Ohio Medicaid, MyCare and Marketplace Plans

Policy Updates June 2018

- Administrative Policies
- Medical Policies
- Reimbursement Policies

The following policies are effective June 1, 2018

CareSource™

AT CARESOURCE, WE LISTEN TO OUR HEALTH PARTNERS, AND WE STREAMLINE OUR BUSINESS PRACTICES TO MAKE IT EASIER FOR YOU TO WORK WITH US.

We have worked to create a predictable cycle for releasing administrative, medical and reimbursement policies, so you know what to expect.
Check back each month for a consolidated network notification of policy updates from CareSource.

HOW TO USE THIS NETWORK NOTIFICATION:

- Reference the Table of Contents and click the policy title to navigate to the corresponding policy summary.
- The summary will indicate the effective date and impacted plans for each policy.
- Within the summary, click the hyperlinked policy title to open the webpage with the full policy.

FIND OUR POLICIES ONLINE

To access all CareSource policies, visit **CareSource.com** and click “Health Partner Policies” under Provider Resources. Select the type of policy and the CareSource plan to access current policies. Each policy page has an archive where you can find previous versions of policies.

CLAIMS AND APPEALS

As indicated in the health partner manual, if you do not agree with the decision of a processed claim, you have 365 days from the date of service or discharge to file an appeal. Please submit your appeal through the Provider Portal or in writing. For detailed instructions, please consult your health partner manual.

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POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Cardiovascular Nuclear Medicine - OH MPP PY-0240	REIMBURSEMENT	JUNE 1, 2018	MARKETPLACE	The Cardiovascular Nuclear Medicine payment policy will reimburse participating providers for medically necessary cardiovascular nuclear medicine services according to the Ohio Department of Medicaid Fee Schedule and the Centers for Medicare and Medicaid Services Fee Schedules. Reimbursement policies are designed to assist you when submitting claims to CareSource.	CareSource does not require prior authorization for the cardiovascular nuclear medicine services covered by this policy but may request documentation to support medical necessity. Appropriate and complete documentation must be presented at the time of review to validate medical necessity. All cardiovascular nuclear tests and stress tests must be referred by a physician or a qualified non-physician provider. Selection of tests should be made within the context of other tests, scheduled and previously performed, so that the anticipated information obtained is unique and not redundant. Cardiovascular nuclear imaging is considered a covered service when indicated by the criteria outlined in this policy. First pass studies will be covered only when the information sought is immediately relevant to the management of the patient's clinical condition, and has not been previously obtained or likely to be obtained from other planned tests such as echocardiography or equilibrium gated blood pool studies. First pass studies may be indicated for the assessment and identification of shunts. Infarct avid scintigraphy is indicated in patients in whom it is not possible to make a definitive diagnosis of myocardial infarction by ECG or enzyme testing. (continued)

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Cardiovascular Nuclear Medicine - OH MPP PY-0240 (continued)	REIMBURSEMENT	JUNE 1, 2018	MARKETPLACE	The Cardiovascular Nuclear Medicine payment policy will reimburse participating providers for medically necessary cardiovascular nuclear medicine services according to the Ohio Department of Medicaid Fee Schedule and the Centers for Medicare and Medicaid Services Fee Schedules. Reimbursement policies are designed to assist you when submitting claims to CareSource.	Patient selection should be based on clinical grounds as outlined in this policy. If criteria are met for selected cardiovascular nuclear imaging to evaluate left ventricular ejection fraction, CareSource covers the evaluation of peripartum cardiomyopathy. Special equipment is indicated for some cardiovascular nuclear imaging tests and studies, including certification of laboratories used during testing. Provider documentation is required for proper reimbursement as outlined in this policy. Some cardiovascular nuclear imaging studies and tests may **not** be considered covered services and will **not** be reimbursed. Please see corresponding policies for further information and *Services Not Covered.*

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Enhanced Ambulatory Patient Groups (EAPG) - OH MCR PY-0368	REIMBURSEMENT	JUNE 1, 2018	MYCARE	ODM has requested MyCare Ohio managed care plans implement contingency plans to handle the processing of EAPG claims.	CareSource will begin processing claims using the EAPG methodology for dates of service on or after Oct. 1, 2017. Until Oct. 1, 2017, CareSource will continue processing outpatient claims using the payment methodology in place prior to implementation of EAPG, effectively delaying the implementation of the EAPG pricing methodology until Oct. 1, 2017. The claims with dates of service Aug. 1, 2017, through Sept. 30, 2017, will not be reprocessed in the future to reflect the EAPG pricing methodology. Payments for the claims awaiting processing will be reflected on the check write the weeks of Sept. 4, 2017, and Sept. 11, 2017.

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Global Obstetrical Services - OH MCD PY-0001	REIMBURSEMENT	JUNE 1, 2018	MEDICAID	Maternity services must be furnished under the supervision of a physician or certified advanced practice nurse midwife. Maternity services enable beneficiaries to voluntarily choose a provider within the CareSource network for maternity care and post-partum care. For billing purposes, the maternity obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period.	The global obstetrical package code may only be claimed when one physician, one midwife, or the same physician group practice provides all of the patient's routine obstetric care, which includes the antepartum care, delivery, and postpartum care. Covered services include office visits for a complete exam, pharmaceuticals (including some over the counter ["OTC"] products with a prescription), such as prenatal vitamins or medication related to gestational diabetes, and fetal ultrasound services when provided by or under the supervision of a medical doctor, osteopath, or eligible maternity provider. Maternity services may include pregnancy testing/laboratory tests, office visits, ultrasounds, fetal delivery, and post-partum visits. Only one prenatal care code may be claimed per pregnancy. CareSource uses a Maternity Global Period of 56 days after the date of vaginal delivery and 60 days after the date of C-section delivery (date of delivery is day zero). The delivery date is used as the date of service for any obstetrical global code, most antepartum care codes, any delivery-only code, any delivery + postpartum code, and any postpartum care only code. Providers must complete the Pregnancy Risk Assessment Form. (continued)

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Global Obstetrical Services - OH MCD PY-0001 (continued)	REIMBURSEMENT	JUNE 1, 2018	MEDICAID	Maternity services must be furnished under the supervision of a physician or certified advanced practice nurse midwife. Maternity services enable beneficiaries to voluntarily choose a provider within the CareSource network for maternity care and post-partum care. For billing purposes, the maternity obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period.	Providers will be paid for the completion of the form a maximum of three times during the pregnancy. This form should be submitted one time during each trimester of pregnancy. Please see the policy for more details on the submission of this form and associated claims. Billing for global services cannot be done until the date of delivery. The global services are broken into the three stage of antepartum care, intrapartum care or delivery, and postpartum care. Please refer to the policy for detailed explanations of these stages. Maternity care and delivery may be billed as a single code except when the following circumstances occur which require the package to be broken into components: • The member has a change of insurer during her pregnancy. • The member has received part of her antenatal care elsewhere, e.g. from another group practice. • The member leaves her care with your group practice before the global obstetrical care is complete. • The member must be referred to a provider from another group practice or a different licensure (e.g. midwife to MD) for a cesarean delivery. • The member has an unattended, precipitous delivery. • Termination of pregnancy without delivery (e.g. miscarriage, ectopic pregnancy). (continued)

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Global Obstetrical Services - OH MCD PY-0001 (continued)	REIMBURSEMENT	JUNE 1, 2018	MEDICAID	Maternity services must be furnished under the supervision of a physician or certified advanced practice nurse midwife. Maternity services enable beneficiaries to voluntarily choose a provider within the CareSource network for maternity care and post-partum care. For billing purposes, the maternity obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period.	• Please refer to the policy for specific guidelines when submitting claims for split obstetrical package services. Special guidelines apply in the event of multiple gestations and births. Please refer to the policy for detailed information. Limitations apply in the event of elective deliveries by cesarean section, or following labor induction. Please refer to the policy for detailed information. Maternity services not reimbursed to providers: • Home pregnancy tests • Ultrasounds performed only for determination of sex of the fetus or to provide a keepsake picture • Three and four-dimensional ultrasounds • Paternity testing • Lamaze classes • Birthing classes • Parenting classes • Home tocolytic infusion therapy Section E, “Conditions of Coverage,” specifies additional claim guidelines for antepartum care, delivery (vaginal and cesarean), and postpartum care, and maternity management services. If required, providers must submit their prior authorization number, their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS. Claims not meeting the necessary criteria as described in the policy document will be denied.

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Medical Necessity – Off Label, Approved Orphan and Compassionate Use Drugs - OH MCD AD-0004	ADMINISTRATIVE	JUNE 1, 2018	MEDICAID	The Medical Necessity – Off Label, Approved Orphan and Compassionate Use Drugs policy will impact all providers who request off label, orphan or compassionate use medications.	There are no changes in criteria from the previous policy version; only the policy format was changed. If required, providers must submit their prior authorization number, their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS. Claims not meeting the necessary criteria as described in the policy document will be denied.

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Medical Necessity – Off Label, Approved Orphan and Compassionate Use Drugs - OH MPP AD-0063	ADMINISTRATIVE	JUNE 1, 2018	MARKETPLACE	The Medical Necessity – Off Label, Approved Orphan and Compassionate Use Drugs policy will impact all providers who request off label, orphan or compassionate use medications.	There are no changes in criteria from the previous policy version; only the policy format was changed. If required, providers must submit their prior authorization number, their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS. Claims not meeting the necessary criteria as described in the policy document will be denied.

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Multi-Ingredient Compound - OH MCD AD-0039	ADMINISTRATIVE	JUNE 1, 2018	MEDICAID	The Multi-Ingredient Compound policy was created to define coverage criteria of compounded drug products for both providers and members. The Multi-Ingredient Compound policy will impact all providers who write prescriptions for a compounded product. The policy was revised for clarity on coverage criteria and circumstances in which compounds would not be covered.	The Multi-Ingredient Compound policy details coverage criteria for medical necessity for approval of the compounded product. The policy also details circumstances in which a compounded product will not be covered. The safety and efficacy of the compounded product and its route of administration must be supported by FDA indication or scientific evidence. For prior authorization review, a Compound Prior Authorization form is available on CareSource.com for provider use. Clinical documentation and literature may also need submitted to support use of the compounded product. If required, providers must submit their prior authorization number, their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS. Claims not meeting the necessary criteria as described in the policy document will be denied.

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Multi-Ingredient Compound - OH MPP AD-0046	ADMINISTRATIVE	JUNE 1, 2018	MARKETPLACE	The Multi-Ingredient Compound policy was created to define coverage criteria of compounded drug products for both providers and members. The Multi-Ingredient Compound policy will impact all providers who write prescriptions for a compounded product. The policy was revised for clarity on coverage criteria and circumstances in which compounds would not be covered.	The Multi-Ingredient Compound policy details coverage criteria for medical necessity for approval of the compounded product. The policy also details circumstances in which a compounded product will not be covered. The safety and efficacy of the compounded product and its route of administration must be supported by FDA indication or scientific evidence. For prior authorization review, a Compound Prior Authorization form is available on CareSource.com for provider use. Clinical documentation and literature may also need submitted to support use of the compounded product. If required, providers must submit their prior authorization number, their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS. Claims not meeting the necessary criteria as described in the policy document will be denied.

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Preferred Obstetrical Services - OH MCD PY-0004	REIMBURSEMENT	JUNE 1, 2018	MEDICAID	Maternity services must be furnished under the supervision of a physician or certified advanced practice nurse midwife. Maternity services enable beneficiaries to voluntarily choose a provider within the CareSource network for maternity care and post-partum care. For billing purposes, the maternity obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period.	Prior authorization is not required for the preferred obstetrical and maternity services covered under this policy. Covered services include office visits for a complete exam, pharmaceuticals (including some over the counter [“OTC”] products with a prescription), such as prenatal vitamins or medication related to gestational diabetes, and fetal ultrasound services when provided by or under the supervision of a medical doctor, osteopath, or eligible maternity provider. Maternity services may include pregnancy testing/laboratory tests, office visits, ultrasounds, fetal delivery, and post-partum visits. CareSource uses a maternity period of 56 days after the date of vaginal delivery and 60 days after the date of C-section delivery (date of delivery is day zero). Providers must complete the Pregnancy Risk Assessment Form. Providers will be paid for the completion of the form a maximum of three times during the pregnancy. This form should be submitted one time during each trimester of pregnancy. Please see the policy for more details on the submission of this form and associated claims. The preferred obstetrical services are broken into the three stage of antepartum care, intrapartum care or delivery, and postpartum care. Please refer to the policy for detailed explanations of these stages. (continued)

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLAN	SUMMARY	IMPACT
Preferred Obstetrical Services - OH MCD PY-0004 (continued)	REIMBURSEMENT	JUNE 1, 2018	MEDICAID	Maternity services must be furnished under the supervision of a physician or certified advanced practice nurse midwife. Maternity services enable beneficiaries to voluntarily choose a provider within the CareSource network for maternity care and post-partum care. For billing purposes, the maternity obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period.	Please refer to the policy for detailed criteria and guidelines for the itemized billing of obstetrical and maternity services, including when: o One provider has given all of the care during the pregnancy and birth; o More than one provider has given care during the pregnancy and birth. Special guidelines apply in the event of multiple gestations and births. Please refer to the policy for information. Limitations apply in the event of elective deliveries by cesarean section, or following labor induction. Please refer to the policy for detailed information. Maternity services not reimbursed to providers: o Home pregnancy tests. o Ultrasounds performed only for determination of sex of the fetus or to provide a keepsake picture. o Three and four dimensional ultrasounds. o Paternity testing. o Lamaze classes. o Birthing classes. o Parenting classes. o Home tocolytic infusion therapy. If required, providers must submit their prior authorization number, their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS.