P.O. Box 8738, Dayton, OH 45401-8738 | 800.488.0134 | CareSource.com

December 2013

Dear CareSource Provider,

The end of the year signals a time of reflection and optimism for the year ahead. 2013 was a year of growth and new opportunities for CareSource, including being selected to offer CareSource Just4Me™, a qualified health plan in the Health Insurance Marketplace, beginning January 1, 2014. In early 2013 we launched our Kentucky Medicaid plan in partnership with Humana, and Humana – CareSource has been chosen to participate in the Kentucky state-wide expansion in 2014. We look forward to the implementation phases of these expansions and the additional endeavors that will come in 2014.

See below for end-of-the-year highlights:

- **Provider E-communication system now available:** We are pleased to announce that our E-communication system has been launched. This system will help you receive targeted information in a timely manner. Please be sure to register for this new system to start receiving this newsletter and other materials electronically.
- **Preparing for ICD-10:** The ICD-10 transition is effective October 1, 2014. Providers who take early proactive measures will help ease the transition and ensure uninterrupted operations.
- **Babies First program improvements:** We have revamped our Babies First program, making it easier for members and providers to participate. Members will now receive a rewards card, rather than coupons, so providers will no longer need to sign coupons. We hope these changes will help reduce paperwork for our providers, increase program efficiency and improve our members' health.
- **Flu season:** Please continue to help your patients understand the most appropriate use of antibiotics, and ensure antibiotics are only prescribed when appropriate.

These programs and updates are discussed in more detail in the latest edition of our *ProviderSource* newsletter, enclosed.

Thank you for your continued partnership, and we look forward to working with you in the New Year.

Sincerely,

C Thiele MD

Craig Thiele, MD
Chief Medical Officer

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What is fraud, waste and abuse?

Fraud is generally defined as intentionally making, or attempting to make, a false claim, representation, or promise in an effort to receive payment or property to which one is not entitled. An example of provider fraud in health care would be billing for services or supplies not provided.

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs, improper payment for services or payment for services that fail to meet professionally recognized standards of care.

Abuse involves practices that are inconsistent with sound fiscal, business or medical practices that result in unnecessary costs, or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. An example of provider abuse in health care would be scheduling and billing for more frequent visits than are medically necessary.

You can report fraud, waste and abuse to the CareSource Special Investigations Unit by:

- Calling **1-800-488-0134** (TTY: 1-800-750-0750 or 711) and selecting the menu option for reporting fraud
- Writing us a letter or completing our Confidential Fraud, Waste and Abuse Reporting Form and sending it to:

  CareSource
  Attn: Special Investigations Unit
  P.O. Box 1940
  Dayton, OH 45401-1940

You do not have to give us your name when you write or call. There are other ways you may contact us that are not anonymous. If you are not concerned about giving your name, you may also use one of the following means to contact us:

- Emailing fraud@caresource.com
- Faxing 1-800-418-0248

If you choose to remain anonymous we will not be able to call you back for more information, so leave as many details as possible including names and phone numbers. Your report will be kept confidential to the extent permitted by law.

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Medical record reviews to begin in spring

In the spring of 2014, CareSource will begin abstracting data from member medical records for Healthcare Effectiveness Data and Information Set (HEDIS®) scoring. HEDIS is a national set of uniform standards used by more than 90 percent of health plans to assess the quality of care delivered. We also use these standards to monitor the care given by CareSource providers.

We have contracted with a vendor to abstract records on our behalf. The vendor is required to maintain the confidentiality of any protected health information (PHI) it may access during this process in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

The vendor will contact your office to secure medical records or to schedule a visit to review records at your office. Collecting this information is required for auditing and is part of your provider agreement with CareSource. We appreciate your help in providing access to records.

HEDIS measures of focus for 2014

HEDIS scores are compiled using both claims and medical records data. Some examples of areas of focus include:

- Comprehensive diabetes care
- Controlling high blood pressure
- Appropriate treatment of children with upper respiratory infection
- Use of appropriate medications for people with asthma
- Prenatal and postpartum care

A complete list of specific measures can be found at www.ncqa.org.

How you can help

Providers can use tools such as the CareSource Clinical Practice Registry on our Provider Portal to assess gaps in care for HEDIS measures. You can look up services and tests needed for members on the Clinical Practice Registry. Also on our Portal, providers have access to the Member Profile showing historical medical and pharmacy data. These convenient tools can help quickly and easily identify HEDIS measures that need to be improved.

Network Notification

Date: 11/21/13 **Number: OH-P-2013-26**

To: Ohio Providers

From: CareSource

Subject: NEW CareSource Provider E-Communication System

CareSource's new Provider E-Communication System is now live. CareSource information can be sent via email to providers and/or designated staff members. Providers, office managers, billing offices, and other contacts can receive information specific to their needs. This process will help us communicate with you more efficiently and effectively, and your office will be less cluttered with mailings that may not be relevant to you.

In order for you to get the most out of this robust system, you will need to register and provide updated contact information. To register:

1. Go to the CareSource website at CareSource.com
2. Select Providers; go to Ohio Providers
3. Select "Register/Update Provider Email" from the "Quick Links"
4. Follow the login instructions
5. You will be asked to complete the contact information and submit your email address

Providers can add multiple contacts to receive email information from CareSource. Designate one contact as the **"Primary Contact,"** and identify others as **"Additional Contacts."**

You will also want to identify each contact as a particular **"Contact Type."** *We request that at least one individual within the office or group be identified as the General Contact.* The General Contact will receive all e-mail notifications from CareSource.

You can also identify additional contact types to help determine the e-mail notifications received from CareSource. For example, billing information will be sent directly to individuals associated with a billing office.

Network Notifications and future editions of the *ProviderSource* newsletter will be delivered electronically in a more timely and efficient manner. It's another way we are working to make "Health Care with Heart" more effectively meet your needs.

Network Notification

Date: October 17, 2013 **Number: OH-P-2013-21**

To: Ohio Providers

From: CareSource

Subject: ICD-10 Training Needs and Provider Checklist

The Centers for Medicare & Medicaid Services (CMS) recommends the following training timelines ICD-10 preparation:

- Provide training six to nine months prior to implementation for coders who will not assign ICD-10-CMS/PCS codes until compliance date
- Provide 50 hours training to hospital inpatient coders (ICD-10 –CM and ICD-10-PCS)
- Provide 16 hours training to other coders (ICD-10-CM only)

Per CMS, ICD-10 coding training will be integrated into the continuing education units (CEUs) that certified coders must take to maintain their credentials.

ICD-10 resources and training materials are available through CMS, professional associations and societies, and software and system vendors.

ICD-10 Provider Checklist

1. Confirm with your practice's Billing Service, Clearinghouse/s and Practice Management Software Vendor/s that they are ready to provide the support needed to meet the compliance deadline.
2. Identify all touch points in your systems and business processes that need to be changed.
3. Determine if billing forms need to be updated for compliance.

CareSource encourages all Providers to continue progress toward ICD-10 compliance. More information is available at www.cms.gov/ICD10.

Questions? Read CareSource's *Frequently Asked Questions* or call Provider Services at **1-800-488-0134.**

Network Notification

Date: September 5, 2013 **Number: OH-P-2013-15**

To: Ohio Providers

From: CareSource

Subject: Provider Issue Resolution Process

In our effort to continue to "make it easier" for you, we would like to take this opportunity to remind you of our problem resolution strategy.

To simplify operational efficiencies for our Providers, you have 365 days from the date of service or, in the case of an inpatient admission from date of discharge, to successfully submit a claim. In addition, CareSource's appeal time frame is 365 days from the Date of Service. This timeline includes submitting corrected claims.

Retrospective review is conducted if requested within 180 days from the date of service, date of discharge or 90 days from the date from the other carrier's Explanation of Benefits (EOB). Retrospective reviews are determined within 30 calendar days of the receipt of the request.

CareSource wants to make sure you receive the best service every time you contact us, and we want to make sure the right teams are called on to do so!

To help enhance the services we provide and to accomplish our goals, we ask you to direct claims inquiries to the Provider Portal and/or our **Provider Services Department**. This team is trained to respond to claims inquiries, equipped to document those inquiries and to route your needs to the most appropriate team for attention when necessary. We ask you to use these sources as outlined below:

Category	**Source(s)**
Member Eligibility Check	IVR Provider Portal
Coordination of Benefits	Provider Portal
Prior Authorization	Provider Portal 1-800-488-0134. Please listen for the menu option.

To offer you the best service, we have standardized internal operations for the **Provider Relations Team** and the **Provider Services Department**.

Provider Relations is responsible for ongoing provider education, PCP capacity changes, provider demographic changes, orientations and any escalated issues that have not been resolved through your first line resources, such as the Provider Portal and/or the Provider Services Department.

Your Provider Relations Representative is available to assist with root cause analysis, to trend any issues your office may be having and to educate you and your office on new offerings and enhancements from CareSource.

Our **Provider Services Department** is trained and equipped to respond to claims and other non-contract related inquiries. The **Provider Services Department** serves as the main point of contact for all providers; they document all calls and inquiries. Reporting on these calls and inquires goes to the management team who reviews for trends and provider needs, then responds accordingly.

If you have a question about:	**Then:**
The status of a claim and it has been less than 45 days since submission,	Please use the Claims Inquiry function on the Provider Portal for the status on the processing of your claim.
A claim that is in the ‘pended’, or P9 status,	There is no action required on your part. This means the claim needs manual intervention and is being reviewed.
A claim that has been in a ‘pended’, or P9 status and it has been greater than 60 days,	Please call the Provider Services Department for the status on this claim.
A claim that has been processed but you disagree with how the claim processed and your claim was submitted correctly.	Please submit a formal appeal within 365 days from the date of payment or denial.

Following the processes outlined above enables us to assist you better, more consistently and in a more efficient manner.

We appreciate your partnership in this matter.