CareSource®

GEORGIA
HEALTH PARTNER MANUAL

GEORGIA FAMILIES® | PEACHCARE FOR KIDS® | PLANNING FOR HEALTHY BABIES®

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

CareSource®
Health Care with Heart

DEAR CARESOURCE® HEALTH PARTNER,

Welcome to CareSource, and thank you for your participation. CareSource values you as a health partner, and we are actively working to make it easier for you to deliver quality care to our members.

The CareSource Health Partner Manual is intended as a resource for working with our plan. The manual communicates policies and information about our programs. This manual also outlines key information, such as claim submission and reimbursement processes, authorizations, member benefits and more to make it easier for you to do business with us.

CareSource communicates updates with our network regularly on our secure **Provider Portal**. The most up-to-date information can be found on the CareSource **Provider Portal** at **https://providerportal.CareSource.com/GA/**.

In an effort to better support our health partners and offer an immediate response to questions, concerns and inquiries, we offer claims, policy and appeals assistance through our call center by calling **1-855-202-1058**. If you have additional questions or concerns, you may ask to speak to a member of our Health Partnerships team by calling our toll free number.

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

Sincerely,

CareSource

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CHAPTER 1
ABOUT CARESOURCE

Welcome

Welcome, and thank you for participating 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 work together to ensure that our members – your patients – can improve their health and well-being. Because you're our partner, we strive to make it simple for you to do business with us. This manual directs you to the solutions you need, whether that's through convenient online self-service solutions, fast prior authorizations, or hassle-free claims payments. It's our strong partnership that allows us together to facilitate a high level of care and a respectful experience for our members.

We are a non-profit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. CareSource serves consumers of:

- Georgia Families®
- PeachCare for Kids®
- Planning for Healthy Babies®

Our goal is to create integrated medical and dental homes for our members. We focus on prevention and partnering with local health partners to offer the services our members need to remain healthy.

As a managed health care organization, 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 practitioners
- Existing practitioners

ABOUT US

CareSource was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a non-profit, we are mission-driven to provide quality care to our members. We offer process efficiencies and value-added benefits for our members and participating health partners.

Vision and Mission

- *Our vision is transforming lives through innovative health and life services.*
- *Our mission is to make a lasting difference in our members' lives by improving their health and well-being.*

At CareSource, our mission is one we take to heart. In fact, we call our mission our "heartbeat." It is the essence of our company, and our unwavering dedication is the hallmark of our success.

Our Services

- Health partner services and support
- Member eligibility/enrollment information
- Claims processing
- Delegated credentialing and recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory/Compliance
- Special investigations for fraud, waste and abuse
- Member services
- CareSource24® (nurse advice line)

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

- High-risk case management
- Onsite case management (clinics and facilities)
- Emergency department diversion
- High emergency department utilization focus (targeted at members with frequent utilization)
- Health care home/patient-centered medical home
- Maternal and healthy baby program
  - Dedicated neonatal intensive care unit (NICU) care management nurses
  - Outreach programs in partnership with community agencies to target members at greatest risk
- Disease management program for asthma, diabetes and cardiovascular management
- Care transitions through discharge planning and transitional care support

For more information on these programs, see the "Member Support Services and Benefits" section.

The CareSource Foundation

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**. CareSource gets actively involved in the communities that we serve, from employees serving on hundreds of nonprofit boards, to The CareSource Foundation investing more than $14 million in communities since its inception. Areas of focus are closely aligned with the greatest needs of our member demographics. Areas of emphasis include: children's health, special populations such as seniors and individuals with disabilities, the uninsured and life issues such as hunger, domestic violence and homelessness.

The Foundation has responded at significant levels and created strategic partnerships with hundreds of non-profit organizations and other charitable funders who are equally committed to better health for all communities. We are addressing tough issues together.

Corporate Compliance

At CareSource, we serve a variety of audiences – members, health partners, 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.

Our 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 CareSource policy

This allows us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties and criminal sanctions.

CareSource's corporate compliance plan is a formal company policy that outlines how everyone who represents CareSource should conduct themselves. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as health partners, consultants and vendors.

Health Partner Expectations

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

For questions about health partner expectations, please call Health Partner Services at **1-855-202-1058**.

The CareSource Corporate Compliance Plan and Fraud, Waste and Abuse Plan are posted on the CareSource website at **CareSource.com**, in the About Us section under Corporate Info.

Please let us know if you have questions regarding the CareSource Corporate Compliance Plan.
We appreciate your commitment to corporate compliance.

GEORGIA FAMILIES® PROGRAM DESCRIPTION

Georgia Families® is a partnership between the Georgia Department of Community Health (DCH) and Care Management Organizations (CMOs). Almost all who are eligible for Medicaid or PeachCare for Kids® must enroll in Georgia Families®. CareSource partners with Georgia Families® to deliver more efficient and effective health care services to our members.

The goals of the Georgia Families® program are:

- To continually and significantly improve quality of health and services
- Offer care coordination to members
- Enhance access to health care services
- Achieve budget predictability and cost containment
- Create system-wide performance improvement
- Improve efficiency for all
- Improve health care status of members
- Establish member-health partner relationships
- Establish a climate of contract accountability
- Slow the growth rate of Medicaid programs
- Expand and strengthen member responsibility and engagement

For more information, visit www.dch.georgia.gov.

PEACHCARE FOR KIDS® PROGRAM DESCRIPTION

PeachCare for Kids® is a program to provide health care coverage to uninsured children in the state of Georgia. Eligibility requirements:

- Under the age of 19
- Does not have health insurance
- Family income level less than or equal to 247 percent of the federal poverty limit

Each child who participates in the program enrolls in a CMO and has a primary care provider (PCP).

PeachCare for Kids® covers the following health benefits:

- Primary care services
- Preventative care
- Specialist care services
- Dental care
- Vision
- Hospitalization
- Emergency room services
- Prescription medications
- Behavioral health care

PLANNING FOR HEALTHY BABIES® PROGRAM DESCRIPTION

Planning for Healthy Babies® (P4HB®) is a 1115 demonstration program that provides family planning services to women who are not otherwise covered under Medicaid or who have lost Medicaid benefits. The goals of P4HB® are to:

- Improve Georgia's very low birth weight (VLBW) and low birth weight rates
- Reduce the number of unplanned pregnancies
- Provide family planning to low income women
- Increase child spacing intervals through effective contraceptive use
- Provide access to inter-pregnancy care health services to women with a previous VLBW infant

CareSource contracts with the state of Georgia Department of Community Health to provide benefits for Planning for Healthy Babies®.

GEORGIA FAMILIES® SERVICE AREAS

CareSource serves Georgia Families® members state-wide in six service regions:

Atlanta

- Barrow
- Bartow
- Butts
- Carroll
- Cherokee
- Clayton
- Cobb
- Coweta
- DeKalb
- Douglas
- Fayette
- Forsyth
- Fulton
- Gwinnett
- Haralson
- Henry
- Jasper
- Newton
- Paulding
- Pickens
- Rockdale
- Spalding
- Walton

Central

- Baldwin
- Bibb
- Bleckley
- Chattahoochee
- Crawford
- Crisp
- Dodge
- Dooly
- Harris
- Heard
- Houston
- Jones
- Lamar
- Laurens
- Macon
- Marion
- Meriwether
- Monroe
- Muscogee
- Peach
- Pike
- Pulaski
- Talbot
- Taylor
- Telfair
- Treutlen
- Troup
- Twiggs
- Upson
- Wheeler
- Wilcox
- Wilkinson
- Johnson

East

- Burke
- Columbia
- Emanuel
- Glascock
- Greene
- Hancock
- Jefferson
- Jenkins
- Lincoln
- McDuffie
- Putnam
- Richmond
- Screven
- Taliaferro
- Warren
- Washington
- Wilkes

North

- Banks
- Catoosa
- Chattooga
- Clarke
- Dade
- Dawson
- Elbert
- Fannin
- Floyd
- Franklin
- Gilmer
- Gordon
- Habersham
- Hall
- Hart
- Jackson
- Lumpkin
- Madison
- Morgan
- Murray
- Oconee
- Oglethorpe
- Polk
- Rabun
- Stephens
- Towns
- Union
- Walker
- White
- Whitfield

Southeast

- Appling
- Bacon
- Brantley
- Bryan
- Bulloch
- Camden
- Candler
- Charlton
- Chatham
- Effingham
- Evans
- Glynn
- Jeff Davis
- Liberty
- Long
- McIntosh
- Montgomery
- Pierce
- Tattnall
- Toombs
- Ware
- Wayne

Southwest

- Atkinson
- Baker
- Ben Hill
- Berrien
- Brooks
- Calhoun
- Clay
- Clinch
- Coffee
- Colquitt
- Cook
- Decatur
- Dougherty
- Early
- Echols
- Grady
- Irwin
- Lanier
- Lee
- Lowndes
- Miller
- Mitchell
- Quitman
- Randolph
- Seminole
- Schley
- Stewart
- Sumter
- Terrell
- Thomas
- Tift
- Turner
- Webster
- Worth

PERSONALLY IDENTIFIABLE INFORMATION

In the day-to-day business of patient treatment, payment and health care operations, CareSource and its health partners 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 health partner, you should be taking measures to secure your sensitive data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure Personal 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 no longer needed
- Encrypt laptops and other portable media like CD-ROMs and flash drives
- 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.

ACCREDITATION

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our Ohio Medicaid and Health Insurance Marketplace plans. We have an Interim accreditation status for our Kentucky, Indiana and West Virginia Health Insurance Marketplace plans. NCQA is a private, non-profit organization dedicated to improving health care quality through measurement, transparency and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement. CareSource has applied for interim NCQA accreditation for Georgia Medicaid. Visit **www.NCQA.org** for more information.

CHAPTER 2
COMMUNICATING WITH CARESOURCE

CareSource communicates with our health partner network through a variety of channels, including phone, fax, Provider Portal, newsletters, CareSource.com and network notifications.

CARESOURCE HOURS OF OPERATION

Health Partner Services

Georgia Families®	M-F	7 a.m. to 7 p.m., excluding state holidays

Member Services

CareSource24®	Available 24 hours a day, seven days a week, 365 days a year	
Georgia Families®	M-F	7 a.m. to 7 p.m., excluding state holidays

Please visit **CareSource.com** for the holiday schedule or contact Health Partner Services for more information.

PHONE AND FAX NUMBERS

To help us direct your call to the appropriate professional for assistance, you will be instructed to select the menu option(s) that best fits your need. Please note that our menu options are subject to change. We also provide telephone based self- service applications that allow you to verify member eligibility.

For member calls, Katie, our automated phone system, will assist in reaching the best person to care for them in the quickest, more efficient way possible.

Phone Numbers

Health Partner Services 1-855-202-1058
Prior Authorizations 1-855-202-1058
Centralized Prior Authorization 1-800-766-4456
Georgia Medicaid Management Information System/GAMMIS
Claims Inquiries 1-855-202-1058
Pharmacy 1-855-202-1058
Grievance & Appeals 1-855-202-1058
Member Services 1-855-202-0729
CareSource24® - Nurse Advice Line 1-844-206-5944
Fraud, Waste and Abuse Hotline 1-855-202-1058
TTY for the Hearing Impaired ..... 1-800-255-0056 or 711

Fax Numbers

Care Management Referral 844-417-6255
Contract Implementation 937-396-3632
Fraud, Waste and Abuse 800-418-0248
Medical Prior Authorization 844-676-0370
*For convenient centralized prior authorization submissions, visit the Georgia Web Portal at **www.mmis.Georgia.gov**.*
Health Partner Appeals 866-317-2157
Health Partner Maintenance 937-396-3076
(e.g., office changes, adding/deleting health partners)

GEORGIA MEDICAID MANAGEMENT INFORMATION SYSTEM (GAMMIS) WEB PORTAL

The GAMMIS portal provides timely communications, data exchange and self-service tools for members and providers with both secure and public access areas. The GAMMIS system can process claims in real time, give claim status, verify eligibility, collect prior authorization requests and more.

The Georgia Web Portal serves as the centralized portal for the submission of Fee-for-Service (FFS) authorization requests, and authorization requests for certain services provided to Medicaid members enrolled in a Care Management Organization (CMO). Access the portal by going to Georgia Medicaid Management Information System (GAMMIS) at **www.mmis.georgia.gov**.

Hewlett Packard Enterprise (HPE) is the fiscal agent for the Georgia Department of Community Health, which includes updating and maintaining the GAMMIS portal. HPE Customer Service Representatives may be reached at 1-800-766-4456, or by inquiring on the GAMMIS portal at: https://www.mmis.georgia.gov.

CARESOURCE.COM

Our website, **CareSource.com**, is a tool to you can use to access important information quickly and easily. On the Provider section of the site, you will find:

- Commonly used forms
- Newsletters, updates and announcements
- The CareSource Health Partner manual
- Claim submission information
- Frequently asked questions
- Clinical and preventive guidelines
- Benefit grid
- Behavioral health information
- And much more

CareSource Provider Portal: https://providerportal.CareSource.com/GA/

Our secure online Provider Portal allows you instant access at any time to valuable information, tools including the Member Profile and CareSource Clinical Practice Registry, various self-service options, clinical and preventive guidelines, and other resources. Simply enter your user name and password (if already a registered user), or submit your information to become a registered user. Assisting you is one of our top priorities in order to deliver better health outcomes for our members.

CareSource Provider Portal Benefits

- Free access to important resources
- Availability 24 hours a day, 7 days a week
- Secure, convenient access to time-saving services and critical information
- Accessibility on any personal computer or device without any additional software

CareSource Provider Portal Functions

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

- **Payment history** – Search for payments by check number or claim number
- **Claims** – Search for status of claims, submit appeals and view claim history (including vision benefits)
- **Coordination of Benefits (COB)** – Confirm COB for patients
- **Prior authorization** – Request authorization for medical and behavioral inpatient/outpatient services and Synagis. Authorizations for the following services should be submitted on the GAMMIS web portal:
  - Inpatient (POS21), outpatient (POS22) or ASC (POS24) setting services
  - Durable medical equipment
  - Children's intervention therapy services
  - Notification of pregnancy
  - Newborn notification
  - Outpatient behavioral health
- **Eligibility termination dates** – View the member's termination date (if applicable) under the eligibility tab
- **Care management referrals** – Submit automated care management forms on our Portal for efficiency in enrolling members
- **Benefit limits** – Track benefit limits electronically in real-time before services are rendered for services like chiropractic visits
- **Care treatment plans** – View care treatment plans for patients on our Provider Portal
- **HEDIS scores** – Review your performance on key HEDIS metrics
- **Monthly membership lists** – View and download current monthly membership lists
- **Member Profile** – Access a comprehensive view of patient medical/pharmacy utilization
- **Information exchange** – Share relevant member information to facilitate better integration of behavioral health, dental and medical care
- **CareSource clinical practice registry** – 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

PORTAL REGISTRATION

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

1. Visit CareSource.com > Providers > Georgia > Medicaid and click on "Provider Login."
2. Click on the "Register Now" button and complete the three-step registration process.
   Note: you will need to have your tax ID number.
3. Click the "Continue" button.
4. Note the username and password you create so that you can access the Portal's many helpful tools.

If you do not remember your username/password, please call Health Partner Services at **1-855-202-1058**.

HEALTH PARTNER DEMOGRAPHIC CHANGES AND UPDATES

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a health partner to your practice helps us keep our records current and are critical for claims processing. You may notify CareSource of any status changes by utilizing the following method.

Email: providermaintenance@CareSource.com

Mail: CareSource
Attn. Provider Maintenance
P.O. Box 8738
Dayton OH 45401-8738

Fax: 1-937-396-3076

HOW TO COMMUNICATE WITH CARESOURCE BY MAIL

Medical Prior Authorization Submission Address

CareSource
Attn: Medical Management Department
P.O. Box 1598
Dayton, OH 45401

Authorizations may also be submitted via the centralized Georgia Web Portal at www.mmis.georgia.gov.

Email: gamedmgmt@CareSource.com

Claims Submission Mailing Address

CareSource
Attn: Claims Department
P.O. Box 803
Dayton, OH 45401

Pharmacy Claims Submission Mailing Address

CVS Caremark
P.O. Box 52066
Phoenix AZ 85072-2136

Health Partner Delegated Credentialing Mailing Address

CareSource
Attn. Vice President/Senior Medical Director
P.O. Box 8738
Dayton OH 45401-8738

Health Partner Appeals Mailing Address

CareSource
Attn: Health Partner Appeals - Georgia
P.O. Box 2008
Dayton, OH 45402
Fax: 844-417-6262

Health Partner Dispute Mailing Address

CareSource
Attn. Quality Improvement
P.O. Box 8738
Dayton OH 45401

Please visit our website at **CareSource.com** for more information on how appeals can be submitted online.

Member Appeals & Grievances Mailing Address

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

Fraud, Waste and Abuse Address

CareSource
Attn. Special Investigations Unit
P.O. Box 1940
Dayton, OH 45401-1940
Email: fraud@caresource.com

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

NEWSLETTERS

CareSource communicates with health partners in a variety of ways. Our newsletter, produced four times a year, is both mailed and posted online at **CareSource.com**. It contains operational updates, clinical articles and new initiatives underway at CareSource.

NETWORK NOTIFICATIONS

Network notifications are published for CareSource health partners to regularly communicate updates to policies and procedures. Network notifications are found on the Updates/Announcements page of our website.

REQUESTING A HARD COPY

The CareSource Health Partner Manual is available online under Plan Resources. You may also request a hard copy by calling Health Partner Services at **1-855-202-1058**. Upon request, CareSource will mail a hard copy to you.

CHAPTER 3
FRAUD, WASTE AND ABUSE

Health care fraud, waste and abuse hurts everyone, including members, health partners, taxpayers and CareSource. As a result, CareSource has a comprehensive Fraud, Waste and Abuse program in our Special Investigations Unit. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

DEFINITION OF TERMS

Fraud

Fraud is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law." (42 CFR, Part 455.2)

Waste

Waste involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients).

Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight (Inspector General).

Abuse

Abuse is defined as "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program" (42 CFR Part 455.2).

Improper 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).

Examples of member fraud, waste and/or abuse:

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple health partners 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
- Changing prescription forms to get more than the amount of medication prescribed by a physician
- 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.

Examples of health partner 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
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking member IDs, 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 billed for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark violations
- Retaining overpayments made in error by CareSource
- Preventing members from accessing eligible or covered services resulting in underutilization of services offered

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

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

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

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

The CareSource Special Investigations Unit 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 health partner education
- Written corrective action plan
- Health partner termination with or without cause
- Health partner summary suspension
- Prepayment review of claims
- 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 Health Partner Agreement for specific information on each type of health partner termination/suspension. Also, refer to the Fair Hearing Plan, located in Chapter 16, for the information on the appeal process. The CareSource Fair Hearing Plan is also available at **CareSource.com**. Search “Fair Hearing Plan” to find information on an appeal process for specific corrective actions.

REPORTING FRAUD, WASTE AND ABUSE

You can report your suspicions of fraud, waste or abuse to the CareSource Special Investigations Unit. Contact information for reporting fraud, waste and abuse is located at **CareSource.com**, in the "Communicating with CareSource" section of this CareSource Health Partner Manual and at the end of this section.

The Federal and State False Claims Acts and other Fraud, Waste and Abuse Laws

Using the False Claims Act (the Act), you can help reduce fraud against the federal government. The Act allows everyone to bring "whistleblower" lawsuits on behalf of the government – known as "qui tam" suits – against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

As amended in 2009, the False Claims Act addresses those who:

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

b. Knowingly* makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim.

c. Conspires to commit a violation of any other section of the False Claims Act.

d. 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.

e. 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.

f. 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.

g. 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.

*"Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.

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

The Deficit Reduction Act of 2005

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.

The time period for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity

Georgia Law

Georgia has enacted a false claims statute that meets the requirements of Section 1909 of the Social Security Act. Section 1909 provides a financial incentive for a state to enact a false claims statute that is at least as effective in rewarding and facilitating qui tam actions for false claims as those described in the federal False Claims Act.

Georgia's Taxpayer Protection Against False Claims statute applies to any individual or entity that:

- Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval;
- Knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;
- Conspires to commit a violation of any other section of the statute;
- Has possession, custody or control of property or money used, or to be used, by the state or local government and knowingly delivers, or causes to be delivered, less than all of that money or property;
- Being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state or local government and, intending to defraud the state or local government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or local government who lawfully may not sell or pledge the property; or
- Knowingly makes, use, 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 state or local government, or knowingly conceals, knowingly and improperly avoids, or decreases an obligation to pay or transmit money or property to the state or a local government

Georgia's Taxpayer Protection Against False Claims statute may be found at Georgia Code 23-3-120, et seq.

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, health partners 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. §1395nn).
- 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).

Protection for Reporters of Fraud, Waste or Abuse

Federal and state law and CareSource's policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our Special Investigations Unit using one of the reporting methods outlined at the end of this section.

Incentives for Whistleblowers

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 on **CareSource.com**.

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, health partner or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. 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 below.

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 health partners 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.

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 using the contact information in the "How to Report Fraud, Waste or Abuse" section.

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 state Medicaid fraud laws. If you have knowledge or information that any such activity may be or has taken place, please contact our Special Investigations Unit. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting anonymously:

- Call: **1-855-202-1058** and follow the appropriate menu option for reporting fraud
- Write: CareSource
  Attn: Special Investigations Unit
  P.O. Box 1940
  Dayton, OH 45401-1940

Options for reporting that are not anonymous:

- Fax: 1-800-418-0248
- Email*: **fraud@CareSource.com**
- Or you may choose to use the Fraud, Waste and Abuse Reporting Form located at **CareSource.com**.

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.

A ROADMAP TO AVOID MEDICARE AND MEDICAID FRAUD AND ABUSE

The Office of the Inspector General (OIG) has created free materials for health partners 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 OIG website at: **http://oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf.**

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

CHAPTER 4
CULTURAL COMPETENCY PLAN

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 systems 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 health partners and staff to ensure that services are delivered in a culturally competent manner.

Participating health partners are expected to provide 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 health partners must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

Health partners 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, health partners are not required to perform any treatment or procedure that is contrary to their religious or ethical principles.

Network health partners must ensure that:

- Members understand that they have access to medical interpreters, signers and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the members’ race/ethnicity and language and its impact/influence on the members’ health or illness
- The office staff that is responsible for data collection make reasonable attempts to collect race-and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify his/her own race/ethnicity and that of his/her children
- Treatment plans are developed and clinical guidelines are followed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physician abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process
- Participating health partners 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 its participating health partners to complete the US Department of Health and Human Services Physician Practical Guide to Culturally Competent Care, which is a free on-line accredited educational program. We provide links to cultural competency training, as well as to our full Cultural Competency Plan for Georgia, online at **CareSource.com.**

CHAPTER 5
CLAIM SUBMISSIONS

In general, CareSource follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. For expedited claim processing and payment delivery, please ensure your address(es) and phone number(s) on file with CareSource are up-to-date. You can email providermaintenance@CareSource.com to update this information.

BILLING METHODS

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

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

ELECTRONIC FUNDS TRANSFER

CareSource offers electronic funds transfer (EFT) as a payment option. Visit the Provider Portal for additional information about the program and to enroll in EFT. Health partners who elect to receive EFT payment will receive an EDI 835 (Electronic Remittance Advice). Health partners can also download their Explanation of Payment (EOP) from the Provider Portal.

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 CareSource's secure Provider Portal to view (and print if needed) remittances and transaction details.

Simply complete the enrollment form, available on the "Claims Payment" page of **CareSource.com**, and fax it back to InstaMed, who will work directly with health partners to enroll in EFT. Free EFT training is also available to CareSource health partners through InstaMed during the enrollment process. You view the training by visiting **www.instamed.com/aha-eraeft/.**

ELECTRONIC CLAIMS 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 health partners. Our EDI system complies with HIPAA standards for electronic claims submission.

EDI Clearinghouses

CareSource prefers electronic claim submission. To submit electronic claims, health partners may use any clearinghouse (trading partner), if it can be validated that the clearinghouse will send the claims to CareSource. If you do not currently use a clearinghouse, please contact the clearinghouse of your choice from our preferred list below or use our free Provider Portal.

Please provide the clearinghouse with the CareSource payer ID number: GACS1

Clearinghouse	Website	Phone
Availity	www.availity.com	1-800-282-4548
Change Healthcare (formerly Emdeon)	www.changehealthcare.com	1-800-845-6592
Quadax	www.quadax.com	440-777-6305
Relay Health	connectcenter.relayhealth.com	1-800-527-8133

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
- 835 Health Care Claim Payments/Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 278 Health Care Services Review (Prior Authorization Requests)
- 834 Benefit Enrollment and Maintenance
- 820 Group Premium Payment for Insurance Products
- NCPDP Version D.0

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).

NPI 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.

Please note: On paper claims, the NPI number should be placed in the following box(es) based on form type:

- CMS 1500: Box 24J for the rendering health partner's NPI 24J and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating health partner's NPI and (if applicable) Box 49 for the group NPI

Location of Provider NPI, TIN and Member ID Number on Professional Claims

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

- Medicaid: 2010AA Loop – Billing provider name
- Medicare: 2310B Loop – Rendering provider name
- 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 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 health partner TIN must be submitted as the secondary provider identifier using a REF segment, which is either the EIN for organizations or the 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 CareSource member ID number should go on:

- 2010BA Loop – Subscriber name
- NM109 = Member ID number

PAPER CLAIMS

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically. Paper claim forms are only encouraged for services that require clinical documentation or other forms to process. If you submit paper claims, please submit on one of the following claim form types:

- CMS 1500
- AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental Claim Form

CMS 1450 (UB-04) paper claim submission must be done using the most current form version as designated by the Centers for Medicare and Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA).

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.cms.hhs.gov/transmittals/downloads/R1104CP.pdf**
- UB-04 Form Instructions: **www.nucc.org**

Please note: On paper claims, the NPI number should be placed in the following box(es) based on form type:

- CMS 1500: Box 24J for the rendering health partner's NPI 24J and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating health partner's NPI and (if applicable) Box 49 for the group 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.
- 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 health partner practice (e.g., legal business entity) has a different tax ID number.
- Signature of physician or supplier – The health partner'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.

Prenatal or Delivery Services Claims

For prenatal or delivery services, the last menstrual period date* is required on claims. For delivery services, the birth weight is required.

* Last menstrual period may be calculated – For Medicaid health partners, 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 health partner who delivers the baby, especially if the member received prenatal care from another health partner or facility. Please remember that participating health partners 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.

What to include on claims that require National Drug Codes (NDC)

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

Instructions for NDC 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:

- EDI claims are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current form version as designated by CMS, NUCC and the ADA.
- No handwritten (including printed claims with any handwritten information) claims or SuperBills will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Fonts should be 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 tax ID number or physician SSN is required for all claim submissions.

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

CareSource
Attn: Claims Department
P.O. Box 803
Dayton, OH 45401

CLAIM SUBMISSION TIMELY FILING

Claims must be submitted within 180 calendar days of the date of service or discharge. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim. If this happens, health partners may submit a corrected claim or file a claim appeal.

Claims Processing Guidelines

- Health partners have 180 calendar days from the date of service or discharge to submit a clean claim. If the claim is submitted after 180 calendar days, the claim will be denied for timely filing.
- If you do not agree with the decision of the processed claim, you may file an appeal.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a member has other insurance and CareSource is secondary, then the health partner must submit for secondary payment within 90 calendar days of date on the primary carrier's EOB, but not more than 12 months from the date of service or discharge. Claims filed timely with a primary carrier, but did not generate a response from the carrier, despite all reasonable actions taken, must be filed not more than 12 months from the date of service or discharge indicating no response was received.
- If a claim is denied for Coordination of Benefits (COB) information needed, the health partner must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date, but not more than 12 months from the date of service or discharge. If a copy of the claim and EOP is not submitted within the required time frame, the claim will be denied for timely filing.

- There will be times when a member is hospitalized for a longer period of time. The health partner will be able to submit interim bills, which CareSource will pay at 30 percent of the billed charges submitted. When the patient is discharged, the health partner 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 health partner will have 180 calendar days 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 CareSource ID number. Do not submit newborn claims using the mother's CareSource ID number; the claim will deny. Claims for newborns must include the birth weight.

Claims that Require Completed Consent Forms

- Abortion – This type of service requires a completed abortion certification form and prior authorization. Please refer to the Referral and Prior Authorization section of this manual for information on the prior authorization process.
  - DMA-311 Certificate for Necessity for Abortion
- Sterilization – This type of service requires a completed Informed Consent For Sterilization Form.
  - DMA-69 Informed Consent for Voluntary Sterilization
- Hysterectomy – This type of service requires a completed Hysterectomy Form.
  - DMA-276 Hysterectomy Form

For additional information please see the Covered Services and Exclusions Section of this manual. The forms referenced above are available at the Georgia Medicaid Management Information System GAMMIS web site at: **www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Forms/tabId/57/Default.aspx.**

SEARCHING FOR CLAIMS INFORMATION ONLINE

Claim status is updated daily on our Provider Portal, and you can check claims that were submitted for the previous 24 months. You can search by member ID number, member name and date of birth or claim number.

Additional claims enhancements on the **Provider Portal**:

- Claim history available up to 24 months from the date of service
- Submit claim appeal
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date
- Dental claim information
- Vision claim information

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 health partners 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/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page.**
- HCFA Common Procedure Coding System (HCPCS). Available at **www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/ MedHCPCSGeninfo/ http://www.cms.hhs.gov/default.asp%20.**
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at **1-800-947-4746 or www.ada.org/en/.**
- National Drug Codes (NDC). Available at **www.fda.gov/.**

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 health partner.

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

HEALTH PARTNER CODING AND PAYMENT POLICIES

CareSource strives to be consistent with all DCH, federal regulations 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 health partner contract. In addition, the Center for Medicare and Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed. Finally, 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: **www.cms.hhs.gov/home/medicare.asp**
- Georgia Medicaid: **www.mmis.georgia.gov/portal/PubAccessProviderInformation/FeeSchedules/tabid/56/BMLUsed/20160127/Default.aspx**

CareSource uses coding industry standards, such as the AMA 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 health partner 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 DCH, federal regulations 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 health partner'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.

EXPLANATION OF PAYMENT (EOP)

Explanation of Payments (EOPs) are statements of the current 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. Health partners 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 health partner'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**. Check **CareSource.com** for a sample EOP.

PENDED CLAIM REPORT

Pended claims have been entered into our system, but have not yet been processed completely.

CareSource is responsible for resolving any pended claims, not the health partner. The report may be sent to you merely to acknowledge receipt. Please do not resubmit pended claims; this may further delay processing.

OTHER COVERAGE – COORDINATION OF BENEFITS (COB)

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 COB on the Provider Portal by:

- Member number
- 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.

COB Overpayment

If a health partner 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 health partner, or the health partner can issue refund checks to CareSource for any overpayments. Health partners should not refund any money received from a third party to a member.

REIMBURSEMENT FOR EMERGENCY HEALTH CARE SERVICES

Emergency services are available twenty-four (24) hours a day, seven (7) days a week to treat emergency medical conditions. CareSource provides reimbursement for emergency services when rendered by qualified health partners, regardless of whether the health partner is in CareSource's network. CareSource will reimburse health partners for all medically necessary emergency services, until the member is stabilized. Once a member's condition stabilized, health partners must notify CareSource as soon as reasonably possible in order for CareSource to issue any applicable authorizations needed.

CareSource will not:

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

In processing claims for emergency health care services, CareSource will consider, at the time that a claim is submitted, at least the following criteria:

1. The age of the patient;
2. The time and day of the week the patient presented for services;
3. The severity and nature of the presenting symptoms;
4. The patient's initial and final diagnosis; and
5. Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.

CareSource will provide reimbursement for medically necessary emergency services in accordance with the health partner's contract with CareSource or in accordance with the Department of Community Health's Fee-For-Service reimbursement rates for health partners that do not have a contract with CareSource, less any applicable percentage.

A member may not be billed for medically necessary emergency services.

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 health partner for all covered services. Then, we will pursue recovery from any third parties involved.

MEMBER BILLING POLICY

Health partners may not bill members for any covered services, with the exception of copayments. In addition, they may not refuse to provide services if a member cannot pay the copayment. However, a health partner may, upon accepting a patient as a Georgia Families®/PeachCare for Kids® member, charge the member for non-covered services. In order to charge the member for non-covered services, the health partner must obtain written acknowledgement that the member is assuming financial responsibilities prior to the service being rendered.

Health partners may not charge members for services which CareSource denied on the basis of lack of medical necessity or lack of compliance to contractual terms. Health partners may not bill members for missed appointments.

ENCOUNTER CLAIMS ELEMENT REPORTING/RECORDS PROTOCOL

CareSource relies on timely, complete and accurate claim information to generate Encounter data, which is submitted to the State of Georgia and used to determine the adequacy of medical services and to evaluate the quality of care rendered to members.

Your State of Georgia Medicaid ID number is required on claims, and each practice location will require a unique State of Georgia Medicaid ID number. All claims must include valid values for all critical data elements such as state Medicaid ID numbers, National Provider Identification (NPI) numbers, SSN numbers, member name, and date of birth (DOB). These items must match the State of Georgia eligibility and provider file.

GEORGIA FAMILIES® AND PEACHCARE FOR KIDS® COVERED SERVICES

Please visit the CareSource website at **CareSource.com** for information on services, including dental services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Referrals and Prior Authorizations" section of this manual for more information about referral and prior authorization procedures, including the centralized prior authorization submission process with GAMMIS. For the most comprehensive and up-to-date list of CareSource covered benefits, please see the full CareSource Covered Benefits grid.

	Georgia Families®			PeachCare for Kids®			
Type of Service	Cost Sharing	Limits	PA Required	Cost Sharing	Limits	PA Required	Additional Comments
Allergy Testing and Treatment	$3	N/A	No	$3 or cost-based	N/A	No	$3 copayment applies if service performed in outpatient facility setting.
Ambulance Services	$0	N/A	Yes	$0	N/A	Yes	Prior authorization is required on fixed wing transports and ambulance transportation with a HR modifier.
Anesthesia	$0	N/A	No	$0	N/A	No	
BEHAVIORAL HEALTH			No			No	
Inpatient Facility	$12.50	Up to age 21	Yes	$12.50	N/A	Yes	
Outpatient Facility	$3	N/A	Yes	$3	N/A	Yes	IOP or PHP requires a prior authorization after 30 visits. Prior authorization is required for applied behavioral analysis.
Psychological Testing	$3	Up to age 21	Yes	$3 or cost-based	N/A	Yes	A $3 copayment applies if the service is performed in an outpatient facility setting. Prior authorization requirements for applied behavioral analysis.
Chiropractic Services	$0	Ages 12 and over 15 visits per year	No	$0	Ages 12 and over 15 visits per year	No	
Dental Services	$0	Adults	No	$0	Prevent-ative	No	Adult services are limited to two teeth cleanings per year, annual x-rays and simple tooth extractions. Preventive services include fillings, teeth cleaning, x-rays and simple extractions.

	Georgia Families®			PeachCare for Kids®			
Type of Service	Cost Sharing	Limits	PA Required	Cost Sharing	Limits	PA Required	Additional Comments
DIAGNOSTIC SERVICES							
Diagnostic Surgery	$3	N/A	No	$3	N/A	No	A $3 copayment applies if service performed in outpatient facility setting.
Diagnostic Radiology	$3	N/A	No	$3	N/A	No	A $3 copayment applies if service performed in outpatient facility setting.
Diagnostic Lab/ Pathology	$3	N/A	No	$3	N/A	No	A $3 copayment applies if service performed in outpatient facility setting.
Durable Medical Equipment	$0	N/A	Yes	$2	N/A	Yes	See Below
	Additional Comments: Prior authorization is required on the following durable medical equipment: Powered or customized wheelchairs, manual wheelchair rental over three months, all miscellaneous codes, continuous positive airway pressure (CPAP), insulin pumps and continuous glucose monitors (CGMs), cranial orthotics, food supplements/nutritional supplements/enteral feeds – greater than 30 cans per month or greater than one can per day, speech generating devices, defibrillators, bone growth stimulation, implantable cardioverter-defibrillator (ICD), implanted spinal cord stimulators (SCS), chest compression vest and intrapulmonary percussive ventilation (IPV), pneumatic artificial voicing systems, standing frames, stretching devices for the treatment of joint stiffness and contracture, wheel mobility devices, UV light therapy, prosthetic and orthotic devices > $1200, contact lens including the fitting fee and hearing aids.						
Education/ Training	$0	N/A	No	Cost-based	N/A	No	
Emergency Room	$3	N/A	No	$0	N/A	No	A copayment applies if the condition is not an emergency medical condition.
Emergent/ Urgent Care	$0	N/A	No	$0	N/A	No	
Family Planning	$0	N/A	No	$0	N/A	No	
Federally Qualified Health Center/Rural Health Center	$2	N/A	No	$2	N/A	No	Limits apply as necessary, based on the services provided.
Habilitative Services	$0	Up to age 21	No	Cost-based	Up to age 21	No	
Hearing Aids	$0	Up to age 21	Yes	$0	N/A	Yes	
Home Health Services	$0	N/A	Yes	$3	N/A	Yes	Prior authorization is required for home health aides, private duty nursing, skilled nurse visits exceeding two per day, social worker vists exceeding two per day.
Hospice Care	$0	N/A	No	$0	N/A	No	
Inpatient Hospital	$12.50	Respite care limited to five days	Yes	$12.50	N/A	Yes	
Skilled Nursing Facility	$0	N/A	Yes	$0	N/A	Yes	

	Georgia Families®			PeachCare for Kids®			
Type of Service	Cost Sharing	Limits	PA Required	Cost Sharing	Limits	PA Required	Additional Comments
DIAGNOSTIC SERVICES (CONTINUED)							
Office Visits	$0	N/A	Yes	Cost-based	N/A	Yes	Prior authorization is required for pain management services.
Oral Maxillofacial Surgery	$0	N/A		Cost-based	N/A		
Orthotics/ Prosthetics	$0	N/A	Yes	$3	N/A	Yes	Prior authorization required for items exceeding $1,200.
Outpatient Hospital	$3	N/A	No	$3	N/A	No	
PHARMACY							
Podiatry	$0	N/A	No	Cost-based	N/A	No	
Preventive Services	$0	N/A	No	$0	N/A	No	Immunizations that are covered under the Vaccines for Children (VFC) program are limited to administration of the vaccine only.
Physical Therapy/ Occupational Therapy/ Speech Therapy	$0	Up to age 21	Yes	Cost-based	N/A	Yes	Prior authorization is required when more than two visits per day in a home setting.
SURGERIES							
Inpatient Facility	$12.50	N/A	Yes	$12.50	N/A	Yes	
Outpatient Facility	$3	N/A	No	$3	N/A	No	
Ambulatory Surgery Center	$3	N/A	No	$3	N/A	No	
Vision	$0	Eye exam and $75 allowance for hardware or contacts	Yes	Cost-based	N/A	Yes	Prior authorization is required for contacts lens and fitting.

* For Georgia Families®, the following are exempted from copayments: children under age twenty-one (21), pregnant women, nursing facility residents, members enrolled in breast and cervical cancer programs, American Indians, Alaska Natives and hospice care members.

** For PeachCare for Kids®, the following are exempted from copayments: children under the age of 6, children in foster care, or children who are American Indian or Alaska Natives.

Health partners may not refuse to provide services to a member if the member indicates that he or she is unable to pay the copayment.

BENEFIT LIMITS

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits are limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Health Partner Services a**t 1-855-202-1058**.

This section describes the services and exclusions to benefits that are provided to our CareSource members. CareSource covers all medically necessary covered services for members. Covered services may require copayments and/or prior authorization. Please visit our website at **CareSource.com** for the most up-to-date list of services that require prior authorization.

Medical Necessity Standards and Practice Guidelines

"Medical necessity" or "medically necessary" means services that are:

- Appropriate and consistent with the diagnosis of the treating health partner and the omission of which could adversely affect the eligible member's medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the member or the convenience of the health partner or hospital;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage; and
- Provided when there is no other effective, more conservative or substantially less costly treatment, service or setting is available

In addition, for Medicaid children under age 21, CareSource will cover medically-necessary services to correct or ameliorate physical and behavioral health disorders, a defect or a condition identified using an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening or preventive visit, regardless of whether the services are included under the State plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.

Some services require prior authorization. CareSource reviews all service requests for Medicaid members under the age of 21 for medical necessity. If a request for authorization is submitted, CareSource will notify the health partner and member in writing of the determination. If a service cannot be covered, health partners 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 of this manual for information on how to file an appeal.

Covered services and exclusions for CareSource members can be found at **CareSource.com**.

COVERED BENEFITS & SERVICES

Abortions and Sterilizations

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

Abortion – Abortion services are covered in the following circumstances without prior authorization:

- This patient suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place this woman in danger of death unless an abortion is performed
- The pregnancy is the result of rape
- The pregnancy is the result of incest

Abortion or abortion-related services are not covered when performed for family planning purposes. CareSource will cover treatment of medical complications as result of elective abortions and treatments for spontaneous, incomplete or threatened abortions and for ectopic pregnancies.

Certification of Necessity for Abortion

Before reimbursement for an abortion can be made, the health partner performing the abortion must certify that one of the three circumstances above has occurred. The certification must be made on the Georgia Department of Medical Assistance Certification of Necessity for Abortion (DMA-311). The health partner's signature must be in the physician's own handwriting. All certifications must contain the patient's name, address and Medicaid ID number. The certification form must be attached to the claim.

Requirements for Sterilization and Hysterectomies

Sterilization procedures are covered only if all 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, in accordance with Georgia Policies and Procedures for Family Planning Service. This includes the completion of all applicable documentation.
- The procedure is scheduled at least 30 calendar days, 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).
- 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.

In addition for hysterectomies, the following requirements must also be met:

- A hysterectomy is only rendered for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental retardation.
- Prior to the hysterectomy, the member must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
- Informed consent is obtained on the Georgia Families® Sterilization Request Consent Form prior to the hysterectomy, regardless of diagnosis or age.
- 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 hysterectomy is not being performed for the purpose of cancer prophylaxis.

A hysterectomy is not a covered service for P4HB® members.

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

Health partners are required to maintain documentation of all sterilizations, hysterectomies and abortions, as consistent with requirements in 42 CFR 441.200 and 42 CFR 441.208 and 42 CFR 441.250 through 42 CFR 441.259 . CareSource will not accept documentation for informed consent completed or altered after the service was rendered.

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.

P4HB® participants ages 19 and 20 shall receive hepatitis B, tetanus-diphtheria (Td) and combined tetanus, diphtheria and pertussis vaccinations according to the ACIP guidelines as needed.

Health partners must administer immunizations obtained through the Vaccines for Children (VFC) program for all members 18 years of age and younger. The vaccines are available free of charge through the VFC program.

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

Please see the "Member Support Services and Benefits" section for more details on immunizations. CareSource will not reimburse costs for vaccines obtained outside the VFC program when provided to children under age 19.

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)
  - 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 age 21 and over

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

CHAPTER 7
CREDENTIALING AND RECREDENTIALING

DCH utilizes a Credentialing Verification Organization (CVO) to streamline the credentialing process for DCH health partners enrolled in Georgia Families®. The CVO will:

- Perform primary source verification
- Check federal and state databases
- Obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS)
- Check required medical malpractice insurance
- Confirm Drug Enforcement Agency (DEA) numbers, etc.

A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 51 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision.

DCH, through its fiscal agent, Hewlett Packard Enterprises, has implemented a Centralized Credentialing Verification Organization which performs credentialing and recredentialing functions for health partners enrolled or seeking to enroll in the Georgia Families® network.

CareSource will include in our network only those health partners who:

- Have been appropriately credentialed by the CVO;
- Maintain a current license; and
- Have appropriate locations to provide covered services to our members.

CONTRACTING AND CREDENTIALING PROCESS

Upon a health partner's interest in contracting with CareSource, the process below is followed:

1. CareSource will review the health partner request and begin building the health partner's contract.
2. CareSource will coordinate with HPE to confirm the status of health partners who request to enroll with us and to confirm their credentialing or recredentialing status.
3. CareSource will refer new health partners who are not Medicaid providers to GAMMIS to complete the credentialing process.
4. Upon receipt of notice that the CVO has completing the credentialing process, CareSource will electronically send the contract to the health partner.

Credentialing

Health partners must enroll in the Medicaid/PeachCare for Kids® program. They can enroll by submitting an application and supporting documentation to the GAMMIS portal.

- **URL**: www.mmis.georgia.gov/portal/PubAccess.Home/tabId/36/Default.aspx
- **HPE Provider Relations Representative Phone**: 1-800-766-4456

CareSource will not conduct its own credentialing processes and will accept the CVO's credentialing and recredentialing determinations. CareSource cannot appeal the CVO's credentialing decision. CareSource cannot require health partners to submit supplemental or additional information for purposes of conducting a second credentialing process.

CareSource will not pay for claims for dates of service prior to the credentialing approval date.

EXCLUSIONS

CareSource will not include any health partners in our network who:

- Have been excluded by the United States Department of Health and Human Services
- Have been excluded by the Office of Inspector General
- Are on Georgia's list of excluded providers

CareSource monitors the exclusions list monthly and shall immediately terminate any health partner found to be excluded. We will notify any impacted members, per contractual requirements.

Delegated Credentialing

For Independent Physician Associations (IPAs) and/or Preferred Hospital Organizations (PHOs), CareSource may also 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.

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

Accreditation Standards

The DCH recognizes the Joint Commission's accreditation/certification programs to provide quality oversight for certain provider types. Visit **https://www.jointcommission.org/state_recognition/state_recognition_details.aspx?ps=25&s=GA** for a list of current state accreditation requirements.

CHAPTER 8
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.

Participating health partners are responsible for providing CareSource with advance written notice of any intent to terminate an agreement with us. This must be done 60 days prior to the date of the intended termination and submitted on your organization's letterhead.

- For PCPs only: Providing 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 health partner 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 health partner and only recommends emergency room use for after hours.
- Submission of clean claims should be submitted within 180 days of the date of service or discharge.
- Health partners should keep all demographic and practice information up-to-date. Email updates to **providermaintenance@CareSource.com**.

Appointment Waiting Times

Appointment Time	Waiting Time
Scheduled Appointments	Waiting times shall not exceed sixty (60) minutes. After thirty (30) minutes, your patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-In Appointments	Waiting times shall not exceed ninety (90) minutes. After forty-five (45) minutes, your patient must be given an update on waiting time with an option of waiting or rescheduling appointment

- Health partners are required to track wait times, which may be reviewed by DCH upon request.

Our agreement also indicates that CareSource is responsible for:

- Paying clean claims within 15 business 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 “Health Partner 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 lessor of the primary carrier allowable or the Medicaid allowable. If the member’s primary insurer pays a health partner equal to or more than CareSource’s fee schedule for a covered service, CareSource will not pay the additional amount.

These are just a few of the specific terms of our agreement. In addition, we expect participating health partners to follow standard practice procedures even though they may not be spelled out in our health partner agreement.

For example:

- Participating health partners, 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 health partners 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 health partners 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 onto 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 health partner 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 health partners or deleting health partners	Immediate
Health partners leave the practice	Immediately upon health partner notice
Phone number change	Immediate
Address change	Immediate
Change in capacity to accept members	Immediate
Health partners intent to terminate	60 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:

Email: providermaintenance@CareSource.com

Fax: 1-937-396-3076

Mail: CareSource
Attn: Provider Maintenance
P.O. Box 8738
Dayton, OH 45401-8738

AMERICANS WITH DISABILITIES ACT (ADA) STANDARDS:

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

a. Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities

b. Accessibility along public transportation routes and/or provide enough parking

c. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities

d. Providing secure access for staff-only areas

CHAPTER 9
MEMBER ENROLLMENT AND ELIGIBILITY

MEDICAID MEMBER ENROLLMENT

The Georgia Department of Community Health (DCH) is solely responsible for member enrollment, including auto-assignment to a CMO, disenrollment, education on enrollment options and outreach activities to those eligible to enroll in a CMO. Once eligible to participate in Georgia Families®, members may select CareSource as their health plan. DCH will implement potential open enrollment and auto-assignment processes in order to enroll all Georgia Families® members with selected CMOs.

Eligibility Categories

Georgia Families©

The following Medicaid eligibility categories are required to enroll in Georgia Families® or PeachCare for Kids®.

1. **Parent/Caretaker with Children Medicaid** – Adults and children who meet the standards of the former AFDC (Aid to Families with Dependent Children) program
2. **Transitional Medicaid** – Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the income limit
3. **Pregnant women** – Pregnant women with family income at or below 220 percent of the federal poverty level who receive Medicaid through the RSM program
4. **Children Under 19** – Children less than 19 years of age whose family income is at or below the appropriate percentage of the federal poverty level for their age and family
5. **Newborns** – A child born to a woman who is eligible for Medicaid on the day the child is born
6. **Women eligible due to breast and cervical cancer** – Women less than 65 years of age who have been screened through Title XV Center for Disease Control (CDC) screening and have been diagnosed with breast or cervical cancer
7. **Refugees** – Individuals, as defined under O.C.G.A. § 38-3-3, including but not limited to those who have the required Immigration and Naturalization Service (INS) documentation showing they meet a status of asylees, Cuban parolees/Haitian entrants, Amerasians or human trafficking victims

Exclusions – The following recipients are excluded from enrollment in Georgia Families®, even if the recipient is otherwise eligible for Georgia Families® per the categories above:

1. Recipients eligible for Medicare
2. Recipients that are Members of a federally recognized Indian Tribe
3. Recipients that are enrolled in fee-for-service Medicaid through Supplemental Security Income (SSI) prior to enrollment in GF
4. Medicaid children enrolled in the Children's Medical Services program administered by the Georgia Department of Public Health
5. Children enrolled in the Georgia Pediatric Program (GAPP)
6. Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act
7. Individuals enrolled in a hospice category of aid
8. Individuals enrolled in a nursing home category of aid
9. Individuals enrolled in a Community Based Alternatives for Youths (CBAY)

PeachCare for Kids®

PeachCare for Kids® is the Children's Health Insurance Program (CHIP) in Georgia. Children less than nineteen years of age who have family income that is less than 247 percent of the federal poverty level, who are not eligible for Medicaid, or any other health insurance program, and who cannot be covered by the State Health Benefit Plan (SHBP) are eligible for services under PeachCare for Kids®.

Planning for Healthy Babies® 1115 demonstration waiver participants (otherwise known as P4HB® participants)

This demonstration includes three distinct groups:

1. Women ages eighteen through 44 who are otherwise uninsured with family income at or below 200 percent of the federal poverty level and are eligible for Family Planning Only Services
2. Women ages eighteen through 44 who are otherwise uninsured with family income at or below 200 percent of the federal poverty level who have delivered a very low birth weight infant and are eligible for Family Planning Services and Interpregnancy Care Services
3. Women ages eighteen through 44 who are current Medicaid recipients, have delivered a very low birth weight infant and are eligible for Resource Mother services only

Exclusions – The following recipients are excluded from the P4HB® 1115 demonstration (hereinafter referred to as "the demonstration"):

1. Women who become pregnant while enrolled in the demonstration
2. Women determined to be infertile (sterile) or who are sterilized while enrolled in the demonstration
3. Women who became eligible for any other Medicaid or commercial insurance program
4. Women who no longer meet the demonstration's eligibility requirements
5. Women who are or become incarcerated

NEW MEMBER IDENTIFICATION CARDS AND 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. The new member kits are mailed separately from the ID card and new member welcome letter.

New Member Kit Contains:

- A Member Handbook, which explains plan services and benefits and how to access them
- A quick start guide for how to get started with CareSource
- Information on how to access or request a health assessment survey
- CareSource's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA)
- Other preventive health education materials and information

Note: Members will receive a Provider Directory only if they requested one at the time of enrollment or if they return a request postcard included in new member kits that indicates they would like a printed copy. The Provider Directory lists participating CareSource health partners and facilities within a certain radius of the member's residence. As the contents of the printed directory are subject to change, we encourage members to call CareSource or the health partner directly to confirm they are in network. The most current list of health partners can be found at any time on CareSource's website under our "Find a Doctor/Provider" tool.

MEMBER ELIGIBILITY VERIFICATION

Health partners must use the Provider Portal to verify member eligibility. Upon logging in to the Provider Portal, health partners will be able to view member eligibility with:

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

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 change the baby's enrollment to another plan. 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 CMO.

MEMBER DISENROLLMENT

We understand that members may choose to select a different CMO from the CMO to which they were assigned by DCH. For various reasons, a member may choose to change CMO, including reenrolling with a previous CMO with which the member has an historical relationship. We support this decision by our members and provide judgement-free disenrollment assistance to our members, including providing disenrollment forms to the member and referring her/him to DCH.

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

Reasons for Member Disenrollment

DCH or its agent will process all CMO disenrollment requests. This includes:

- Disenrollment due to nonpayment of the PeachCare for Kids® premiums
- Loss of eligibility for Georgia Families® due to other reasons
- All disenrollment requests Georgia Families® members, P4HB® participants or CareSource submits via telephone, surface mail, internet, facsimile and in person

Disenrollment Initiated by the Member

A member may request disenrollment or a change in CMO enrollment without cause during the 90 calendar days following the date of the member's initial enrollment with the CMO or the date DCH or its agent sends the member notice of the enrollment, whichever is later. A member may request a change in CMO enrollment without cause every 12 months thereafter.

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

- The member moves out of the CMO's service region;
- The CMO 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 health partner or another health partner have determined that receiving related services from in-network and out-of-network health partners would subject the member to unnecessary risk;
- The member requests to be assigned to the same CMO as family member(s); and
- The member's Medicaid category of eligibility changes to a category ineligible for Georgia Families®, and/or the member otherwise becomes ineligible to participate in Georgia Families®.

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 health partners experienced in addressing the member's health care needs. DCH or its agent will make the determination of these reasons.

Disenrollment Initiated by CareSource

CareSource may request disenrollment if:

- The member's utilization of services is fraudulent or abusive.
- The member is placed in a long-term care nursing facility, state institution or intermediate care facility for individuals with intellectual disabilities.
- The member's Medicaid eligibility category changes to a category ineligible for Georgia Families®, and/or the member otherwise becomes ineligible to participate in Georgia Families®. Disenrollments due to member eligibility will follow the normal monthly process. Disenrollments will be processed as of the date that the member eligibility category actually changes and will not be made retroactive, regardless of the effective date of the new eligibility category. Note exception when members become eligible and enrolled in any retroactive program (such as SSI) after the date of an inpatient hospitalization.
- The member has died, been incarcerated or moved out of state, thereby becoming ineligible for Medicaid.
- The P4HB® participant no longer meets the eligibility criteria for the demonstration.
- The inter-pregnancy care (IPC) P4HB® participant has reached the end of the 24 months of eligibility for the IPC component of the demonstration.
- The P4HB® participant becomes pregnant while enrolled in the demonstration.
- The P4HB® participant becomes infertile through a sterilization procedure.

Prior to requesting disenrollment of a member, CareSource will document at least three interventions over a period of 90 calendar days that occurred through treatment, case management and care coordination to resolve any difficulty leading to the request. CareSource will provide at least one written warning to the member, certified return receipt requested, regarding implications of his or her actions. This notice will be delivered within ten business days of the member's action.

EMERGENCY DEPARTMENT DIVERSION PROGRAM

CareSource is committed to making sure our members access the most appropriate health care services at the appropriate time for their needs. Members are informed to call 911 or go to the nearest emergency room (ER) if they feel they have an emergency. CareSource covers all emergency services for our members.

We instruct members to call their PCP or the CareSource24 nurse advice line if they are unsure if they need to go to an ER. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. We also offer enhanced reimbursement to PCP offices for holding evening or weekend hours to help ensure that our members have alternatives other than the ER available to them when they need medical care outside of normal business hours. Please see the "Primary Care Providers" section of this manual for more information.

Member ER utilization is tracked closely. If there is frequent ER utilization, members are referred to our Care Management and Outreach 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.

CHAPTER 10
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.

CARESOURCE24®, NURSE ADVICE LINE

Members can call our nurse advice line 24-hours a day, seven days a week. With CareSource24, 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.

CareSource24 nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the primary care provider (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 access CareSource24 anytime night or day. The phone number is on the member's ID card.

CARESOURCE CARE MANAGEMENT

CareSource provides the services of care management medical and behavioral health nurses, social workers and outreach specialists to provide one-on-one, personal interaction with patients. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team. Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging compliant patients, reinforcing medical instructions and assessing social and safety needs, as well as educating pregnant women on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many conditions.

Direct Access for Medicaid

"Direct Access" for Care Management referrals and assistance with member needs is available at **1-855-202-0729**.

Care4U – Population Health Model

At CareSource, we believe it is vital to deliver targeted and integrated care coordination services that are member-centric, collaborative and supported by evidence-based care to facilitate improved member outcomes, enhanced member satisfaction and optimal resource utilization for the CareSource member population.

The focus of the Care4U model is to provide a dynamic, community based, member-centric model of service delivery. The model, designed as a population health management approach with care coordination for members, is implemented by regional, multi-disciplinary teams responsible for a defined population and sub-populations within a region.

As a population management model, the ultimate goal of the model is to:

1. Improve the member experience of care (including clinical quality and satisfaction)
2. Improve the health of populations; and
3. Reduce the per capita cost of health care

The 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, and we can assist in arranging transportation to the health partner's office. This one-on-one personal interaction with outreach specialists and professional care managers helps provides 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.

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 and Emergency Department (ED) utilization, scheduled or planned services. This information provides you with critical information necessary to make informed decisions pertaining to your patient. In addition, we invite and encourage you to direct and provide input into patient assessment activity and participate in the development and monitoring of a care plan individualized to the needs of your patient. We believe communication, coordination and collaboration are integral to ensure the best care for these 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
- Members with special health care needs
- Members with serious and persistent mental illness (SPMI)

Care Management of High-Risk Members

CareSource applies a particular community-based management model for our high and intensive 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 health partner and community resource partnerships through collaboration.

Our services include face-to-face meetings with our most at-risk members. Ideally, these are conducted at the point of care to ensure development of a treatment plan that is comprehensive and collaborative. Typical 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.

CARE TRANSITIONS PLANNING

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

Our Care Transitions program has focused outreach and discharge planning activities, 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 Care Transitions 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 our primary care providers (PCPs) to provide our members with the services they need along the continuum of care.

CARESOURCE DISEASE MANAGEMENT PROGRAM

CareSource Medicaid members with chronic conditions, including asthma, diabetes and cardiovascular conditions will be automatically enrolled into CareSource's enhanced disease management program.

Members enrolled in the program will receive free information to help them better manage their specific conditions. Information sent to members will include care options for them to discuss with their health partners.

Members identified as high risk will have a nurse assigned to their case to help educate, coordinate and provide resources and tools to help the member reach their health care goals.

How to Refer Medicaid Members to Disease Management

If you have a CareSource patient with asthma or diabetes or a cardiovascular condition who you believe would benefit from this program and is not already enrolled, call **1-855-202-0729**.

PERINATAL AND NEONATAL CARE MANAGEMENT

CareSource's perinatal and neonatal care management program utilizes a multi-disciplinary team with extensive neonatal intensive care unit (OB/NICU) clinical experience. Specialized nurses are available to help manage high-risk pregnancies and medically complex newborns by working in conjunction with health partners and members. The expertise offered by the staff includes a focus on patient education and care coordination and involves direct telephone contact with members and health partners.

We encourage our prenatal care health partners to notify our Care Management Department at **1-855-202-0729** when a member with a high-risk pregnancy has been identified. Health partners may complete the Pregnancy Risk Assessment Form and 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 use code H1000 on the associated claim to indicate that an assessment form was submitted. Women who meet any of the risk factors listed on the form are eligible for perinatal care management services and will receive further screening and evaluation by CareSource care management staff. Care Management is notified of medically complex infants at the time of admittance to the neonatal intensive care unit.

Babies First Program

Babies First is a free program offered to pregnant members and parents or guardians of babies less than 18 months of age. Through this program, which will run through MyHealth, members can earn rewards. The program focuses on encouraging pregnant members to visit their doctor for prenatal care early in their pregnancies, and then as often as their doctor recommends. Additionally, the program encourages well-baby visits as recommended to help ensure mom and baby will be as healthy as possible.

Upon completion of milestones, members will be rewarded and will have the option of choosing a gift card or other limited baby supplies and health and wellness items from a limited selection of merchants. Regardless of the merchant selected, the rewards card will block the purchase of items such as alcohol or tobacco and cannot be converted to cash. Members can enroll in Babies First by calling Member Services at **1-855-202-0729**.

INTERPRETER SERVICES

Non Hospital Health Partners

CareSource offers sign and 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, 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 potential members, members or health partners. As a health partner, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. To arrange services, please contact our Health Partner Services Department at **1-855-202-1058**. 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 Health Partners

CareSource requires hospitals, at their own expense, to offer sign and language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking ability. We can provide, at no charge, 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 members. 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 Health Partner Services at **1-855-202-1058**. 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.

EPSDT GUIDELINES

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. The EPSDT benefit is also available to PeachCare for Kids® members up to 19 years of age. The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of the EPSDT benefit is to assure that individual children get the health care they need when they need it. The EPSDT benefit also covers medically necessary diagnostic services. The Health Check 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.

Preventive Health Visit Components

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

- A comprehensive health, psycho-social and developmental history;
- Documentation of vital signs;
- An unclothed comprehensive physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination);
- Assessment of growth and nutritional status;
- Assessment of immunization status and provision of appropriate immunizations. Use the Advisory Committee on Immunization Practices (ACIP) schedules;
- Screening for vision, hearing, lead poisoning and development, as per AAP guidance;
- Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance;
- Oral health screening, preventive counseling and referral to a dentist for ongoing dental care;
- Screening for and if suspected, reporting of child abuse and neglect;
- Anticipatory guidance (health education); and
- Referrals/follow-ups where appropriate based on history and exam findings.

PREVENTIVE HEALTH EXAM FREQUENCY

The recommended schedule for preventive health exams is as follows:

- Birth
- Three to five days
- One month
- Two months
- Four months
- Six months
- Nine months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- At three years, one exam per year until age 21

PCPs receive a list of eligible CareSource members at the beginning of each month who have chosen or been assigned to the PCP as of that date. The list also includes indicators for patients who appear not to have had their initial preventive health exam and/or who are not in compliance with the EPSDT periodicity schedule. Initial preventive health exams are to be completed with 24 hours of birth for all newborns and within 90 days of the initial effective date of membership for new enrollees. PCPs are required to outreach to members via phone/mail to encourage them to schedule and keep their preventive health appointment. You can find this list on the Provider Portal.

Preventive Health Exam Referrals

If the PCP is unable to provide all of the components of the preventive health exam, or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating health partner within CareSource's health partner network in accordance with CareSource's referral procedures. The member's medical record must indicate where the member was referred.

EPSDT CODES

Well Visit		Lead Screen	Dev
Primary Dx	CPT with modifier EP	CPT	CPT
0 - 7 days	Less than 1 yr	83655	96110
Z00.110	99381		
8 - 28 days	99391		
Z00.111	1 through 4 years		
29 days - 14 years	99382		
Z00.121	99392		
Z00.129	5 through 11 years		
15 - 17 years	99383		
Z00.121	99393		
Z00.129	12 through 17 years		
Z00.00	99384		
Z00.01	99394		
18 - 20 years	18 through 20 years		
Z00.00	99385		
Z00.01	99395		
0 - 20 years			
Z02 - Z02.89			

Referral	
Box 24 of claim	
NU	No follow up needed
AV	Available, Not Used: Patient refused referral
S2	Under Treatment: Patient is currently under treatment for health problem and has a return appointment.
ST	New Services Requested: Referral to another provider for diagnostic or corrective treatment/scheduled.

IMMUNIZATIONS

Vaccines for Children Program

The Vaccines for Children (VFC) program makes designated vaccines available at no cost to VFC participating health care health partners to administer to children under the age of 19 who are eligible for Medicaid and/or PeachCare for Kids®. This program is administered by the Georgia Department of Public Health and is available for all children enrolled in Medicaid and Georgia PeachCare for Kids® Program. It is also available for P4HB® participants who are 18 years of age.

CareSource encourages health partners to participate with the VFC program. Vaccines administered to children 18 years of age and younger must be obtained through the VFC program, which supplies vaccines to program participating health partners 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.

For more information about the Georgia VFC program and how to enroll and obtain vaccines, please contact:

Immunization Program Address: 2 Peachtree St. NW, 13-276, Atlanta, GA 30303
Email: DPH-gavfc@dph.ga.gov
Phone: 1-800-848-3868 or 404-657-5013/5015

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during preventive health 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**.

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. Effective October 1, 2015, CareSource requires health partners to use ICD-10-CM Codes and CPT Codes on claims. To view the most recent list of VFC-covered vaccine codes, please refer to the Department of Community Health “Part II Policies and Procedures for EPSDT (Health Check) Services ” Appendix C. 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 health partners must report all immunizations to the statewide web-based immunization registry called GRITS, found at **www.grits.state.ga.us/production/security_ui.showLogin**.

The registry consolidates immunizations from multiple health partners into one central record and provides reliable immunization history that is electronically accessible from multiple health care practice sites. The system is designed to save time and money, reduce paperwork and provide quick and efficient tracking of immunizations. It also assures that all persons in Georgia receive appropriate, timely immunizations to lead healthy, disease-free lives.

GEORGIA HEALTH INFORMATION NETWORK

Health partners are encouraged to participate in the Georgia Heath Information Network (GaHIN). 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 Georgia Health Information Network gives its members the ability to access a more complete view of their patient health information directly from their electronic health record (EHR) systems. At any time, a patient may choose to "opt-out" of having his or her electronic records shared through the network. He or she can simply complete an opt-out form from their doctors. If a patient does opt-out, no health partner can share his or her health records through the network. If patient does opt-out, but changes his or her mind, he or she can easily opt back into the system.

The GaHIN supports the following types of health partners:

- Physicians
- Mid-level practitioners (physician assistants, nurse practitioners, certified nurse midwives)
- Doctors of dentistry, optometry and podiatry
- Hospitals
- Safety net clinics
- Behavioral and mental health partners
- County/State departments of public health
- Long-term care
- Home health
- Hospice
- Labs
- Imaging centers
- Urgent Care Clinics

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

For more information, visit **www.gahin.org/products-services/georgia-connectedcare.**

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.

MEMBER RIGHTS AND RESPONSIBILITIES

As a CareSource health partner, 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 Georgia Families®, PeachCare for Kids® and Planning for Healthy Babies® 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:

1. CareSource notifies members of their rights and responsibilities in the Member Handbook.
2. As a member of CareSource, members have the following rights:
   a. To receive information about CareSource, its services, its practitioners and health partners, and member rights and responsibilities.
   b. To receive all services that CareSource must provide.
   c. To be treated with respect and with regard for their dignity and privacy.
   d. To be sure that their medical records and personal information will be kept private.
   e. 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 who 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.
   f. To get information on any appropriate or medically necessary treatment options for the member's condition.
   g. To participate in decisions regarding his or her health care, including the right to refuse treatment.
   h. To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
   i. To be sure that others cannot hear or see the member when he/she is getting medical care.
   j. 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.
   k. To request and receive a copy of his or her medical records and request to amend or correct the record.
   l. To be able to say yes or no to having any information about himself/herself given out unless CareSource has to by law.
   m. 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.
   n. To be able to file an appeal, a grievance (complaint) or state hearing, and that the exercise of those rights will not adversely affect the way the member is treated
   o. To be able to get all CareSource written member information from CareSource:
      i. At no cost to the member.
      ii. In the prevalent non-English languages of members in CareSource's service area;
      iii. In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
   p. To be able to get help free of charge from CareSource and its health partners if the member does not speak English or needs help in understanding information.
   q. To be able to get help with sign language if the member is hearing impaired.
   r. To be told if the health care health partner is a student and to be able to refuse his/her care.

s. To be told of any experimental care and to be able to refuse to be part of the care.

t. To make advance directives.

u. 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.

v. To know that CareSource must follow all federal and state laws, and other laws about privacy that apply.

w. To choose the health partner that gives the member care whenever possible and appropriate.

x. To be able to get a second opinion from a qualified health partner on CareSource's panel. If a qualified health partner is not able to see the member, CareSource must set up a visit with a health partner not on its panel.

y. To not be held liable for CareSource's debts in the event of insolvency.

z. To not be held liable for the covered services provided to the member for which DCH does not pay CareSource.

aa. To not be held liable for covered services provided to the member for which DCH or CareSource does not pay the health partner that furnishes the services.

bb. 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 CareSource provided the services directly.

cc. To be responsible for cost sharing only in accordance with 42 CRF 447.50 through 42 CRF 447.60

dd. To not be billed for any service covered by Medicaid.

ee. To make recommendations regarding CareSource's member rights and responsibility policy.

ff. To contact the United States Department of Health and Human Services Office of Civil Rights at the address 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 for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697

Members of CareSource are also Informed of the Following Responsibilities:

1. Use only approved health partners, except in emergency or other situations approved by CareSource.
2. Keep scheduled doctor appointments, be on time and call 24 hours in advance of a cancelation.
3. Follow the advice and instructions for care he/she have agreed upon with his/her doctors and other health partners.
4. Always carry his/her ID card and present it when receiving services.
5. Never let anyone else use his/her ID card.
6. Notify his/her county Division of Family and Children Services (DFCS) and CareSource of a change in phone number or address.
7. 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.
8. Let CareSource and the county DFCS know if he/she has other health insurance coverage.
9. Provide the information that CareSource and his/her health partners need in order to provide care.
10. Understand as much as possible about his/her health issues and take part in reaching goals that the member and his/her health partner agree upon.

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 on 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 health partner, please remember that as a covered entity, you are obligated to follow the same HIPAA regulations as a covered entity CareSource and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

ADVANCE DIRECTIVES

An advance directive is a written instruction, recognized under Georgia law, relating to the provision of health care when a member is incapacitated.

Under Georgia law, CareSource members have the right to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

Health partners delivering medical care to CareSource members must ensure all adult CareSource members eighteen (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 health partner's offices and discussed with CareSource members or health partner's staff when questions arise.

Health partners 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. Health partners 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, health partners shall not discriminate against CareSource members based on whether or not the member has executed an advance directive.

TELEMEDICINE

CareSource provides telehealth services to ensure our members can have access to health care services, particularly in rural areas where it is difficult to access offices. CareSource partners with the Georgia Partnership for TeleHealth (GPT) to provide these services.

Frequently Asked Questions about GPT

What is telemedicine?

Telemedicine uses the latest computer technology, software, medical cameras and high-speed telecommunications to enable physicians to consult and conduct medical examinations remotely.

Why is telemedicine used?

Rural patients are given greater access to specialty care. These patients often have difficulty seeing a specialist because they do not have a particular specialist near their home and have to travel long distances for appointment access.

Do patients favor telemedicine?

Yes. Patients appreciate telemedicine clinics because:

- Patients can have appointments with physicians located all around Georgia without having to leave their local area;
- Working patients miss less time from work due to not having to travel;
- In a 2011 study conducted by Mercer University, on average, patients saved 124 miles of travel;
- Patients have access to specialty medical services that may not be available in the area where they live.

How does telemedicine work?

Live video. The local physician and the patient can see a remote physician or specialist in real time using medical cameras and video conferencing equipment.

- The primary care provider refers the patient to a specialist.
- An appointment is scheduled through the GPT scheduling center with a participating specialist.
- The patient arrives for the appointment and consults with the remote physician face to face via video.
- The consulting physician makes recommendations for patient care to a referring physician

What telemedicine services does GPT provide?

- Specialists - adult & pediatric (over 45 specialties)
- Primary care
- Trauma
- Skilled nursing facilities
- Mental health
- Child advocacy
- School systems
- Continuing education
- Consultative services in network design, telemedicine development and implementation

Who is Georgia Partnership for Telehealth, Inc.?

Georgia Partnership for Telehealth is the leading agency in Georgia and the Nation focusing on increasing access to healthcare through innovative use of technology including telemedicine, health information exchange and Telehealth.

How do telemedicine clinics gain consent from patients?

Prior to being seen in a telemedicine clinic, patients/parents/guardians must fill out a comprehensive health questionnaire. This packet will include HIPPA forms, consent acknowledgement that telemedicine will be used, and any other pertinent consent forms.

Does telemedicine take money away from local health partners?

No. Usually when a telemedicine appointment is needed, it is because that specialty or level of care is not offered locally. Local health partners can benefit by receiving reimbursement for being a presenting site.

(FAQs provided by Georgia Partnership for Telehealth)

CHAPTER 11
BEHAVIORAL HEALTH

CareSource provides behavioral health benefits to our Medicaid members. Members may self-refer to behavioral health services without a referral from their PCP.

Behavioral health is critical to each member's overall health. CareSource ensures that all members have access to behavioral health resources and that behavioral health is integrated across all interventions.

PHYSICAL HEALTH AND BEHAVIORAL HEALTH COORDINATION

CareSource encourages communication and care coordination between PCPs and behavioral health partners to achieve optimal health for our members. CareSource requires behavioral health partners to send initial and at least quarterly status reports to PCPs. Communication between PCPs and behavioral health partners is necessary to ensure continuity of care and member safety.

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

CareSource requires that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any 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, CareSource's referral process for behavioral health services, and clinical coordination requirements for such services. CareSource shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions. Training may be found at **CareSource.com**.

CareSource members have access to specialty behavioral health case managers for assistance in obtaining both routine and higher complexity health care services. CareSource PCPs also can contact CareSource for assistance in facilitating specialty behavioral health services for our members. CareSource provides a comprehensive range of behavioral health care services for our members. Services include outpatient routine office visits for therapy and medication management, a broad range of hospital-based services for both behavioral health and substance use disorders, home-based therapy services and access to community-based resources. CareSource will assist members and PCPs with health partner referrals and with making appointments for members in need of therapy and/or psychiatric services.

CareSource coordinates between behavioral health partners and PCPs. CareSource requires that behavioral health partners 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 partners may only provide physical health care services if they are licensed to do so.

CareSource requires that all members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. CareSource shall ensure that behavioral health partners contact members who have missed an appointment within 24 hours to reschedule appointments.

CareSource requires that behavioral health partners send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the member's or the member's legal guardian's consent.

CareSource requires that PCPs send status reports to the member's behavioral health partner with the member's or the member's legal guardian's consent.

CHAPTER 12
PHARMACY

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

Details of MCPs Administering Prescription Drug Coverage:

- **Co-payment requirements** – Members will not be required to pay a co-payment for prescription drugs. Some medical supplies are covered under the pharmacy coverage, including diabetes supplies, spacers, peak flow meters and condoms.
- **Other medical supplies and Durable Medical Equipment (DME)** – To support member access and convenience, other 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 health partner.
- **Medications administered in the health partner setting** – Medications that are administered in a health partner setting, such as a physician office, hospital outpatient department, clinic, dialysis center, or infusion center will be billed to the MCP. Prior authorization requirements exist for many injectables.
- **Transition period** – A 30-day transition period applies for members moving from Fee-For-Service to CareSource, some medications are excluded from the transition period.. After the 30-day transition period has ended, prior authorization may be applicable depending on the member's medication. Please check our website for what medications require prior authorization.

FORMULARY

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

CareSource uses a Preferred Drug List (PDL) or Formulary. Some drugs require prior authorizations. The online Formulary contains information about prior authorizations, quantity limits, step therapy protocols and therapeutic interchanges for most drug classes.

STEP THERAPY AND QUANTITY LIMITS

Certain medications on the Preferred Drug List are covered if utilization criteria are met. Step therapy is one such utilization technique that requires using a Formulary medication before the non-formulary medication would be approved for use.

Quantity limits are also placed on many medications, based on normal manufacturers' 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. In the online formulary, **boldface type** indicates generic availability. However, not all strengths or dosage forms of the generic name in boldface type may be generically available. In most instances, a brand-name drug for which a generic product becomes available will become non-formulary, with the generic product covered in its place, upon release of the generic product onto the market.

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

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).

A list of preferred drugs is available at **CareSource.com**. This site also includes other information about the CareSource pharmacy program.

PRIOR AUTHORIZATION REQUESTS

CareSource will process prior authorizations requests within 24 hours of receipt, unless additional information is required from the prescriber, in accordance with Georgia Medicaid regulations. If we need additional information from the prescriber, we will contact the prescriber every 24 hours up to a final disposition within 27 hours of receipt of the request. 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 Georgia Department of Community Health regulations and determine medical necessity for formulary exception requests that will be reviewed based on drug-specific prior authorization criteria or standard non-formulary prescription request criteria.

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

Pharmacy Questions

Online (preferred):	**CareSource.com**
Fax (preferred):	**1-866-930-0019**
Phone:	**1-800-488-0134**

CareSource Specialty Pharmacy Program

All specialty medications are provided by CVS Caremark Specialty pharmacy to improve medication compliance, side effect management and disease state management. CVS Caremark Specialty Pharmacy provides specialty medications directly to the member or the prescribing physician and coordinates nursing care if required. Please visit our website at **CareSource.com** to see more details about the Specialty Pharmacy Program.

PHARMACY LOCK-IN PROGRAM

It is the policy of CareSource to take appropriate steps to control fraud, abuse and overutilization of medical/pharmacy services by placing or continuing members in a Lock-in Program.

The CareSource Special Investigations Unit (SIU) monitors complaints and referrals regarding potential fraud, member abuse, health partner abuse or overutilization. SIU responds to any complaint or data finding by conducting a utilization review of the member. A member utilization review includes a review of medical and pharmacy claims to identify if the member utilized Medicaid services at a frequency or amount which exceeds utilization criteria; and to determine if the member should be placed in the Lock-in Program restricting him/her to receiving services from designated providers.

Lock-in Program Eligibility

Potential Lock-In members are scored based on the likelihood that they are engaging in behaviors of abuse or unnecessary use of prescription or non-prescription drugs including, but not limited to:

- Opiate use;
  - High dose inconsistent with safety, efficacy, or medical necessity.
  - Long term use consistent with addiction.
- Suboxone use;
- Use of other controlled substances;
- Drug combinations associated with abuse;
- Dosing intervals (gaps or overlapping scripts) indicating possible diversion or abuse;
- Non-coordination of care evidenced through the use of multiple providers or pharmacies;
- Diagnosis indicating drug dependence or abuse; and
- Inpatient or emergent care resulting from or exacerbated by drug abuse or dependence.

Members may be excluded from the Lock-in Program if:

1. Members utilize Medicaid services at a frequency or amount which was medically necessary to treat a complex, life threatening medical condition as determined by review by the lock-in coordinator or with the assistance of a Medical Director and Pharmacist.
2. The Lock-In Coordinator, in collaboration with the Pharmacy Department, Behavioral Health Department, and/or a Medical Director determines that not enrolling a member in the lock-in program is in the best interest of the member.

Members identified as “high risk” will be locked into:

- One or more controlled substance providers, and
- One pharmacy

Upon identifying a member for the Lock-In Program, CareSource will:

1. Send a written notification to the member including:
   a. The reason for enrolling the member in the Lock-In Program;
   b. A description of the Lock-In Program;
   c. The effective date of Lock-In Program enrollment;
   d. Identification of the member’s designated health partners;
   e. Information relating to the member’s right to an appeal; and
   f. Contact information of an individual who may be contacted in writing or by telephone for information relating to the Lock-In Program.
2. Enroll the member in the Lock-in Program.
3. Refer the member to care management for management, education and reinforcement of appropriate medication use.

Once enrolled, the Lock-In member will be restricted to receiving Medicaid services from designated health partners, including;

- One or more controlled substance prescriber(s) who will serve as the prescriber and manager of controlled substances for the lock-in member; and
- One pharmacy who will serve as the sole establishment to fill the member’s prescriptions.

Except for a member who requests an appeal relating to a lock-in determination, CareSource will enroll the member in the Lock-In Program within thirty days of sending the written notification.

Designated Health Partners

A designated health partner for a member will be chosen by CareSource, not by the member. A member will not have more than one change in a designated health partner within a twelve month period except as allowed in the section below.

The designated controlled substance health partner(s) will be the designated health partner(s) of a Lock-In member for up to twelve months except if:

1. The designated health partner submits to CareSource a written request for a release from serving as the member's designated health partner. The health partner will continue to serve as the member's designated health partner until a comparable designated health partner is selected;
2. The member relocates outside of the designated health partner's geographic area;
3. The member submits a written request to CareSource which:
    a. Requests a designated health partner change;
    b. Includes information to support cause or a necessary reason for the change, including the member:
        – Was denied access to a needed medical service;
        – Was unable to obtain prescribed drug at designated health partner;
        – Received poor quality of care; or
        – Does not have access to a health partner qualified to treat the member's health care needs; and
            i. After discussion with the designated health partner and pharmacist, CareSource determines good cause it shown.
4. The designated health partner withdraws or is terminated from participation in the Medicaid Program; or
5. CareSource or care mananagement determines that it is in the best interest of the Lock-In member to change the designated health partner.

Annual Review Process

CareSource will annually assess the need for lock-in for each member. Members enrolled into the Lock-In Program will either be disenrolled or re-enrolled for an additional 12 month period.

Prior to consideration for disenrollment from the Lock-In Program, CareSource will conduct a utilization review to:

1. Measure the effectiveness of the member's enrollment in the Lock-In Program; and
2. Determine if the member will:
    a. Continue enrollment in the Lock-In Program.
    b. Be discharged from the Lock-In Program.

CareSource will provide the Lock-In member with a written notification, which will include:

- Findings of a utilization review; and
- A decision to maintain enrollment in or discharge the member from the Lock-In Program.

Lock-in Member Requirements

A Lock-In member may not transfer to another pharmacy, PCP, or care management program while enrolled in the Lock-In Program, with exceptions as specified above.

CHAPTER 13
PRIMARY CARE PROVIDERS

PCP SELECTION

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

- 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; or
    - Pediatrics
    - NP-Cs in independent practice must also have a current collaborative agreement with a licensed physician who is a network health partner, who has hospital admitting privileges and 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 FQHCs and 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, Walgreens and HealthSpot
- Specialists treating a member's chronic condition(s) and agree to act as their PCP

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

ROLE OF THE PCP

All CareSource members choose or are assigned to 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.

Members select a PCP from our health plan's Provider Directory. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling our Member Services Department.

CareSource allows for PCPs to include not only traditional health partner types that have historically served as PCPs but also alternative health partner types such as specialists and patient-centered medical homes (PCMH) with documented physician oversight and meaningful physician engagement. CareSource shall include in its network as PCPs psychiatrists who agree to serve as PCPs for members who have a primary diagnosis of a severe persistent mental illness. Members who have a primary diagnosis of a severe persistent mental illness may be permitted to have any physician including a psychiatrist as their PCP.

MEDICAL HOME

To facilitate total care integration for our members, CareSource encourages a medical home care model. A medical home is a long-term partnership between the PCP/health partner team, the patient and the patient's family. The care model focuses on the whole patient, with support and advice for prevention, behavioral health and dental health. The model provides many benefits to the member and health partner, including fewer hospital/ER visits, higher patient satisfaction, improved access for members in rural environments and higher quality at a lower cost to the health care system.

CareSource encourages health partners to attain National Committee on Quality Assurance (NCQA) patient-centered medical home (PCMH) recognition. We will offer tiered financial incentives for health partners who have NCQA PCMH recognition. To support health partners working to attain NCQA PCMH accreditation, CareSource offers free consultative assistance to navigate the recognition process with NCQA.

PCP ROLES AND RESPONSIBILITIES

PCP care coordination responsibilities include at a minimum, the following:

1. Assisting with coordination of the member's overall care, as appropriate for the member.
2. Serving as the ongoing source of primary and preventive care.
3. Recommending referrals to specialists, as required.
4. Triaging members.
5. Participating in the development of case management care treatment plans, and notifying CareSource of members who may benefit from care management. Please see the "Member Support Services and Benefits" section on how to refer members for case management.

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.

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.
- Providing preventive care and teaching healthy lifestyle choices.
- Assessing the urgency of member's medical needs and directing members to the best place for that care.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week.
- Making referrals to medical specialists when necessary.
- Following all referral and prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plan and DCH.
- 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.

DENTAL HEALTH PARTNERS & DENTAL HOME

CareSource supports the ongoing relationship between our network dentists and our members. We want to ensure our members have access to a full array of dental services that deliver appropriate and timely dental care. We offer eligible members access to a comprehensive dental network across the State of Georgia that leverages the model of a "health home" to organize and coordinate access to dental care for all of our qualified populations. Our dental home model is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and family-centered way. For a list of covered services, please see the Covered Services and Exclusions section of this manual.

CareSource communicates with its members to provide information about the importance of preventive dental care and selecting a dental home as early as possible. We encourage our members to select a primary dentist at the time of enrollment along with a PCP. If a member does not select a dentist to coordinate care at the time of enrollment, we will assign a dentist using the following criteria:

1. Claim history indicates that the member has a historical dental relationship
2. Based on geographic proximity, if the member does not make a selection

We notify our members within 10 calendar days of dental PCP assignment and provide the member with the option to change their dental home anytime during the first 30 days.

CareSource continually assesses the quality of our network and health homes to ensure members have access to the dental care they need. We perform periodic quality checks of our network to guarantee the timely and high quality treatment of our members.

CHAPTER 14
MEDICAL RECORDS

Health partners 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.

MEDICAL RECORDS STANDARDS

Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, health partner 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 health partner of service. The PCP also must maintain a primary medical record for each member that contains sufficient medical information from all health partners involved in order to ensure quality of care.

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

a. Member/patient identification information, on each page;
b. 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;
c. Date of data entry and date of encounter;
d. Health partner identification by name;
e. Allergies, adverse reactions and known allergies shall be noted in a prominent location;
f. Past medical history, including serious accidents, operations, illnesses. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (i.e., documentation of chickenpox);
g. Identification of current problems;
h. The consultation, laboratory and radiology reports filled in the medical record shall contain the ordering health partner's initials or other documentation indicating review;
i. Documentation of immunizations;
j. Identification and history of nicotine, alcohol use or substance abuse;
k. Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or Department for Public Health;
l. Follow-up visits provided and (secondary) reports of emergency room care;
m. Hospital discharge summaries;
n. Advanced Medical Directives, for adults;
o. All written denials of service and the reason for the denial; and
p. 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:

a. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health and substance abuse status;
b. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (Health Check/EPSDT) addressed from previous visits;
c. Plan of treatment including:
    1. Medication history, medications prescribed, including the strength, amount, directions for use and refills;
    2. Therapies and other prescribed regimen; and
    3. 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:

a. Identification of the beneficiary.
b. Physician name.
c. 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).
d. 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).
e. Reasons and plan for continued stay if applicable.
f. Other supporting material the committee believes appropriate to include.
g. For non-mental hospitals only:
    1. Date of operating room reservation.
    2. Justification of emergency admission if applicable.

CHAPTER 15
MEMBER AND HEALTH PARTNER (PROVIDER) GRIEVANCES AND APPEALS

Availability of Assistance

CareSource gives members any reasonable assistance in completing forms and taking other procedural steps for both grievances and administrative reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability.

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by CareSource to make an authorization decision.

MEMBER GRIEVANCES

Members have the right to file a grievance at any time. As a CareSource health partner, we may contact you to obtain documentation when a member has filed a grievance. State and federal agencies require CareSource to comply with all requirements, which include aggressive resolution time frames.

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. Detailed grievance and appeal procedures are explained in the member handbook. Members can contact CareSource at **1-855-202-0729** (TTY: 1-800-255-0056 or 711) to learn more about these procedures.

TIMEFRAMES AND REQUIREMENTS FOR MEMBER GRIEVANCES

Any time a member informs us that they are dissatisfied with CareSource, or one of our health partners, it is a grievance. CareSource will acknowledge receipt of a grievance within ten (10) business days of receipt. A health partner cannot file a grievance on behalf of a member.

CareSource investigates all grievances. If the grievance is about a health partner, CareSource calls the health partner's office to gather information for resolution.

CareSource ensures that the individuals who make decisions on grievances that involve clinical issues are health care professionals, under the supervision of CareSource's Medical Director, who have the appropriate clinical expertise, in treating the member's condition or disease and who were not involved in any previous level of review or decision-making.

CareSource has procedures in place to ensure all members are notified in their primary language of the grievance resolution.

- If a member's grievance is about not being able to get medical care, CareSource responds within two (2) business days.
- CareSource responds to all other grievances as soon as possible, but no later than ninety (90) calendar days from receipt.

If members are not satisfied with our response to a grievance, they can ask us to reconsider it by sending us a letter within one-hundred-eighty (180) days. A meeting is held within thirty (30) days of the date CareSource receives the request. Members, or their authorized representatives, have the right to attend the meeting and present information.

MEMBER APPEALS

A member appeal is request for review of a Adverse Benefit Determination. CareSource notifies members in writing when an adverse benefit determination is taken against the member. This can include:

1. The denial or limited authorization of services of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction suspension, or termination of a previously authorized service;
3. The denial, in whole or part of payment for a service;
4. Failure to provide services in a timely manner, or
5. The failure of CareSource to act with the appropriate time frames.
6. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities.

Members have the right to appeal the adverse benefit determination if they contact CareSource within sixty (60) calendar days from the date on their adverse benefit determination notice. Members can contact CareSource at **1-855-202-0729** (TTY: 1-800-255-0056 or 711) to learn more about the appeal procedures.

A member, the member's authorized representative, or health partner acting on behalf of the member with the member's written consent, may file an appeal orally or in writing. Unless requesting an expedited appeal, all oral filings of appeal must be followed up in writing.

CareSource will ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making and who are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:

1. An appeal of a denial that is based on lack of medical necessity; or
2. An appeal that involves clinical issues.

CareSource will provide the member, the member's Authorized Representative, or health partner acting on behalf of the member with the member's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing, and to examine the member's case file, including medical records, and any other documents and records considered during the appeal process. CareSource will inform the member of the limited time available to provide this in case of expedited review.

Notification of Resolution or Adverse Action

CareSource will verbally notify the health partner/facility of the appeal resolution or adverse action if the member is in an inpatient setting and will send written notification to both the health partner and member on the same business day of the decision.

CareSource will respond to the appeal in writing as expeditiously as the member's health condition requires, but not later than thirty (30) calendar days of when it was received for a standard appeal or within seventy-two (72) hours for expedited appeals. Appeals will be expedited when a health partner indicates, or CareSource determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Extending an Appeal

A member or their authorized representative can verbally request that CareSource extend the time frame to resolve a standard or expedited appeal up to 14 calendar days. CareSource may also request that the time frame to resolve a standard or expedited appeal be extended up to 14 calendar days if CareSource demonstrates to the Department of Community Health's (DCH) satisfaction that there is a need for additional information and how the delay is in the member's best interest. CareSource will immediately give the member written notice of the reason for the extension and the date that a decision must be made.

PEACHCARE FOR KIDS® STATE REVIEW

The Department of Community Health allows a review by a Formal Grievance Committee, on behalf of PeachCare for Kids® members. If the member, parent or other authorized representative of the member does not agree with CareSource's decision on appeal, then the member may ask for review by the Department of Community Health's Formal Grievance Committee. PeachCare for Kids® members must complete CareSource's internal appeal process before requesting review by Department of Community Health's Formal Grievance Committee.

PeachCare for Kids® members must request a review by the Formal Grievance Committee within thirty (30) calendar days of receipt of CareSource's decision to uphold its decision in response to a PeachCare for Kids® member's appeal.

Reviews should be completed by the Formal Grievance Committee within ninety (90) calendar days of receipt of request for standard reviews or within seventy (72) hours of the receipt of request for expedited reviews. The decision of the Formal Grievance Committee will be the final recourse available to the PeachCare for Kids® member. CareSource will comply with the decision of the Formal Grievance Committee.

The PeachCare for Kids® State Review process is in lieu of an Administrative Law Hearing for all other members.

MEMBER'S RIGHT TO A STATE ADMINISTRATIVE LAW HEARING

CareSource members can request an Administrative Law Hearing if the member has exhausted CareSource's internal appeal process and CareSource has upheld it decision in response to a member's appeal.

Members must request an Administrative Law Hearing within one-hundred twenty (120) calendar days of date on CareSource's notice to uphold its decision in response to a member's appeal. A health partner is permitted to request an Administrative Law Hearing on behalf of a member. CareSource will comply with the decisions reached as a result of the Administrative Law Hearing.

Member's Right to Request Continuation of Benefits While an Appeal or Administrative Law Hearing is Pending

CareSource will continue the member's benefits if the member, or the member's authorized representative files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized health partner; the original period covered by the original authorization has not expired; and the member requests extension of the benefits. Health partners may not request the continuation of benefits on behalf of a member.

"Timely" means filing on or before the later of the following:

1. Within ten (10) calendar days of CareSource mailing the notice of benefit determination (appeal decision); or
2. The intended effective date of the CareSource's proposed adverse benefit determination.

If, at the member's request, CareSource continues or reinstates the member's benefits while the appeal or administrative law hearing is pending, the benefits will be continued until one of the following occurs:

1. The member withdraws the appeal or request for the administrative law hearing;
2. The member fails to request an administrative hearing and continuation of benefits within 10 calendar days after CareSource sends the notice of adverse benefit determination.
3. An administrative law judge issues a hearing decision adverse to the member; or
4. The time period or service limits of a previously authorized service has been met.

If the final resolution of an appeal is adverse to the member, that upholds CareSource's appeal decision, CareSource may recover from the member the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

If CareSource or the administrative law judge reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, CareSource will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.

If CareSource or the administrative law judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, CareSource will pay for those services.

HEALTH PARTNER GRIEVANCES (COMPLAINTS)

CareSource will thoroughly investigate each Georgia Families® health partner complaint using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying the CareSource written policies and procedures. Health partners are permitted to submit grievances to CareSource regarding CareSource's policies, procedures, or any aspect of CareSource's administrative functions. All health partner grievances should be clearly documented.

Health partners have thirty (30) calendar days from the date of the incident to file a provider grievance:

CareSource Health Partner Appeals-Georgia
P.O. Box 2008
Dayton OH 45401
Phone: 1-855-202-1058

CareSource strives to resolve all health partner grievances within thirty (30) days.

We ensure that CareSource executives with the authority to require corrective action are involved in the health partner complaint process.

CareSource also allows health partners to consolidate grievances or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual members or payment claims included in the bundled grievance or appeal.

Appeals of Claim Denials or Adverse Decisions

If you do not agree with the decision of a processed claim, you will have thirty (30) calendar days from the date the adverse action, denial of payment, remittance advice, or initial review determination was mailed to you to submit an appeal. The appeal request should include all grounds for appeal and be accompanied by supporting documentation and an explanation on why you disagree with our decision.

If the claims appeal is not submitted in the required time frame, the claims appeal will not be considered and the appeal will be denied. If the appeal is denied, health partners will be notified in writing.

How to Submit Appeals

Health partners may submit appeals through our secure Provider Portal or in writing:

- Provider Portal: https://providerportal.CareSource.com/GA
  - Under the Provider Portal, click on the "Claims Appeals" tab on the left.
- Writing: use the Health Partner Claim Appeal Request Form. Please include:
  - Member's name and CareSource member ID number
  - The health partner's name and ID number
  - The code(s) and why the determination should be reconsidered
  - If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or Electronic Data Information (EDI) for reconsideration
  - If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.

    CareSource
    Attn: Health Partner Appeals - Georgia
    P.O. Box 2008
    Dayton, OH 45402
    Fax: 866-317-2157

If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim within (180) days of the date of service or discharge. You do not need to file an appeal.

Appeal Resolutions

In the event the outcome of the review of the claim appeal is adverse to the health partner, CareSource will provide a notice of adverse action. The notice of adverse action will state that you may request an administrative law hearing in accordance with O.C.G.A. § 49-4-153, O.C.G.A. § 50-13-13 and O.C.G.A. § 50-13-15.

If the appeal is approved, payment will show on the health partner's Explanation of Payment (EOP).

Appeals may be reviewed by the CareSource grievance staff, medical directors, claims staff, health partnership relations staff and any department that may have reason to assist in resolving a grievance or appeal.

Exhaustion of CareSource Internal Appeals Process

Health partners who have exhausted CareSource's internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal have the option either to:

1. Pursue the administrative appeals process described in O.C.G.A. § 49-4-153(e), or to
2. Select binding arbitration by a private arbitrator who is certified by a nationally-recognized association that provides training and certification in alternative dispute resolution as described in O.C.G.A. § 33-21A-7.

If CareSource and the health partner are not able to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this code shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety

(90) calendar days of being selected, unless CareSource and the health partner mutually agree to extend this deadline. All costs for arbitration, not including attorney's fees, shall be shared equally by the parties.

Caresource requires exhaustion of the internal health partner complaint/appeal process prior to requesting an Administrative Law Hearing (state fair hearing).

Administrative Law Hearing

A request for an administrative law hearing must include the following information:

- A clear expression by the health partner that he/she wishes to present his/her case to an administrative law judge;
- Identification of the action being appealed and the issues that will be addressed at the hearing;
- A specific statement of why the health partner believes CareSource's action is wrong; and
- A statement of the relief sought.

The Department of Community has delegated its authority to receive Administrative Law Hearing requests to CareSource. Health partners should send all requests for Administrative Law Hearings to CareSource:

CareSource
Attn: Administrative Law Hearing Request – Georgia
P.O. Box 2008
Dayton, OH 45402
Fax: 866-317-2157

CHAPTER 16
CARESOURCE FAIR HEARING PLAN

CARESOURCE FAMILY OF COMPANIES FAIR HEARING PLAN

A Provider subject to an Action proposed by or issued by Plan shall have the rights set forth in this Fair Hearing Plan. This Fair Hearing Plan applies only to Actions, as defined herein. Prior to the issuance of an Action, the Provider will have the opportunity to take corrective action. Following the issuance of a Notice of Action by Plan, the levels of appeal available to the Provider are as follows:

Level 1 Meeting with CMO or Designee

Level 2 Provider Fair Hearing Panel

Level 3 Review by the Board of Trustees

Except as set forth in Section 11(8) herein, Provider under review for failing to meet standards for quality or utilization in the delivery of health care service will generally retain his or her status as a Participating Provider during the Provider's appeals under the provisions of this Fair Hearing Plan.

I. DEFINITIONS

Action. An action of Plan affecting the ability of Provider to provide services to individuals enrolled with Plan, including but not limited to rejection of the Provider's application for participation or summary suspension or termination of the Provider's Provider Agreement on the basis of Provider's failure to meet Plan's standards for quality or utilization in the delivery of health care services. Exclusions are set forth in Section II, herein.

Board. The Plan's Board of Trustees.

Board Decision. The decision issued by the Board, which may include affirmance, modification, or reversal of the PFHP Decision.

CEO. The Chief Executive Officer of Plan. Duties assigned to the CEO hereunder may be assigned to his or her designee.

CMO. The Chief Medical Officer of Plan. Duties assigned to the CMO hereunder may be assigned to his or her designee.

CMO Decision. The decision issued by the CMO or his or her designee following a meeting with the Provider, which may include affirmance, modification, or reversal of the Action.

Notice of Action. A written notice of an Action issued by Plan to Provider, which shall include the nature of the Action and the Provider's appeal rights.

Participating Provider. A health care professional or facility that has been credentialed or approved by Plan and entered into a Provider Agreement with Plan, to provide services to individuals enrolled with Plan in accordance with Plan requirements.

PFHP. The Provider Fair Hearing Panel.

PFHP Decision. The decision of the PFHP, which may include affirmance, modification, or reversal of the CMO Decision.

Plan. The entity within the CareSource Family of Companies that, through contracts with its Participating Providers, provides or arranges for the provision of medical services to its enrollees. This includes CareSource, CareSource Indiana, Inc., and CareSource Kentucky Co.

Provider. A health care professional or facility that is the subject of a proposed Action or an Action.

Provider Agreement. The contract between Provider and Plan for the provision of services by Provider to individuals enrolled with Plan, including but not limited to contracts titled "Provider Agreement" and "Group Practice Services Agreement."

II. PROPOSED ACTION, NOTICE OF ACTION, AND EXCLUSIONS

A. PROPOSED ACTION AND NOTICE OF ACTION

Prior to finalizing an Action, Plan will give Provider notice of the reason or reasons for the Action and an opportunity to take corrective action, if appropriate. When necessary, Plan will develop a performance improvement plan in conjunction with Provider. If the Provider declines to participate in a performance improvement plan or agrees to participate but fails to comply, in the reasonable determination of Plan, Plan may finalize the Action. If Plan finalizes the Action, the CMO or his or her designee will send a Notice of Action via certified mail, return receipt requested, to the Provider. The Notice of Action will include information regarding the Provider's further appeal rights. The procedures set forth in this Section II(A) shall not apply to a Provider whose participation has been summarily suspended in accordance with Section 11(8).

B. EXCLUSIONS

This Fair Hearing Plan shall not apply, and the Provider shall have none of the rights set forth herein under any of the following circumstances:

1. The Provider Agreement is terminated without cause pursuant to the terms of the Provider Agreement;
2. The health care needs of Plan's enrollees are being met and no need exists for the Provider's continued services; or
3. Plan determines that the Provider docs not otherwise meet the terms and conditions of the Provider Agreement.

Nothing in this Fair Hearing Plan will be construed as precluding Plan from summarily suspending a Provider's participation for the following reasons: the Provider's conduct presents an imminent risk of harm to an enrollee or enrollees; there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating Provider's field; or a governmental action has impaired the participating Provider's ability to practice.

The rejection of a Provider's application for participation with Plan due to the Provider's failure to submit a complete application does not constitute an Action for purposes of this Fair Hearing Plan.

III. MEETING WITH CHIEF MEDICAL OFFICER OR DESIGNEE

A Provider for whom an Action has been taken has a right to request an informal meeting with the CMO or his or her designee to discuss the Action. The Provider must request such a meeting, in writing, within thirty (30) days of receipt of the Notice of Action. The request must be addressed to the CMO and must be hand delivered or sent via certified mail, return receipt requested. The request must be received by the CMO within the thirty (30) day period.

A. NOTICE OF MEETING

Upon receipt of a Provider's request for a meeting, the CMO or his or her designee will schedule the meeting. In no event will the meeting be scheduled for later than thirty (30) days after the Provider's request for a meeting is received, unless otherwise agreed to by the parties or, at the sole discretion of the CMO, for good cause. Promptly after the meeting is scheduled, the CMO or his or her designee will send a notice to the Provider, via certified mail, return receipt requested, of the date, time and place of the meeting.

B. MEETING PROCEDURE

During the meeting, the CMO or his or her designee and the Provider will discuss the reason or reasons for the Action. This is an informal meeting and not a hearing. The following procedural requirements apply:

1. Personal presence will be required. Failure of the Provider to appear at the meeting, without good cause, will constitute a waiver of the right to a meeting and a voluntary acceptance of Action involved;
2. Representation of the Provider by legal counsel or any other individual is not permitted, unless such representation is approved in advance of the meeting by the CMO or his or her designee; and
3. The Provider may submit any documents or other evidence or a written statement to the CMO or his or her designee either before or during the meeting.

C. TIMING AND NOTICE OF DECISION

No later than fourteen (14) days after the meeting, the CMO or his or her designee will make a decision regarding the Action. The CMO or his or her designee will report the CMO Decision to the Chairperson of the Board. The CMO or his or her designee will, within seven (7) days after making the report to the Chairperson of the Board, send notice via certified mail, return receipt requested, to the Provider, of the CMO Decision and the Provider's further appeal rights.

IV. PROVIDER FAIR HEARING PANEL

Following the procedures set forth in Section Ill above, the Provider may appeal the Action by requesting a hearing with the Provider Fair Hearing Panel ("PFHP"). The Provider must request such a hearing, in writing, within thirty (30) days of receipt of the CMO Decision. The request must be addressed to the CEO and must be hand delivered or sent via certified mail, return receipt requested. The request must be received by the CEO within the thirty (30) day period. Failure to file such a request within the required time period shall constitute the Provider's complete and final waiver of any right to a meeting, hearing, and/or any appellate review of the Action.

A. NOTICE OF HEARING

Upon receipt of a Provider's request for a hearing, the CEO or his or her designee will promptly arrange for and schedule the hearing. Promptly after the hearing is scheduled, the CEO or his or her designee will send a notice to the Provider, via certified mail, return receipt requested, of the date, time and place of the hearing.

B. COMPOSITION OF THE PROVIDER FAIR HEARING PANEL

The hearing will be conducted by the PFHP, composed of not less than three (3) members selected by the CEO. The PFHP will be composed of Participating Providers with comparable or higher levels of education and training than the Provider and not otherwise involved in Plan's network management. If possible, a representative of the Provider's specialty will be a member of the PFHP. No one who has participated in the case or circumstances giving rise to the hearing, and no one in direct economic competition or professionally associated with the Provider will be appointed to the PFHP. Knowledge of the matter involved will not preclude any individual from serving as a member of the PFHP.

The CEO or his or her designee will designate one of the PFHP members as the Chairperson. The names of the PFHP members will be promptly communicated to both parties, both upon the initial appointments and in the event of any subsequent substitute appointments. Within five (5) days of receiving the list of names, the Provider may object to any PFHP member. The objection must be in writing stating the basis of the objection. The decision as to whether to replace any PFHP member will be at the sole discretion of the CEO or his or her designee.

C.HEARING PROCEDURE

1. **Appearances**. The personal presence of the Provider is required. If the Provider fails to appear without good cause, as determined by the PFHP, the Provider will be deemed to have completely and finally waived his/her rights to the hearing and any appellate review. Both the Provider and Plan are entitled to have legal counsel, or any other person, represent them at the hearing. The PFHP may also have separate legal counsel to advise it regarding the procedures herein. If a party is represented by an attorney or anyone else, that attorney or person will be responsible for presenting the case. If the Provider will be represented by legal counsel or any other person, the Provider will notify Plan of such representation, in writing, at least fourteen (14) days in advance of the hearing.
2. **Presiding Officer**. The Chairperson of the PFHP will preside at the hearing. The presiding officer will determine the order of procedure and will make all rulings on procedure, including postponements and recesses, and the admissibility of evidence. The presiding officer may, in his or her sole discretion, call a pre-hearing conference in order to make decisions regarding exhibits, objections, or any other procedural matters as chosen by the presiding officer.
3. **Attendance of PFHP Members**. A majority of the PFHP must be present throughout the hearing and the PFHP deliberations. If a member is absent from any part of the proceedings, the member will not be permitted to participate in the deliberations or decision of the PFHP.
4. **Rights of Parties**. During the hearing, each of the parties will have the right:
   a. to call and examine witnesses;
   b. to introduce exhibits;
   c. to cross-examine any witness on any matter relevant to the issues;
   d. to rebut any evidence; and
   e. to submit a written statement at the close of the hearing.

   Oral evidence will be taken only on oath or affirmation administered by a person entitled to notarize documents.
5. **Procedure and Evidence.** The following rules of procedure and evidence will apply to the hearing:
   a. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of their affairs will be admitted regardless of the admissibility of such evidence in a court of law. Each party will, prior to or during the hearing, be entitled to submit memoranda that will become part of the hearing record. State and Federal Rules of Evidence do not apply to the hearing. It is the intent of this section that evidentiary disputes be resolved in favor of admissibility, with the PFHP deciding the appropriate weight to be accorded all evidence.
   b. If requested by either party or at the direction of the presiding officer, copies of the exhibits to be introduced and the names of the witnesses to be called will be exchanged by the parties no later than seventy-two (72) hours before the hearing is scheduled to begin. Additional exhibits and witnesses can only be introduced or called upon a showing of good cause
   c. If the Provider does not testify in his/her own behalf, the Provider may be called and examined as if under cross-examination by the Plan representative or the members of the PFHP.

d. In reaching a decision, the PFHP may take official notice before the submission of the matter for decision of any generally accepted technical or scientific matter relating to the issues under consideration. Parties present at the hearing will be informed of the matters to be noticed and those matters will be noted in the hearing record. Any party will be given the opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noted matters by evidence or by written or oral presentation of authority. The manner of such refutation will be determined by the PFHP.

e. It will be the obligation of the Plan representative to present appropriate evidence in support of the Action. The Provider will thereafter have the burden of proving by clear and convincing evidence that the Action was arbitrary or capricious.

6. **Record**. A record of the hearing will be kept by a court reporter, and a copy thereafter may be obtained by the Provider upon payment of reasonable charges associated with the preparation thereof.

7. **Deliberation and Adjournment**. Upon conclusion of the presentation of oral and written evidence, the hearing will be closed, unless the PFHP permits the parties to submit final written statements. The PFHP will thereupon, at a time convenient to itself within twenty-one (21) days after the later of hearing closure or the submission of written statements, conduct its deliberations outside of the presence of the parties. The conclusion of deliberations will constitute adjournment of the PFHP.

D. TIMING AND NOTICE OF DECISION

Within seven (7) days of adjournment of the PFHP, the PFHP Decision will be sent to the Chairperson of the Board, the CEO, and the CMO. The Chairperson of the Board will, within seven (7) days of receipt of the PFHP Decision, send notice via certified mail, return receipt requested, to the Provider, of the PFHP Decision and the Provider's further appeal rights.

V. REVIEW BY THE BOARD OF TRUSTEES

Following issuance of the PFHP Decision, the Provider may request that the Board review the PFHP Decision. Such a request must be addressed to the Chairperson of the Board and must be hand delivered or sent via certified mail, return receipt requested. The request must include a brief statement of the grounds for appeal. If such request for Board review is not received by the Chairperson of the Board within fourteen (14) days of the date of the PFHP Decision, the PFHP Decision will thereupon become final and immediately effective. The Provider has the burden of proving by clear and convincing evidence that the PFHP Decision was arbitrary or capricious. Within thirty (30) days after its receipt of the request for review, the Board will affirm, modify, or reverse the PFHP Decision. The Board Decision will be final and conclusive of the matter. The Board Decision will be in writing, and the Board will deliver copies thereof to the Provider, to the Chairperson of the PFHP, in person or by certified mail, return receipt requested.

VI. ADOPTION AND AMENDMENT OF FAIR HEARING PLAN

This Fair Hearing Plan will be effective upon adoption by Board. In the event of any conflict between this document and any other Plan rule, policy or agreement, the provision(s) of this Fair Hearing Plan will prevail. This Fair Hearing Plan may be amended by a majority vote of the Board, at any meeting of the Board at which a quorum is present. Proposed changes must be provided to each Board member at least seven (7) days before the meeting.

COMPUTATION OF DAYS

Any reference to "days" throughout means calendar days. In computing any period of time pursuant to this policy, the day of the act or event from which the period of time begins to run will not be included. The last day of the period so computed will be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday.
Revised: October 2014

CHAPTER 17
QUALITY IMPROVEMENT PROGRAM

PROGRAM PURPOSE

The purpose of the CareSource Quality Improvement Program is to ensure that CareSource has the necessary infrastructure to:

- Coordinate care
- Promote quality
- Ensure performance and efficiency on an ongoing basis
- Improve the quality and safety of clinical care and services provided to Georgia Medicaid members.

There are two guiding tenets for the program:

Our mission, which is our heartbeat, is to make a lasting difference in our members' lives by improving their health and well-being. Our vision is to transform lives through innovative health and life services.

The Institutes for Healthcare Improvement's Triple Aim: simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and the per capita cost of care for the benefit of communities.

The Quality Improvement Program includes both clinical and non-clinical services and is revised as needed to remain responsive to member needs, health partner feedback, standards of care and business needs.

PROGRAM GOALS AND OBJECTIVES

CareSource strives to be a top performing health plan nationally. Performance goals are determined and aligned with national benchmarks where available.

The goals and objectives of the program are:

- NCQA Accreditation
  - Attain NCQA Accreditation for Georgia Medicaid in alignment with contract requirements
  - Attain NCQA Commendable or Excellent accreditation status within three years of the operational start date
  - Compliance with NCQA Accreditation standards
  - High level of HEDIS performance
  - High level of CAHPS performance
  - Comprehensive population health management program
  - Comprehensive health partner engagement program

PROGRAM SCOPE

The Quality Improvement Program governs the quality assessment and improvement activities for CareSource. The scope includes:

- Meeting the quality requirements of CareSource's Contract with the Department of Community Health
- Complying with 42 CFR 438.206, et seq. (CMO Standards), 42 CFR 438.310 et seq. (Quality Measurement and Improvement, External Quality Review), and 42 CFR Part 164 (HIPAA Privacy Requirements)
- Establishing safe clinical practices throughout our health partner network
- Providing quality oversight of all clinical services
- Ensuring Compliance with NCQA accreditation standards
- Performing HEDIS compliance audit and performance measurement
- Monitoring and evaluating member and health partner satisfaction
- Managing all quality of care and quality service complaints
- Developing organizational competency of the Institute for Healthcare Improvement's (IHI) Model for Improvement
- Ensuring that CareSource is effectively serving members with culturally and linguistically diverse needs
- Ensuring that CareSource is effectively serving members with complex health needs
- Assessing the characteristics and needs of our member population
- Assessing the geographic availability and accessibility of PCPs and specialists

The quality program is overseen by the Georgia Chief Medical Officer in conjunction with the Georgia Quality Improvement Director, and the CareSource Vice President, Quality Improvement and Performance Outcomes. On an annual basis, CareSource makes information available about our quality program to health partners on our website. CareSource gathers and uses health partner performance data to improve quality of services.

QUALITY MEASURES

CareSource continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

CareSource uses HEDIS® to measure the quality of care delivered to members. Potential quality measures include:

- Wellness and prevention
  - Preventive screenings (breast cancer, cervical cancer and chlamydia)
  - Well-child care
- Chronic disease management
  - Comprehensive diabetes care
  - Controlling high blood pressure
- Behavioral health
  - Follow-up after hospitalization for mental illness
  - Antidepressant medication management
  - Follow-up for children prescribed ADHD medication
- Safety
  - Use of imaging studies for low back pain

CareSource uses the annual member survey, Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) Surveys, to capture member perspectives on health care quality. Potential CAHPS® measures include:

- Customer service
- Getting care quickly
- Getting needed care
- How well doctors communicate
- Ratings of all health care, health plan, personal doctor and specialists

Health partners can use tools on our Provider Portal to look up services and tests needed and historical medical and pharmacy data.

PREVENTIVE GUIDELINES AND CLINICAL PRACTICE GUIDELINES

CareSource recommends nationally accepted standards and guidelines to help inform and guide the clinical care provided to members. Guidelines are reviewed at least every two years or more often as appropriate, and updated as necessary. The use of these guidelines allows CareSource to measure the impact of the guidelines on outcomes of care. Review and approval of the guidelines are completed by the CareSource Clinical Advisory Committee every two years or more often as appropriate. The guidelines are then presented to the CareSource Quality Enterprise Committee. CareSource will submit all guidelines to DCH for review prior to approval and as updated. Topics for guidelines are identified through analysis of members. Guidelines may include, but are not be limited to:

- Behavioral health (depression)
- Adult health (hypertension, diabetes, cardiovascular disease, cerebrovascular disease and chronic obstructive pulmonary disease)
- Population health (obesity and tobacco cessation)

Guidelines will be promoted to health partners through health partner newsletters, the CareSource health partner website, direct mailings, health partner manual and through focused meetings with CareSource Health Partner Relations representatives. Information about clinical practice guidelines and health information will be made available to CareSource members via member newsletters, the CareSource member website or upon request.

To ensure consistent application of the guidelines, we will require health partners to use the guidelines and will measure compliance with the guidelines until 90 percent or more of health partners are consistently in compliance. Caresource will conduct our review on a quarterly basis. We will perform a review of a minimum random sample of 50 members' medical records per evidenced –based clinical practice guidelines each quarter. We appreciate health partner participation in this review process.

EXTERNAL QUALITY REVIEW

Through our contract with DCH, we are required to participate in periodic record reviews. DCH retains an External Quality Review Organization (EQRO) to conduct medical record review for CareSource Georgia Members. You may periodically receive requests for medical record copies from CareSource or from DCH contracted EQRO for these purposes. Your contract with CareSource requires that health partners furnish copies of patient medical records for this purpose. EQRO and CareSource reviews are a permitted disclosure of a member's personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPPA). CareSource realizes that supplying medical records for review requires your staff's valuable time, and we appreciate your cooperation with our requests and associated timelines.

If you would like more information on CareSource Quality Improvement, please call Health Partner Services at **1-855-202-1058.**

VALUE-BASED PURCHASING

Your success is important to us. We offer a series of value-based reimbursement (VBR) programs for our health partners. These programs provide a progressive approach along a continuum of payment programs that will reward you as you attain higher levels of quality.

Our flexible approach will enable you to participate in VBR programs at an initial level and grow to successively higher levels of reimbursement. Under the guidance of CareSource quality improvement, you are rewarded for providing better value for services and achieving better health outcomes for our members.

CHAPTER 18
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 health partners. Please keep in mind the following access standards for differing levels of care. Participating health partners are expected to have procedures in place to see patients within these time frames and to offer office hours to their CareSource patients that are at least the equivalent of those offered to any other patient. Thank you for adhering to these standards.

Primary Care Providers (PCPs)

Patients with…	Should be seen…
Emergency needs	Immediately upon presentation
Sick visits (adult and pediatric)*	Within 24 hours of initial contact with the PCP site
Routine care needs	Not to exceed 14 calendar days

Non-PCP Specialists

Patients with…	Should be seen…
Emergency needs	Immediately upon presentation
Persistent symptoms*	No later than 30 calendar days after their initial contact with the specialist site
Routine care needs (stable condition)	No later than 30 calendar days

Behavioral Health

Patients with…	Should be seen…
Emergency needs	Immediately upon presentation
Non-life threatening emergency needs	Within 6 hours of initial contact with behavioral health partner
Routine care needs (stable condition)	No later than 14 calendar days
Follow up routine care	No later than 14 calendar days

Maternity Care Health Partners

Patients with…	Should be seen…
Routine maternity care	First Trimester – within 14 calendar days of initial contact with maternity care health partner Second Trimester – within 7 calendar days initial contact with maternity care health partner Third Trimester – within 3 business days initial contact with maternity care health partner

Urgent Care Health Partners

Patients with…	Should be seen…
Urgent care needs (non-dental)	Within 24 hours of initial contact with urgent care health partner
Urgent dental care needs	Within 48 hours of contact with urgent care health partner

Emergency Care Health Partners

Patients with…	Should be seen…
Emergency care needs	Immediately upon presentation (24 hours a day, 7 seven days a week and without prior authorization)
Elective Hospitalizations	Within 30 calendar days of initial presentation

Dental Health Partners

Patients with…	Should be seen…
Routine care needs	Within 21 calendar days of initial contact with dental health partner

VISION Partners

Patients with…	Should be seen…
Routine care needs	Within 30 calendar days of initial contact with vision health partner

Therapy Providers (Physical, Occupational, Speech, and Aquatic)

Patients with…	Should be seen…
Routine care needs	Within 30 calendar days of initial contact with therapy health partner

**A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. It is expected that if a health partner is unable to see the member within the appropriate time frame, CareSource will facilitate an appointment with a participating health partner or a non-participating health partner, if necessary.*

For the best interest of our members and to promote their positive healthcare outcomes, CareSource supports and encourages continuity of care and coordination of care between medical care health partners as well as between medical care health partners and behavioral healthcare partners.

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

Email: providermaintenance@caresource.com
Fax: 937-396-3076
Mail: CareSource
Attn: Health Partner 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.

CHAPTER 19
REFERRALS AND PRIOR AUTHORIZATIONS

This section describes the referral and prior authorization processes and requirements for services provided to CareSource members in Georgia Families®, PeachCare for Kids®, and Planning for Healthy Babies®. Please visit our Provider Portal at CareSource.com for the most current information on prior authorization (PA) and referral requirements.

REFERRALS INFORMATION

If you have questions about referrals and prior authorizations, please call our Medical Management Department at **1-855-202-1058**.

Services That Do Not Require a Referral

Some health care services provided by specialists do not require a referral from a primary care provider (PCP). Members may schedule self-referred services from participating health partners themselves. 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 (within benefit limits)
- Dental care (excluding oral surgery and orthodontics)
- Services to treat an emergency
- Family planning services
- Laboratory services (must be ordered by a participating health partner)
- Podiatric care
- Psychiatric care at Community Mental Health Centers only
- 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 health partner)
- Routine eye exams (at participating vision centers, within benefit limits)
- Speech and hearing services
- Care from obstetricians and gynecologists
- Care at urgent care centers after hours
- Services for children with medical handicaps

Members May Go to Non-Participating Health Partners For:

- Emergency care
- Care at community mental health centers
- Family planning services provided at qualified family planning health partners
- Care at FQHCs and RHCs

Referral Procedures

A referral is required for specialty services not listed above and for members to be evaluated or treated by most specialists. Any treating provider can refer CareSource members to specialists. Please refer to our website for more information on services that require a referral.

Simply put a note about the referral in the patient's chart. Please remember, non-participating specialists must request prior authorization for any services rendered to CareSource patients. You can request a prior authorization by calling our Medical Management Department at **1-855-202-1058** and select the option to request a prior authorization. Or you can submit a request online at **CareSource.com** and select the Provider Portal option from the menu.

If you have difficulty finding a specialist for your CareSource member, please call our Health Partner Services Department at **1-855-202-1058**.

Steps 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 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.

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

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. However, health partners or members may request a second opinion at no additional cost to the member if the service was obtained in network.

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

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

PRIOR AUTHORIZATION INFORMATION

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

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

Email: gamedmgmt@CareSource.com

Fax: Fax the prior authorization form to 844-676-0370. The prior authorization form can be found on **CareSource.com**.

Mail: Send prior authorization requests to:
CareSource
Attn: Medical Management Dept.
PO Box 1598
Dayton, OH 45401

Phone: **1-855-202-1058** and follow the appropriate menu prompts for the authorization requests, depending on your need.

Georgia Medicaid Management Information System (GAMMIS)
Authorizations may also be submitted via the Georgia Web Portal. The Georgia Web Portal serves as the centralized portal for the submission of Fee-for-Service (FFS) authorization requests, and authorization requests for certain services provided to Medicaid members enrolled in a Care Management Organization (CMO). Access the portal by going to Georgia Medicaid Management Information System (GAMMIS) at **www.mmis.Georgia.gov.**

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 on the CareSource website 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

There will be two ways ordering health partners can obtain prior authorization from NIA for an imaging procedure:

- Online – **www.radmd.com**
- By Phone – **1-866-392-5173**
  (follow the options to obtain a prior authorization and select the option for advanced radiology prior authorization), Monday through Friday, from 8 a.m. to 8 p.m. EST

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

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.

Synagis Prior Authorization

CareSource's medical policy for administration of Synagis follows the American Academy of Pediatrics (AAP) guidelines for Respiratory Syncytial Virus (RSV). CareSource will review according to the guidelines in determining payment authorization for Synagis immunization. Consistent with epidemiologic findings, CareSource considers "RSV season" to be November 1 through March 31.

Coverage for the RSV season will end March 31 with an extension possible if RSV is still in the community. Requests for Synagis injections can be submitted on our secure Provider Portal.

In addition, any health partner who is not a participating health partner with CareSource must obtain prior authorization for all non-emergency services provided to a CareSource member.

CareSource does not require prior authorization for unlisted procedure CPT codes. However, it requires a clinical record be submitted with your claim to review the validity of the unlisted procedure CPT code.

Claims submitted without clinical records for unlisted procedure CPT codes will be denied. Denials will be reconsidered through the appeal process with pertinent clinical records.

PRIOR AUTHORIZATION PROCEDURES

When requesting an authorization, please provide the following information:

- Member/patient name and CareSource member ID number
- Health partner name and NPI
- 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 health partner, if applicable
- Clinical information to support the medical necessity for the service

If the request is for inpatient admission (whether it is elective, urgent or emergency), 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.

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 authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and 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. Health partners must verify eligibility on the date the 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 health partner.

CareSource will notify you of prior authorization determinations by a letter mailed to the health partner's address on file.

For standard prior authorization decisions, CareSource provides notice to the health partner and member as expeditiously as the member's health condition requires, but no later than three (3) business days after receipt of the request for service.

Urgent prior authorization decisions are made within twenty-four (24) hours of receipt of request for service. 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.

Authorization Type	Decision	Extension
Standard Pre-service	Three (3) business days	Fourteen (14) calendar days*
Expedited Pre-service	Twenty-four (24) hours	Five (5) business days *
Urgent Concurrent	Twenty-four (24) hours	Forty-eight (48) hours
Post service (Retrospective Review)	Thirty (30) calendar days	

*Extensions may be granted if the member or a health parter request an extension or CareSource justifies to the Department of Community Health a need for additional information and how the extension is in the member's best interest.

UTILIZATION MANAGEMENT

Utilization management (UM) helps maintain the quality and appropriateness of health care services provided to CareSource members. The Medical Management 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 medical care is rendered in the most appropriate setting using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the CareSource care management team are made, if needed. CareSource makes the UM criteria available in writing by mail, fax or email and via the web.

Mail: CareSource
Attn: Medical Management Dept.
PO Box 1598
Dayton, OH 45401
Fax: 1-844-676-0370
Email: gamedmgt@caresource.com

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

Access to Staff

- Staff members are available from 8 a.m. to 5 p.m. during normal business hours for inbound calls regarding utilization management (UM) issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours.
- 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.

Criteria – CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. This criterion is designed to assist health partners in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients. CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services.

CareSource also has a medical policy developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource Clinical Peer Reviewer for further review and determination. Clinical Peer Reviewers from CareSource are available to discuss individual cases with attending physicians upon request. Criteria are also available upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health partners or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

Our members' health is always our number one priority. Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations. You may request the information by calling or faxing the CareSource Medical Management Department. If you would like to discuss an adverse decision with CareSource's physician reviewer, please call the Medical Management Department at **1-855-202-1058** within five business days of the determination.

HEALTH PARTNER APPEALS PROCEDURE

If you are dissatisfied with a determination made by our Medical 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.

RETROSPECTIVE REVIEW

A retrospective review is a request for an initial review for authorization of care, service or benefit for which an authorization is required, but was not obtained prior to the delivery of the care, service or benefit. Prior authorization is required to ensure that services provided to our members are medically necessary and provided appropriately. In the event that you fail to obtain prior authorization, you will have 180 days from the date of service, date of discharge, or 90 days from the other carrier's EOB (whichever is later).

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.

Please note: If you are appealing on our member's behalf with their written consent, you have up to 90 days to request the appeal from date of service, discharge date or date of the denial if the service is not yet rendered (whichever is later).

A request for retrospective review can be made by contacting the Medical Management Department at **1-855-202-1058** and following the appropriate menu prompts, or by faxing the request to **1-844-676-0370**. Clinical information supporting the request for services must accompany the request.

POST STABILIZATION SERVICES

Please call **1-855-202-1058** 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 by a participating health partner. To request prior authorization for observation services as a non- participating health partner or to request authorization for an inpatient admission please call **1-855-202-1058**. When calling, follow the prompt for post-stabilization. During regular business hours, your call will be answered by our Medical Management Department. If calling after regular business hours, the call will be answered by CareSource24, our nurse advice line. "Post-Stabilization Care Services" are defined by 42 CFR 438.11.

CHAPTER 20
AMERICANS WITH DISABILITIES ACT (ADA)

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, health partners 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, health partners' diagnostic equipment must accommodate individuals with disabilities.

The CareSource health partner network will reasonably accommodate persons and ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. CareSource and its health partner network will comply with the ADA (28 C.F.R. 35.130) and the Rehabilitation Act of 1973 (29 U.S.C. 794) and will maintain capacity to deliver services in a manner that accommodates the needs of its members.

Please see the following pages for information about the ADA. More information on this subject may be obtained at **www.cdihp.org**.

Q. Which health partners are covered under the ADA?

A. Private hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists and health clinics are among the health partners covered by the Title III of the ADA. Title III applies to all private health partners, regardless of size. It applies to health partners of both physical and mental health care. If a professional office is located in a private home, the portion of the home used for public purposes is covered by the ADA.

Hospitals and other health care facilities that are operated by state or local governments are covered by Title II of the ADA. Health partners that offer training sessions, health education, or conferences to the general public must make these events accessible to individuals with disabilities.

POLICIES AND PROCEDURES

Health partners are required to modify policies and procedures when necessary to serve a person with a disability. The ADA, however, does not require health partners to make changes that would fundamentally alter the nature of their service.

Q. What kinds of modifications to policies or procedures might be required?

A. Modifying standard policies, practices or procedures can be an inexpensive but effective way to provide access to health care services. This may mean taking extra time to explain a procedure to a patient who is blind or ensuring that a patient with a mobility impairment has access to an accessible exam room.

EFFECTIVE COMMUNICATION, AUXILIARY AIDS & SERVICES

Health partners must find appropriate ways to communicate effectively with persons who have disabilities affecting their ability to communicate. Various auxiliary aids and services such as interpreters, written notes, readers, large print or Braille text can be used depending on the circumstance and the individual.

Q. Why are auxiliary aids and services so important in the medical setting?

A. Auxiliary aids and services are often needed to provide safe and effective medical treatment. Without these aids and services, medical staff runs the risk of not understanding the patient's symptoms, misdiagnosing the patient's medical problem and prescribing inappropriate treatment. Similarly, patients may not understand medical instructions or warnings that may have a serious impact on their health.

Q. How does a health partner determine which auxiliary aid or service is best for a patient?

A. The health partner can choose among various alternatives consulting with the person and carefully considering his or her expressed communication needs in order to achieve an effective result.

Q. Can a patient be charged for part or all of the costs of receiving an auxiliary aid or service?

A. No. A health partner cannot charge a patient for the costs of auxiliary aids and services, either directly or through the patient's insurance carrier.

Q. In what medical situations should a health partner obtain a sign language interpreter?

A. If a patient or responsible family member usually communicates in Sign Language, an interpreter should be present in all situations in which the information exchanged is lengthy or complex (for example, discussing a patient's medical history, conducting psychotherapy, communicating before or after major medical procedures and providing complex instructions regarding medication).

If the information to be communicated is simple and straightforward, such as prescribing an X-ray or a blood test, the physician may be able to communicate with the patient by using pen and paper.

EXISTING FACILITIES / BARRIER REMOVAL

Q. When must private medical facilities eliminate architectural and communication barriers that are structural in nature from existing facilities?

A. When the removal of those barriers is readily achievable, meaning easy to accomplish, without much difficulty or expense. Like undue burden, readily achievable is determined on a case-by-case basis in light of the resources available to an individual health partner.

Q. How does one remove "communication barriers that are structural in nature"?

A. For instance, install permanent signs, flashing alarm systems, visual doorbells and other notification devices, volume control telephones, assistive listening systems and raised character and Braille elevator controls.

COMPLAINTS

Q. What if a patient thinks that a health partner is not in compliance with the ADA?

A. If a health partner cannot satisfactorily work out a patient's concerns various means of dispute resolution, including arbitration, mediation, or negotiation, are available. Patients also have the right to file an independent lawsuit in federal court and to file a formal complaint with the U.S. Department of Justice.

Excerpted from and based on, "ADA Q and As" by Deborah Leuchovius, ADA Specialist, PACER (Parent Advocacy Coalition for Educational Rights) 8161 Normandale Blvd., Bloomington, MN 55437.

CHAPTER 21
PLANNING FOR HEALTHY BABIES® PROGRAM (P4HB®)

The Planning for Healthy Babies® Program (P4HB®) is an 1115 Medicaid Demonstration Waiver that expands the provision of family planning services to women who are Georgia residents, who do not qualify for other Medicaid benefits, any other insurance coverage, or who have lost Medicaid coverage for any reason and who meet specific eligibility criteria. Eligible P4HB® participants will be enrolled in one of three components of the P4HB® family planning waiver program:

1. Family Planning Only Component: family planning and family planning related services for eligible participants for the duration of the waiver
2. Interpregnancy Care Component: family planning and additional services for women who have delivered a very low birth weight (VLBW) (<1500 grams or 3.3 pounds) baby
3. Resource Mother Outreach: inclusive of a specially trained case manager to women on traditional Medicaid plans who have delivered a VLBW baby

PARTICIPANT ELIGIBILITY CATEGORIES

Enrollees who meet the following requirements are eligible to enroll in P4HB®:

- Be a US citizen or person with qualified proof of citizenship
- Be ages 18 through 44 years
- Be a Georgia resident
- Be able to become pregnant
- Not be eligible for any other Medicaid program or managed care program
- Meet family gross income requirements of no more than 200 percent of the federal poverty level (FPL)

If losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum, not otherwise be eligible for Medicaid or the Children's Health Insurance Program (CHIP).

Disenrollment

Women who no longer meet the eligibility criteria outlined for the P4HB® program will be disenrolled from the P4HB® program. These include women who:

- Become pregnant
- Receive a sterilization procedure and complete all necessary follow-up
- Move out of the state
- Become incarcerated
- Change income status
- Become unable to become pregnant
- Women who have aged out

Women who participate in the Interpregnancy Care Program (IPC) will be disenrolled after two years of participation. They may transition to the Family Planning only component if deemed eligible following their IPC participation.

Redeterminations of eligibility for the P4HB® Program are conducted at least every 12 months.

APPLYING

Health partners are encouraged to refer women to the P4HB® Program who have delivered a VLBW infant to determine if they would be eligible to participate in the Inter-pregnancy Care or Resource Mother Outreach program components.

Members can apply for the P4HB® program online at **www.planning4healthlybabies.org** or pick up an application at the local:

- Public Health Department
- Division of Family and Children Services Office

BENEFITS

There are three components that women who qualify for the waiver are eligible to participate in:

Family Planning

If a member meets the above eligibility requirements, she is eligible for the Family Planning component of the P4HB® program. This component covers family planning and family planned related services.

Inter-pregnancy Care

If a member meets the above eligibility requirements and also has delivered a Very Low Birth Weight (VLBW) baby on or after January 1, 2011, she also is eligible for the Interpregnancy Care (IPC) component of P4HB®. This component covers family planning and additional services for women who have delivered a VLBW baby.

Resource Mother

If a member currently receives Medicaid and delivered a VLBW baby on or after January 1, 2011, she is eligible for the Resource Mother component of P4HB®. This component offers specially trained Resource Mothers who provides support to mothers and equips them with information on parenting, nutrition and healthy lifestyles.

COVERED SERVICES

Family Planning Services

Women enrolled in P4HB® are eligible for the following family planning and family planning related services:

Services	Notes/Limitations
Family planning initial or annual exams (one per year)	• Initial comprehensive and Annual Examinations • Infertility assessment services, including infertility review, education, physical examination, appropriate lab testing and counseling and referral related to infertility are excluded benefits for P4HB® participants.
Follow up family planning or family planning related service visits	Services are generally performed as part of, or as follow-up to, a family planning service for contraception, or for a family planning-related problem identified/diagnosed during a routine/periodic family planning visit. Follow-up visits occur after the initial or annual examination and include services outlined in sections 901.2 and 901.3 of the DCH Family Planning and Family Planning Waiver Services Policies and Procedures Manual. Follow up service visit examples include: • Contraceptive services and supplies clearly provided or performed for the primary purpose of family planning • Procedures or services clearly provided or performed for the primary purpose of family planning - periodic or inter-periodic contraceptive management - patient education and counseling • Rescreening for an abnormal pap smear • Screening or rescreening for a STD • Colposcopy (and procedures done with/during a colposcopy). • A LEEP procedure • Treatment/drugs for Sexually Transmitted Infections (STIs), except for HIV/AIDS and hepatitis, when the STI's were identified/diagnosed during a routine/periodic family planning visit. • Treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders and urinary tract infections • Treatment of major complications such as: - A perforated uterus due to an intrauterine device insertion; - Severe menstrual bleeding caused by a Depo-Provera; injection requiring a dilation and curettage - Surgical or anesthesia-related complications during a sterilization procedure.
Family planning lab tests	Lab tests may be performed to address family planning problems when those problems are identified during a family planning visit: • Pregnancy tests • Pap Smear • STI tests
Screening, treatment and follow up for STI(s), except HIV/AIDS and Hepatitis	• Antibiotic treatment for STI(s) • Treatment for limited infections identified during routine family planning visit

Services	Notes/Limitations
Tubal Ligation (Sterilization)	Sterilizations are covered when provided in a family planning setting and when the P4HB® participant: • Is at least twenty-one (21) years of age at the time consent is obtained; • Is mentally competent; • Voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Clinic Services. This includes the completion of all applicable documentation; • Is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility. • Additionally: - At least thirty (30) Calendar Days, but not more than one hundred and eighty (180) Calendar Days, have passed between the date of informed consent and the date of sterilization. - An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a participant who is visually impaired, hearing impaired or otherwise disabled; and - A hysterectomy is not considered a covered service for P4HB® participants
Pharmacy services	Prescriptions for family planning related services and devices and for multivitamins with folic acid and Folic Acid only.
Vaccinations	Hepatitis B, tetanus-diphtheria (Td) and combined tetanus, diphtheria and pertussis (TdAP) vaccinations for P4HB® participants ages eighteen (18) to twenty (20). There is no coverage under the P4HB® program for Human Papilloma Virus (HPV) vaccine.
Abortions or abortion-related services	Not a covered service for P4HB® participants.

Inter-pregnancy Care Services (IPC)

In addition to family planning services listed above, women who give birth to a VLBW baby on or after January 1, 2011, and do not receive Medicaid or are losing Medicaid coverage, are eligible for inter-pregnancy care services:

Services	Notes/Limitations
Primary care	PCP coordinates care for the participant and makes referrals to CMO and non-CMO specialty care as needed.
5 office/outpatient visits	Per year
Management and treatment of chronic diseases	
Substance abuse treatment (detoxification and intensive outpatient rehabilitation)	Participants can self-refer to an in network health partner for an initial mental health or substance abuse visit but prior authorization may be required for subsequent visits. Participants may also receive detoxification and intensive outpatient rehabilitation services only.
Case management/Resource Mother Outreach	See below
Limited Dental	For a list of benefits, contact Member Services.
Prescription Drugs (non-family planning)	
Non-emergency medical transportation	

Resource Mother Services

Women served under the IPC component of the P4HB® program and women enrolled in other Medicaid programs who have delivered a VLBW baby on or after January 1, 2011 will have access to case management including a Resource Mother (RM). The Resource Mother mentors women who give birth to VLBW babies and provides information regarding parenting, nutrition and healthy lifestyles, in addition to the following services:

- Meet with P4HB® participants over the phone or in person to encourage them to adopt healthy behaviors, including healthy eating and smoking cessation
- Support compliance with primary care medical appointments including assistance with non-emergency transportation arrangements
- Consult with physicians, nurses, social workers and case managers about problems identified and assist in the development of an appropriate action plan
- Support P4HB® participants' compliance with medications to treat chronic health conditions including assisting the P4HB® participant with obtaining needed medications and reinforcing the need for medication compliance
- Assist the P4HB® participant with the coordination of social services support for family and life issues
- Assist P4HB® participants in locating and utilizing community resources including legal, medical, financial assistance and other referral services (including WIC). Follow-up to make sure the baby receives regular well-baby check-ups and immunizations
- Provides peer and emotional support needed to meet the health demands of her VLBW baby

Reimbursement

Services	Notes/Limitations
Initial and annual comprehensive family planning visits	Only one initial or annual comprehensive visit is available per member per 12 months. The initial or annual comprehensive visit cannot be billed on the same date of service with a general comprehensive medical visit. Health partners should use CPT codes 99204 (for new patient) or 92215 (for an established patient) when conducting the initial or annual comprehensive visit. The FP modifier must be used with either of these codes.
Brief medical visit	A follow-up visit that occurs after the initial or annual comprehensive visit. Typically, 10 minutes of face-to-face time with the patient. Health partners should use CPT code 99212 (for an established patient) when conducting the brief medical visit. The FP modifier must be used with this code.
Comprehensive medical visit	A follow-up visit that occurs after the initial or annual comprehensive visit. Typically, 15 to 25 minutes of face-to-face with the patient. Health partners should use CPT codes 99213 (for an established patient; typically a 15 minute visit) or 99214 (for an established patient; typically a 25 minute visit) when conducting the comprehensive medical visit. The FP modifier must be used with either of these codes.
NOTE: Health partners cannot bill for an initial exam or the annual exam on the same date of service with the comprehensive medical visit or brief medical visit.	
Supply visit	The purpose of the supply visit is to allow the patient to obtain additional contraceptives and counseling if indicated. Typically, five minutes are spent performing or supervising these services. The presenting problems are minimal. The visit may not require the presence of a physician. Health partners should use CPT code 99211 when conducting this office visit. The FP modifier must be used with this code.

Services	Notes/Limitations
Implantable contraceptive capsules	Physicians, nurse practitioners, midwives and physicians' assistants will be reimbursed for the insertion and removal of implantable contraceptive capsules only after their training requirements have been completed. Staff training should be conducted according to the manufacturer's guidelines. Documentation of training must be maintained in the health partner's personnel or training record. The insertion, management and removal of the capsule must be accomplished according to the manufacturer's recommendations. Health partners should use the codes below when billing for this service. The FP modifier must be used with these codes. J7307 Etonogestrel (Implanon/Nexplanon) Implant System - Modifier FP 11981 Insertion, Implantable Contraceptive Device – Modifier FP 11976 Removal, Implantable Contraceptive Capsule – Modifier FP Insertions are limited to one within a three year period. The insertion or removal may be billed in conjunction with one of the above mentioned visits.
Intrauterine devices	Physicians, nurse practitioners, midwives and physicians' assistants will be reimbursed for the insertion and removal of intrauterine devices only after their training requirements have been completed. Staff training should be conducted according to the manufacturer's guidelines. Documentation of training must be maintained in the health partner's personnel or training record. The insertion, management and removal of these devices must be accomplished according to the manufacturer's recommendations. Health partners should use the codes below when billing for this service. The FP modifier must be used with these codes. J7300 Paragard / Intrauterine copper contraceptive – Modifier FP J7297 Liletta IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 3 year - Modifier FP J7298 Mirena IUD Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG, 5 year - Modifier FP J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System (Skyla), 13.5MG- Modifier FP. 58300 Insertions, Intrauterine Device – Modifier FP
Injectable contraceptives	The Depo-Provera injection may be billed with any type of visit code. Coverage is limited to one injection every three months or one every 12-13 weeks. Health partners should use the code below when billing for this service. The FP modifier must be used with this code. J1050 Medroxyprogesterone Acetate 1 mg (Injection) - Modifier FP 1 mg = 1 unit. The health partner must bill the appropriate units administered to the patient.
Other contraceptive methods	Oral contraceptives are available as a Pharmacy Benefit. Health partners should use the codes below when billing for Other Contraceptive Methods services. The FP modifier must be used with these codes. 57170 Diaphragm or cervical cap fitting with instructions – Modifier FP A4267 Contraceptive Supply, Condom, Male, - Modifier FP Condoms may be billed with any type visit code. Condoms are limited to four (4) units per visit or 14 units annually. (1 unit = 40 condoms).
Pregnancy test	The pregnancy test may be billed through the Family Planning Program only when the test is family planning related under the following circumstances: A. It is performed at the time family planning services are initiated for an individual; B. It is performed at a visit after the initiation of family planning services where the patient may not have used the particular family planning method properly or where the patient is having an unusual response to the method; or C. It is performed during the infertility evaluation. Health partners should use CPT code 81025 when billing for the urine pregnancy test. The FP modifier must be used with this code.
NOTE: Please Use the FP modifier for all Family Planning related Laboratory services.	

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