometry and podiatry
- Hospitals
- Safety net clinics
- Behavioral and mental providers
- County/state departments of public health

- Long-term care
- Home health
- Hospice
- Labs
- Imaging centers
- Urgent care clinics

Participation in the HealtHIE Nevada gives immediate access to send or receive data from any other participating provider, working to connect the state, vendors and other key stakeholders.

At any time, patients may choose to opt-in of having their electronic records shared through the network. He or she can simply complete an opt-in form from the provider. If an opt-in patient changes his or her mind, he or she can easily opt back out the system.

For more information, visit https://healthienevada.org/.

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 ensures our Provider Directories are up to date and 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.

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. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Provider Responsibilities

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 our Member Rights & Responsibilities.

Participating providers are responsible for providing CareSource with advance written notice of any intent to terminate an agreement with us. 60-day notice is required if you plan to close your

practice to new patients. If we are not notified within this time period, you will be required to continue accepting CareSource members for a 60-calendar day period following notification.

For PCPs only:

- Provide 24-hour availability to your CareSource 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.
- Be available to see members at least three days per week for a minimum of 20 hours per week, or any combination of visits at no more than two locations.
- Provide members telephone access to the PCP (or appropriate designate) in English and Spanish 24/7.

For behavioral health providers only:

- Notify CareSource of missed appointments.
- Schedule members receiving inpatient psychiatric services for outpatient follow-up and/or continuing treatment prior to discharge, within seven calendar days from the member's date of discharge.
- Document and share with physical health providers the following information:
    - Primary and secondary diagnoses,
    - Findings from assessments,
    - Medication prescribed,
    - Psychotherapy prescribed, and
    - Any other relevant information.
- Notify CareSource within five calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications and other pertinent information.
- Claims should be submitted within 90 days of the date of service or discharge.
- Corrected claims should be submitted within 60 days from the date of the EOP.
- Claim disputes should be submitted 60 calendar days from the date of receipt of the claim decision notification.
- Providers should keep demographic and practice information up to date. Email updates to ProviderMaintenance@CareSource.com or submit change on the Provider Portal.
- Our agreement also indicates that CareSource is responsible for:
    - Paying clean electronic claims within 21 days of receipt.
    - Paying clean paper claims within 30 days of receipt.
    - Providing you with an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our appeal process is outlined in the "Provider Appeals" section of this manual.
    - 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 lesser of the primary carrier allowable or the Medicaid allowable. If the member's primary insurer pays a provider equal

to or more than Nevada's Medicaid fee schedule for a covered service, CareSource will not pay the additional amount. The Medicaid fee schedule is based on the Medicaid fee schedule, and the Nevada Plan fee schedule is based on the Medicare fee schedule.

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.

For example:

- 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 in the "Member Support Services and Benefits" section of this manual.

CareSource expects participating providers to verify member eligibility and ask for all of their health care insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other health care insurance coverage that we have on file by logging on to the Provider Portal from the menu options.

Advance written notice of status changes, such as a change in address, phone, or adding, or deleting a provider to your practice helps us keep our records current and are critical for claims processing.

Timeline of Provider Changes:

Type of Change	Notice required (Please notify CareSource of the change prior to the time frames listed below)
New providers or deleting providers	30 business day
Providers leave the practice	30 business days
Phone number change	30 business days
Address change	30 business days
Change in capacity to accept members	30 business days
Intent to terminate Provider Agreement	90 calendar days

Why Is It Important to Give Changes to CareSource?

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.

How to Submit Changes to CareSource:

The CareSource Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Provider Portal, entering your login credentials, and selecting "Provider Maintenance" from the left-hand navigation. You may also use the methods below.

Email: ProviderMaintenance@CareSource.com

Fax: 937-396-3076

Mail: CareSource
P.O. Box 8738
Dayton, OH 45401

Marketing Activities and Standards

The state of Nevada allows Managed Care Plans, like CareSource, to utilize its provider network to distribute marketing materials. Examples include displaying posters or other materials in common areas, such as a waiting room, advertisements announcing affiliations between providers and a specific managed care plan or allowing long term care facilities to provide Managed Care Plan materials in admission packets.

It is important to note the following guidelines when marketing a Managed Care Plan relationship:

- Providers shall remain neutral.
- Providers are permitted to make available and/or distributed Managed Care Plan marketing materials as long as the provider does so for all Managed Care Plans with which the provider participates.
- Long term care facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.
- Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (i.e., radio, television, websites).
- Providers may make new affiliation announcements within the first 30 days of the new provider agreement.
- Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.
- Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider has agreements.

The Managed Care Plan may **not** permit providers to:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge, or attempt to persuade potential enrollees to enroll or enrollees to remain enrolled in the Managed Care Plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of the Managed Care Plan.

- Offer anything of value to retain enrollees or persuade potential enrollees to select them as their provider or to enroll in a particular Managed Care Plan.
- Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.

Americans with Disabilities Act (ADA) Standards:

Additionally, providers will remain compliant with ADA standards, including but not limited to:

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

For more information on these ADA standards and how to be compliant, please see the ADA section of this manual.

Fraud, Waste and Abuse

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.

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 (i.e., 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 Payment is 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 (Improper Payments Elimination and Recovery Act, IPERA). Any improper payment may constitute fraud, waste and/or abuse. CareSource has the right to recoup improper payments.

Examples of 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 form to get more than the amount of medication prescribed by their physician
- Sharing a member ID card
- Non-disclosure of other health insurance coverage
- Obtaining unnecessary equipment and supplies
- Member receiving services or picking up prescriptions under another person's name or ID (identity theft)
- Providing inaccurate symptoms and other information in order get treatment, drugs, etc.
- Any other action by a member that CareSource considers to be fraud, waste and/or abuse

Note: This is not an all-inclusive list.

Examples of Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower Medicaid/Medicare reimbursement rates
- Billing for services not provided
- Requiring members to pay for CareSource covered services
- 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
- Not checking member ID numbers, resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using member/enrollee lists for the purpose of submitting fraudulent claims
- Billing drugs for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark violations
- Not reporting overpayments or over billing including those made in error by CareSource
- Preventing members from accessing eligible or covered services resulting in underutilization of services offered
- Failing to comply with federal and/or state laws

Note: This is not an all-inclusive list.

Examples of Pharmacy Fraud, Waste and/or Abuse:

- Dispensing prescription drugs not dispensed as written inconsistent with the order
- 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, tainted, or illegal drugs
- Billing prescriptions not filled or picked up

Note: This is not an all-inclusive list.

Examples of 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

Note: This is not an all-inclusive list.

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

Examples of Vendor Fraud, Waste and/or Abuse:

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

Note: This is not an all-inclusive list.

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. **It is important for you to tell us if a CareSource vendor acts inappropriately.**

Corrective Actions

The CareSource Program Integrity department routinely monitors for potential fraud, waste and abuse. We review claims data and medical records to look for billing discrepancies. When found, an investigation is initiated and, if warranted, a 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

- Reporting to one or more applicable state and federal agencies
- Contract termination
- Employee disciplinary actions
- Legal action

Refer to your Provider Agreement for specific information on each type of provider termination/ suspension. Also, refer to the Provider Participation Plan, for the information on the appeal process. The CareSource Provider Participation Plan is available at **CareSource.com** > Provider Overview > Provider Education > Provider Disputes and Appeals. The "Provider Participation Plan" provides information on an appeal process for specific corrective actions.

Network providers are to report and return to CareSource any overpayment within 60 calendar days of identification and notify CareSource in writing of the reason for the overpayment.

Reporting Fraud, Waste and Abuse

You can report your suspicions of fraud, waste or abuse to the CareSource Program Integrity department. Contact information for reporting fraud, waste and abuse is located at **CareSource.com** > Provider Overview > Education > Fraud, Waste & Abuse, in the "Communicating with CareSource" section of this manual and at the end of this section.

Federal and State False Claims Acts and Other Fraud, Waste and Abuse Laws

The Federal False Claims Act (the "Act") was first signed into law in 1863, but the Act has recently undergone significant changes. Using the False Claims Act, individuals can help reduce fraud against the federal government. The Act allows individuals to bring "whistleblower" lawsuits on behalf of the government, also known as "qui tam" suits, against businesses or individuals that are defrauding the government through programs, agencies or contracts.

The False Claims Act applies when a company or person:

i. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
ii. Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
iii. Conspires to commit a violation of any other section of the Act;
iv. Has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
v. Is 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, makes or delivers the receipt without completely knowing that the information on the receipt is true;
vi. Knowingly buys, 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; or
vii. Knowingly makes, uses, or causes 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 conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.

An example would be if a health care provider, such as a hospital or a physician, knowingly “upcodes” or overbills, resulting in overpayment of the claim using Medicaid or Medicare dollars.

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

Nevada Specific:

Nevada has enacted a false claims statute under Chapter 357 of the Nevada Revised Statute:

a. A person who, with or without specific intent to defraud, does any of the following listed acts is liable to the State or a political subdivision, whichever is affected:

1. Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval.

2. Knowingly makes or uses, or causes to be made or used, a false record or statement that is material to a false or fraudulent claim.

3. Has possession, custody or control of public property or money used or to be used by the State or a political subdivision and knowingly delivers or causes to be delivered to the State or a political subdivision less money or property than the amount of which the person has possession, custody or control.

4. Is authorized to prepare or deliver a document that certifies receipt of money or property used or to be used by the State or a political subdivision and knowingly prepares or delivers such a document without knowing that the information on the document is true.

5. Knowingly buys, or receives as a pledge or security for an obligation or debt, public property from a person who is not authorized to sell or pledge the property.

6. Knowingly makes or uses, or causes to be made or used, a false record or statement that is material to an obligation to pay or transmit money or property to the State or a political subdivision.

7. Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the State or a political subdivision.

8. Is a beneficiary of an inadvertent submission of a false claim and, after discovering the falsity of the claim, fails to disclose the falsity to the State or political subdivision within a reasonable time.

9. Conspires to commit any of the acts set forth in this subsection. b. For each act described above that is committed by a person, the person is liable for:

a. Three times the amount of damages sustained by the State or political subdivision, whichever is affected, because of the act of the person;

b. The costs of a civil action brought to recover the damages

c. A civil penalty of not less than $5,500 or more than $11,000. A civil penalty imposed pursuant to this paragraph must correspond to any adjustments in the monetary amount of a civil penalty for a violation of the federal False Claims Act, 31 U.S.C. § 3729(a), made by the Attorney General of the United States in accordance with the Federal Civil Penalties Inflation Adjustment Act of 1990, Pub. L. 101-410

Protection for Reporters of Fraud, Waste or Abuse (Whistleblowers)

In addition, federal and state law and CareSource 's policy prohibits 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.

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement. Additional information on the False Claims Act and our fraud, waste and abuse policies can be found at **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 by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities (42 C.F.R. § 438.610). Relationships must be terminated with any trustee, officer, employee, provider, or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. Additionally, if a provider is currently suspended or terminated from the Nevada Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider. Suspension and termination are described further in Rule 59G-9.070, F.A.C.

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 utilizing the contact information in the “How to Report Fraud, Waste or Abuse” reporting section.

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.

Disclosure of Ownership, Debarment and Criminal Convictions

Before CareSource enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment or suspension status, and any criminal convictions related to federal health care 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 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 (CFR) 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 or any Nevada Medicaid fraud laws. As a contracted provider we require you to report any knowledge or information that any such activity may be taking or has taken place to our Program Integrity department. Reporting fraud, waste, abuse and member harm and neglect can be anonymous or not anonymous.

Options for reporting anonymously:

- **Call: 1-833-230-2112** and follow the appropriate menu option for reporting fraud
- **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
- **Phone:** Navex Hotline 1-844-415-1272

Or you may choose to use the Fraud, Waste and Abuse Reporting Form located on **CareSource.com** > Providers > Tools & Resources > Forms.

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

*Most email systems are not protected from third parties. Please do not use email to send confidential information. If you will be sending confidential or health information, please use the form or phone number to report your concerns to help protect your privacy.

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 https://oig.hhs.gov/compliance/physician-education/.

CMS provides training on their website at https://www.cms.gov/Outreach-and-Education/MLN/WBT/MedicareFraudandAbuse/FraudandAbuse/story.html

Once you have completed a Fraud, Waste and Abuse training program, please attest to completing this training at **CareSource.com** > Providers > Forms > Provider Education Attestation Form.

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

Frequently Asked Questions

How can I reach CareSource?

Call Provider Services at **1-833-230-2112** to reach CareSource. Provider Services is available Monday through Friday, 8 a.m. to 6 p.m. PT. See the “Communicating with CareSource” section for more information.

How do I check member eligibility?

It is important to verify member eligibility before providing services. Patients must be eligible CareSource members at the time of service in order for services to be covered. CareSource offers several ways to check member eligibility, including by phone, the Availity Clearinghouse or our secure Provider Portal.

How do I submit a claim?

CareSource accepts paper and electronic claims. We encourage you to submit electronic claims for quicker processing. Please see the “Claim Submission” section for more information.

How do I optimize my claim payment time frame?

Claims submitted electronically are typically received and processed more quickly than paper claims. Providers may submit claims electronically through the CareSource Provider Portal or through Electronic Data Interchange (EDI) clearinghouses listed in the “Claim Submission” section of this manual.

For paper claim submissions, we require the most current form versions as designated by the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee (NUBC). We cannot accept handwritten claims or superbills.

How do I file a claim appeal?

We hope you will be satisfied with CareSource and the service we provide. However, providers who are unhappy with CareSource’s action concerning a medical necessity decision, or a claim payment may appeal it. Please see our “Member Grievance and Appeals” section on page 96 for more information.

Can I bill my CareSource patients?

Generally, providers enrolled in the Nevada Medicaid can bill members only under certain condition. See the “Member Billing Policy” section in the “Claim Submission” chapter for more information about billing CareSource members.

How do I obtain a prior authorization?

Prior authorizations for health care services can be obtained by contacting the Utilization Management department online, by email, phone, fax or mail:

Online: Visit **CareSource.com** and select the Provider Portal option from the menu

Phone: 1-833-230-2112 and follow the appropriate menu prompts for the authorization requests, depending on your need.

Fax: Fax the prior authorization form to 866-930-0019 or 888-399-0271 for drugs under medical benefit. The prior authorization form can be found on **CareSource.com**.

Is authorization needed to make referrals to specialists?

Some health care services provided by specialists do not require a referral from a PCP. Members may schedule self-referred services from participating providers themselves, provided the service is covered under their specific plan. PCPs do not need to arrange or approve these services for members as long as any applicable benefit limits have not been exhausted.

If you have questions about referrals and prior authorizations, please call our Utilization Management department at **1-833-230-2112**.

What benefits does CareSource offer its members?

Please visit the CareSource website at **CareSource.com** for information on services, including the member's coverage status and other information about obtaining services.

How do I make a referral?

Follow the steps below to make a referral:

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. All out-of-network providers require prior authorization.

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. In accordance with 42 CFR 438.206(b)(3), CareSource complies with all member requests for a second opinion from a qualified professional. If our network does not include a provider who is qualified to give a second opinion, CareSource shall arrange for the member to obtain a second opinion from a provider outside the network at no cost to the member.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization 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.