buckeye health plan

Your Guide to Better Health™

2022-2023

Provider Manual

as of 12-1-22

BHP-MM-100322

Welcome to Buckeye Health Plan

ABOUT US

Buckeye Health Plan, Inc. (Buckeye) is a managed care plan (MCP) contracted with the Ohio Department of Medicaid (ODM) to serve Medicaid and other government services program members. Buckeye has developed the expertise to work with Medicaid members to improve their health status and quality of life. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Buckeye works to accomplish this goal by partnering with the primary care providers (PCP) who oversee the healthcare of Buckeye members.

Goals of Buckeye

Buckeye has been designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Improve access to all necessary health care services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

Buckeye strives to provide members with an improved health status. Buckeye continually seeks to improve member and provider satisfaction.

All our programs, policies and procedures are designed with these goals in mind. We hope that you will assist Buckeye in reaching these goals.

Buckeye Mission Statement

Better health outcomes, lower costs.

Buckeye Guiding Principles

- High quality, accessible, cost-effective healthcare for our members
- Integrity and the highest ethical standards
- Mutual respect and trust in our working relationships
- Communication that is open, consistent, and two-way
- Diversity of people, cultures, and ideas
- Innovation and encouragement to challenge the status quo
- Teamwork and meeting our commitments to one another

Buckeye allows open practitioner/patient communication regarding appropriate treatment alternatives. Buckeye does not penalize practitioners for discussing medically necessary or appropriate care with the patient.

Buckeye Approach

Recognizing that a strong health plan is predicated on building mutually satisfactory associations with providers Buckeye is committed to:

- Working as partners with participating providers
- Demonstrating that healthcare is a local issue; and
- Performing its administrative responsibilities in a superior fashion.

All of Buckeye's programs, policies and procedures are designed to minimize the administrative responsibilities in the management of care, enabling you to focus on the healthcare needs of your patients, our members.

Buckeye Summary

Buckeye's philosophy is to provide access to high quality, culturally sensitive healthcare services to Ohio's Medicaid eligible, by combining the talents of primary care providers and specialty providers with a highly successful, experienced managed care administrator. Buckeye believes that successful managed care is the delivery of appropriate, medically necessary services not the elimination of such services.

It is the policy of Buckeye to conduct its business affairs in accordance with the standards and rules of ethical business conduct and to abide by all applicable federal and state laws. For specific detail related to topics within this handbook, please call Provider Services at 1-866-296-8731 to receive the additional information upon request.

At Buckeye we take privacy and confidentiality of our member's health information seriously. We have processes, policies, and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy law requirements. If you have any questions about Buckeye's privacy practices, please contact the Privacy Official at 1866-246-4356.

You may access most of Buckeye's information/forms/etc. on our website at www.buckeyehealthplan.com/providers. Our website includes claims status and member eligibility search capabilities; numerous forms; patient listings; Provider Directories; Provider Manual; Quality Improvement Standards; and our Drug List (DL), to name a few.

Contact Information

KEY CONTACTS

The following chart includes a list of important telephone and fax numbers that providers will need. When contacting any department, please have the following information available:

National Provider Identifier (NPI) number
Tax ID Number (TIN)
If calling about a member-related issue, please know the member's ID Number

Buckeye's hours of operation are Monday – Friday 8 a.m. to 5 p.m. (EST) excluding holidays. Buckeye is closed on these holidays:

New Year's Day
Martin Luther King Jr.'s Birthday
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Day after Thanksgiving
Christmas Day

A holiday that falls on a Saturday is observed on the Friday before it. One that falls on a Sunday is observed on the Monday after it.

Beginning December 1, 2022, under the Next Generation of Managed Care, Buckeye's Member and Provider Services hours of operation will change to Monday-Friday 7 a.m. to 8 p.m. (EST).

Health Plan Information		
Website	buckeyehealthplan.com/providers	
Main Address	4249 Easton Way, Suite 120 Columbus, OH 43219	
Department	**Toll Free Telephone Numbers**	**Fax Number**
Provider Services	1-866-296-8731	N/A
Member Services	1-866-246-4358 (Medicaid) TTY: 1-800-750-0750	N/A
Member Eligibility	1-866-246-4358 (Medicaid)	N/A
Prior Authorization Request ****Beginning on December 1, 2022, prior authorization requests will need to be*	1-866-246-4359	SN/Rehab/LTAC requests: 1-866-529-0291 1-866-535-4083

submitted through the Provider Network Management (PNM) system. Fax will no longer be an option.		1-866-529-0290 Home Health Care and Hospice requests: 1-855-339-5145
Concurrent Review	1-866-246-4359	1-866-786-1039 1-866-709-1109 1-866-535-4081 1-866-535-2895 1-866-753-7547
Care Management	1-866-246-4359	1-866-528-9920
Envolve Vision https://visionbenefits.envolvehealth.com/	1-866-442-6173	N/A
Envolve Dental https://www.envolvedental.com/	1-844-464-5634	N/A
24 Hour Nurse Advice Line (24/7 Availability)	1-866-246-4358 say "Nurse" when prompted	N/A
National Imaging Associates (NIA) www.radmd.com	1-800-642-6551	N/A
Non-Emergency Medical Transportation (NEMT)	1-866-531-0615	N/A
Ohio Medicaid Provider Hotline www.medicaid.ohio.gov	800-686-1516	N/A
Ohio Medicaid Consumer Hotline www.medicaid.ohio.gov	800-324-8680 (Toll Free)	N/A
Buckeye Health Plan Admissions	1-866-246-4358	N/A
To report suspected waste, fraud, and abuse to Buckeye Health Plan	1-866-296-8731	N/A
Interpreter Services	1-866-246-4358	N/A
Paper Claims Submission		
Buckeye Health Plan PO Box 6200 Farmington, MO 63640 ****Beginning on December 1, 2022, claims will no longer be accepted via paper submission. Claims should be submitted electronically through ODM's Fiscal Intermediary (FI).*		

Electronic Claims Submission
Buckeye Health Plan c/o Centene EDI Department Payer ID: 68069 1.800.225.2573, ext. 6075525 or by e-mail to: EDIBA@centene.com

Payer IDs
Buckeye Health Plan Payer IDs (Effective December 1, 2022): • 0004202 BUCKEYE OHIO MEDICAID (837 P & I ONLY) • V004202 BUCKEYE/ENVOLVE VISION • D004202 BUCKEYE/ENVOLVE DENTAL (837 Dental) • T004202 BUCKEYE/ACCESS2CARE https://managedcare.medicaid.ohio.gov/managed-care/fiscal-intermediary

Provider Representative

PROVIDER RELATIONS

The Provider Relations Department is dedicated to making your experience with Buckeye a positive one by serving as your advocate within the organization. Provider Relations is responsible for providing the services listed below which include but are not limited to:

- Initial Point of Contact regarding Provider Data Management.
- Maintenance of existing Buckeye Provider Manual.
- Development of alternative reimbursement strategies.
- Researching of trends in claims inquiries to Buckeye.
- Network performance profiling.
- Physician and office staff orientation.
- Hospital and ancillary staff orientation.
- Ongoing provider education, updates, and training.

To contact the Provider Relations representative for your area, please call the Provider Services Toll Free Help Line at 1-866-296-8731.

Provider Relations Representative Territory Assignment Map can be found on our website at https://www.buckeyehealthplan.com/providers/provider-relations-rep-territories.html.

PROVIDER SERVICES

The Provider Services Toll Free Help Line staff is available to you and your staff to answer questions, listen to your concerns, assist with patients, respond to your Buckeye Plan inquiries, connect you to the Buckeye Provider Relations Specialist for your area, etc.

Provider Services and Provider Relations Representatives are dedicated to building strong relationships with Buckeye providers serving as advocates to ensure you receive timely assistance and the highest quality of service and support.

Provider Services hours of operation are Monday – Friday 8:00 a.m. to 5 p.m. (EST) excluding holidays. Beginning December 1, 2022, under the Next Generation of Managed Care, Buckeye's Provider Services hours of operation will change to Monday-Friday 7 a.m. to 8 p.m. (EST).

Contact the Provider Services Toll Free Help Line at 1-866-296-8731.

Provider Resources

Buckeye is dedicated to delivering the tools and support providers need to deliver the best quality of care to our members. Below are a few resources providers can utilize.

BUCKEYE WEBSITE

The Providers should use Buckeye Health Plan as their main source of information related to our plan and products. Providers can access the following information at www.BuckeyeHealthPlan.com/Providers:

- Provider Manual and Billing Manual
- Member Handbook and benefit information
- Prior Authorization Check Tool
- Clinical Guidelines
- Provider Forms
- Policies and Procedures
- Newsletters and other Buckeye news.

We are continually updating our website with the latest news and information, so save BuckeyeHealthPlan.com/providers to your Internet "Favorites" list and check our site often!

PROVIDER PORTAL

The Buckeye Provider Portal allows providers to check member eligibility and benefits, submit and check status of claims and send/receive messages to communicate with Buckeye staff. Buckeye's contracted providers and their office staff can register for our Provider Portal in just four easy steps.

The Provider Portal offers tools which make obtaining and sharing information easy! It's simple and secure! Go to www.BuckeyeHealthPlan.com/Providers to get started.

Through the Provider Portal, you can:

- View the PCP panel (patient list)
- View and submit a claims dispute
- View authorizations
- View payment history
- View member gaps in care
- View quality scorecard
- Check member eligibility; and
- Contact us securely and confidentially

Please contact your Provider Relations representative for a tutorial on the Provider Portal.

LISTSERV SUBSCRIPTIONS

Buckeye uses the Benchmark Core marketing platform to manage our provider communications. Anyone can sign up to receive our communications via a Sign-Up Form. Access to the Sign-Up Form is available on our website pages - Provider Home Page and Provider Communications. It can also be accessed on each monthly newsletter delivered to providers. Providers can opt out of communications from the monthly newsletter. Provider Communications are delivered via the Benchmark platform using the Buckeye Provider Communications email address Buckeye_Provider_Communications@CENTENE.COM.

https://www.buckeyehealthplan.com/providers.html
https://www.buckeyehealthplan.com/providers/provider-communications.html

CLAIMS PAYMENT SYSTEMIC ERRORS (CPSE)

A CPSE is defined as the MCO's claims adjudication incorrectly underpaying, overpaying, or denying claims that impact five or more providers. A report containing all active CPSEs is updated monthly and can be found on our website under Provider Resources at https://www.buckeyehealthplan.com/providers.html.

The Claims Payment Systemic Errors (CPSE) issues are reported in ascending order with the most recently identified issue listed last.

Buckeye Health Plan encourages you to review this log often and prior to contacting Buckeye Health Plan Provider Contact Center. If you still have questions, please call 1-866-296-8731 to speak to a Provider Services Representative.

PROVIDER ADVISORY COUNCIL

Buckeye Health Plan will utilize the opportunity afforded from developing a Provider Advisory Council to identify challenges and barriers faced by the provider community. The Council will enhance communication between Buckeye and providers across the network and offer an opportunity to collectively problem solve for the issues identified. Ultimately improving the health care delivery system and improving outcomes for their patients/our members.

The Provider Advisory Council will be chaired by the Chief Medical Officer, as designated by the CEO, for Buckeye Health Plan. Membership will consist of a variety of specialties, including Behavioral Health and Dental providers, and sizes of provider groups from across the state. Cadence of meetings is at a minimum of three times annually.

Buckeye Health Plan will monitor and report out on the activities of the Provider Advisory Council via a Provider Advisory Council Activity Report as specified in the Appendix P, Chart of Deliverables within the Provider Agreement with the Ohio Department of Medicaid.

PROVIDER POLICIES

Clinical and Payment Policies are found on our website under Provider Resources at www.buckeyehealthplan.com/providers/resources/clinical-payment-policies.html

PROVIDER SERVICES

Provider Services are providers' first point of contact at Buckeye. This department works with all other departments to ensure that providers and their support staff receive the necessary assistance and information.

Provider Services is available Monday – Friday 8 a.m. - Noon and 1- 5 p.m. (EST) excluding holidays. Beginning December 1, 2022, under the Next Generation of Managed Care, Buckeye's Provider Services hours of operation will change to Monday-Friday 7 a.m. to 8 p.m. (EST).

If you have questions about Buckeye's operations, benefits, policies, and/or procedures; contact the Provider Services department at 1-866-296-8731.

PROVIDER TRAINING & WEBINARS

Provider Training and Webinars are found on our website under Provider Resources at https://www.buckeyehealthplan.com/providers/training-and-education.html

FORMS

Medicaid Forms
Ohio Department of Medicaid Forms Library:
https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/forms/forms

Hysterectomy, Abortion, or Sterilization Form(s)
The appropriate sterilization/abortion forms can be located at:
https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-english-2025.pdf
https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-spanish-2025.pdf

Please refer to the specific criteria found in 42 CFR 441 and Ohio Administrative Code rule 5160-21-02.2 for additional sterilization/abortion guidelines.

Pre-Service Appeal Authorization Release Form
(Effective December 1, 2022)
For a Pre-Service Appeal, (when provider is submitting on behalf of the patient), the link below must be used to obtain the required form that must be submitted along with the appeal request.
https://www.buckeyehealthplan.com/members/medicaid/resources/complaints-appeals.html

Provider Claim Dispute Medical Necessity Review Form
(Effective December 1, 2022)
For a Post-Service claim that requires medical necessity review, they are no longer considered appeals. These would fall under the provider claims dispute process. This applies to all claims that require medical necessity review and a claim has already been submitted.
https://www.buckeyehealthplan.com/providers/resources/forms-resources.html

External Medical Review Form
(Effective December 1, 2022)
Pre and Post Review that requires External Medical Review still qualifies as an appeal. This applies to all claims that require medical necessity review and a claim has already been submitted and the provider is requesting external review of the claim decision.
https://www.buckeyehealthplan.com/providers/resources/forms-resources.html

Medicaid Addendum
Medicaid addenda for use in subcontracting by managed care plans.
https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/medicaid-addendum

SUD Residential Treatment (ODM)
https://www.bh.medicaid.ohio.gov/manuals > Resources
ODM Form 06653 Instructions for Community Medicaid BH Providers
https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM06653fillx.pdf

Out-of-Network Provider Application (ODM)
If you are a provider who is not currently enrolled and wish to enroll to provide any services under the Next Generation of Ohio Medicaid, please visit the following link to the Ohio Medicaid online application.
https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/provider-enrollment/provider-enrollment-lp

Ohio Medicaid Provider Agreement
Ohio Medicaid Provider Agreement for Managed Care Organization
https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/38e87337-f168-4a0f-a341-d3379b5dcf9c/MCO+Provider+Agreement_2021+06+29_final+for+signature.pdf?MOD=AJPERES&CVID=nGHQqH

Provider Responsibilities

PATIENT PRIVACY AND SECURITY

- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- To follow Buckeye's policies and procedures on Patient Privacy, Confidentiality, and Security.
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allow members to request restriction on the use and disclosure of their personal health information.
- All health information, including that related to patient conditions, medical utilization, and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

PRIMARY CARE PROVIDER (PCP)

The primary care provider (PCP) is the cornerstone of Buckeye. The PCP serves as the "medical home" for the patient. The "medical home" concept assists in establishing a patient- provider relationship and ultimately better health outcomes. The PCP may be a physician (M.D. or D.O.) or advanced practice nurse. Acceptable specialty types include family/general practice, internal medicine, and pediatrics.

The PCP is required to adhere to the responsibilities outlined below.

COVERED PHYSICIAN SERVICES

The PCP shall arrange for other participating providers to provide covered persons with covered physician services as stipulated in their contract. This enables them to provide the same care and attention that physicians customarily provide to all patients. Each participating provider shall provide all covered physician services in accordance with generally accepted clinical, legal, and ethical standards in a manner consistent with physician licensure, qualifications, training, and experience. These standards of practice for quality care are generally recognized within the medical community in which the physician practices.

Covered services include:

- Professional medical services, both inpatient and outpatient, provided by the PCP, nurses, and other

personnel employed by the PCP. These services include the administration of immunizations, but not the cost of biologicals.

- Periodic health assessments and routine physical examinations (performed at the discretion of the PCP, and consistent with nationally recognized standards recommended for the age and sex of the Enrollee).
- Vision and hearing screenings.
- All supplies and medications used or provided during a covered patient office visit. Injectable drugs costing over $100 require a Prior Authorization, which can be obtained by submitting a prior authorization request through ODM's Fiscal Intermediary (FI). Oncology drugs given in the office are excluded from Prior Authorization requirements.
- All tests routinely performed in the PCP's office during an office visit.
- The collection of laboratory specimens.
- Voluntary family planning services such as examinations, counseling, and pregnancy testing.
- Well-childcare and periodic health appraisal examinations, including all routine tests performed as customarily provided in a PCP's office.
- Referral to specialty care physicians and other health providers with coordination of care and follow-up after referral.
- PCP's supervision of home care regimens involving ancillary health professionals provided by licensed nursing agencies. Please note, these services are subject to prior authorization by Buckeye.
- Any other outpatient services and routine office supplies normally within the scope of the PCP's practice.

PCP AVAILABILITY AND ACCESSIBILITY

Each participating provider shall maintain sufficient facilities and personnel to provide covered physician services and shall ensure that such services are available as needed 24 hours a day, 365 days a year. Each participating provider shall offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service if the provider serves only Medicaid members.

PCP COVERAGE

The participating provider shall arrange for coverage with a physician who must have executed a Participating Provider Agreement with the Buckeye. If the participating provider is capitated for professional services, compensation for the covering physician is included in the capitation payment. If the participating provider is on a fee-for-service agreement with Buckeye, the covering provider is compensated in accordance with the fee schedule in his/her Participating Agreement.

APPOINTMENT AVAILABILITY

The following standards are established with regards to appointment availability:

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency medical condition	24 hours, 7 days/week
Urgent Care (includes medical, behavioral health, and dental services)	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Acute illness or substance dependence that impacts the ability to function, but does not present imminent danger	24 hours, 7 days/week within 48 hours of request.
Behavioral Health Non-Life-Threatening Emergency.	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care.	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is Earlier.
CANS Initial Assessment	Assessment for the purposes of OhioRISE eligibility	Within 72 hours of identification
ASAM Residential/Inpatient Services – 3: 3.1, 3.5, 3.7	Initial screening, assessment and referral to Treatment.	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services – 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week
Primary Care Appointment	Care provided to prevent illness or injury; examples include but are not limited to routine physical examinations, immunizations, mammograms, and pap smears.	Within 6 weeks
Non-Urgent Sick Primary Care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 calendar days

Prenatal Care – First or Second Trimester Care	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	First appointment within 7 calendar days; follow up appointments no more than 14 calendar days after request
Prenatal Care – Third Trimester or High Risk Pregnancy	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	Within 3 calendar days
Specialty Care Appointment	Care provided for a non-emergent/non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

TELEPHONE ARRANGEMENTS

Providers are required to develop and use telephone protocol for all the following situations:

- Answering the enrollee telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by an enrollee.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special enrollee needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally deficient.
- Response time for telephone call-back waiting times:
    - After hours telephone care for non-emergent, symptomatic issues within 30 to 45 minutes
    - same day for non-symptomatic concerns
    - crisis situations within 15 minutes
- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

After hours calls should be documented in a written format in either an after-hour call log or some other method and transferred to the patient's medical record.

Note: *If after hours urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care or emergency center to notify the facility.*

Buckeye will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement Program.

REFERRALS

As the Medical Home, PCPs should coordinate all healthcare services for Buckeye Health Plan members. Paper referrals are not required to direct a member to a specialist within our participating network of providers. All out

of network services (excluding ER and family planning) require prior authorization. PCPs should track receipt of consult notes from the specialist provider and maintain these notes within the patient's medical record.

HEALTHCHEK

Healthchek, otherwise known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, is a program of comprehensive preventive health services available to Medicaid recipients from birth through 20 years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems.

Healthchek is a preventive program that combines diagnostic screening and medically necessary follow-up care for: dental, vision and hearing examinations for eligible Ohio enrollees under the age of 21.

Managed care plans must ensure that members under the age of 21 have access to services that are available in accordance with federal EPSDT requirements. This would include medically necessary services covered by Ohio Medicaid as well as any medically necessary screening, diagnostic and treatment services available to Medicaid consumers that exceed coverage or benefit limits for members under age 21. Providers can request prior authorization to exceed coverage or benefit limits for members under age 21.

PCPs are required to perform Healthchek medical check-ups in their entirety and at the required intervals. All components of exams must be documented and included in the medical record of each Healthchek eligible member. Healthchek exams are to be completed within 90 days of the initial effective date of membership for those children found to have a possible ongoing condition likely to require care management services.

For additional information on the Healthchek program see **Ohio Administrative Code** Chapter 5160-14 or access the State of Ohio website at: http://medicaid.ohio.gov/FOROHIOANS/Programs/Healthchek.aspx.

MEMBER PANEL CAPACITY

The current maximum limit on the number of members a PCP can have assigned to his/her practice is stated above the signature line on the signature page of the provider's Medicaid Addendum. All PCPs reserve the right to state the number of members they are willing to accept into their practice. Member assignment is based on the member's choice and auto assignment; therefore, Buckeye **DOES NOT** guarantee that any provider will receive a set number of members.

If a PCP does declare a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact the Buckeye Provider Services Department at 1-866-296-8731. A PCP shall not refuse to treat covered enrollees if the physician has not reached their requested panel size and shall notify Buckeye at least 45 days in advance of his or her inability to accept additional covered enrollees under Buckeye agreements.

OTHER PCP RESPONSIBILITIES

- Educate patients on how to maintain healthy lifestyles and prevent serious illness.
- Provide follow up on emergency care.
- Report all encounter data on CMS 1500 claim forms.
- Maintain confidentiality of medical information.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current Prior Authorization List, except for emergency services up to the point of stabilization.

Buckeye providers should refer to his/her Buckeye contract for complete information regarding Buckeye PCP obligations and mode of reimbursement.

SPECIALIST RESPONSIBILITIES

Selected specialty services require a formal authorization from ODM. The specialist must abide by the prior authorization requirements when ordering diagnostic tests or rendering services. All non-emergency inpatient admissions require prior authorization from ODM.

The specialist must maintain contact with the PCP. This could include telephone contact, written reports on consultations or verbal reports if an emergency exists.

The specialist provider must:

- Obtain prior authorization through ODM's Fiscal Intermediary (FI) as needed before providing services.
- Coordinate the patient's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five (5) business days.
- Be available for or provide on-call coverage through another source 24 hours a day for management of patient care.
- Maintain the confidentiality of medical information.

HOSPITAL RESPONSIBILITIES

Buckeye utilizes a network of hospitals to provide services to Buckeye members. Hospitals must:

- Obtain authorizations for all inpatient and selected outpatient services as listed on the current Prior Authorization List, except for emergency stabilization services.
- Notify Buckeye's Medical Management Department within two business days of an admission.

ADVANCE DIRECTIVES

Buckeye is committed to ensuring that its members know of and can avail themselves of their rights to execute Advance Directives. Buckeye is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding Advance Directives.

Any provider delivering care to Buckeye members must ensure **adult** members over the age of 18 years receive information on Advance Directives and are informed of their right to execute Advance Directives. Providers **must** document such information in the permanent medical record.

Buckeye recommends to its providers that:

- The first point of contact in the PCP's office should ask if the member has executed an Advance Directive. The member's response should be documented in the medical record.

- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Directive to the PCP's office and document this request.

- An Advance Directive should be included as a part of the member's medical record.

- If an Advance Directive exists, the provider should discuss potential medical emergencies with the member and/or family member/significant other (if named in the Advance Directive and if available) and with the referring provider, if applicable. Discussion should be documented in the medical record.

- If an Advance Directive has not been executed, the first point of contact within the office should ask the member if they desire more information about Advance Directives. If the member requests further information, Member Advance Directive education/information should be provided.

Member Services, Care Management and Member CONNECTIONS representatives will assist members with questions regarding Advance Directives. **However, no employee of Buckeye may serve as witness to an Advance Directive, or as a member's designated agent or representative.**

Buckeye's Quality Improvement Department may monitor compliance with this provision during initial office site visits and as scheduled thereafter.

If you have any questions, regarding Advance Directives, contact:

Medical Management Department
1-866-246-4359

PROVIDER ASSISTANCE WITH PUBLIC HEALTH SERVICES

Buckeye is required to coordinate with public health entities regarding the provision of public health services. Providers must assist Buckeye in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.

- Assisting in the notification or referral of any communicable disease outbreaks involving members to the local public health entity, as defined by state law.

- Referring to the local public health entity for tuberculosis contact investigation, evaluation, and the preventive treatment of persons whom the member has come into contact.

- Referring to the local public health entity for STD/HIV contact investigation, evaluation, and preventive treatment of persons whom the member has come into contact.

- Referring for Women, Infant and Children (WIC) services and information sharing as appropriate.

- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.

INCIDENT REPORTING

Providers are required to assure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500, and accidental/unnatural deaths. If actions were not taken to assure the immediate health and safety of the member, the provider will do so immediately. Such actions

may include calling police or EMS, reporting to county Adult Protective Services (APS), the county Public Child Services Agency (PCSA) or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to the MCO within 24 hours of becoming aware of the incident.

ADDITIONAL REPORTING REQUIREMENTS

Buckeye in accordance with its contract with the ODM must report the existence of certain information regarding its membership. For example, if your patient is involved in an accident or becomes injured, this information should be shared with us. This includes any incidents that occur prior to your patient's coverage with Buckeye. To report this type of information, please call us at 1-866-246-4359. Please be prepared to supply as many details as possible including, the date and the cause of the accident, the injuries sustained by your patient and any legal proceedings that have been initiated. In addition, you must immediately report the death of a Buckeye member.

CLINICAL PRACTICE AND PREVENTIVE HEALTH GUIDELINES

https://www.buckeyehealthplan.com/providers/quality-improvement/practice-guidelines.html

Preventive and Clinical Practice guidelines are based on the health needs and opportunities for improvement identified as part of the Quality Assurance Program Improvement (QAPI) program. Whenever possible, Buckeye Health Plan adopts preventive and clinical practice guidelines that:

- are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of health care professionals in the applicable field
- consider member needs; and
- are reviewed at a minimum of every two years by Buckeye Health Plan's Quality Improvement Committee.

Buckeye Health Plan provides annual notice of these guidelines via fax, website, and/or mail.

To request a copy of any guideline, please contact Buckeye Health Plan at 1-866-246-4358.

NON-COMPLIANT PATIENTS

There may be instances when a PCP feels that a member should be removed from his or her panel. All requests to remove a patient from a panel must be made in writing, contain detailed documentation, and must be directed to:

Buckeye Member Services Department
4349 Easton Way Suite 400
Columbus OH 43219
1-866-246-4358
Fax: 1- 866-719-5435

Upon receipt of such request, staff may:

- Interview the provider or his/her staff that are requesting the disenrollment, as well as any additional relevant providers

- Interview the member
- Review any relevant medical records
    - An example of a reason that a PCP may request to remove a patient from their panel could include, but not be limited to:

      A member is disruptive, unruly, threatening, or uncooperative to the extent that the member seriously impairs the provider's ability to provide services to the member or to other members and the member's behavior is not caused by a physical or behavioral condition.

A PCP should *never* request a member be dis-enrolled for any of the following reasons:

- *Adverse change in the member's health status or utilization of services which are medically necessary for the treatment of a member's condition.*
- *Based on the member's race, color, national origin, sex, age, disability, political beliefs, or religion.*
- *Previous inability to pay medical bills or previous outstanding account balances prior to the patient's enrollment in the Program.*

Cultural, Linguistic & Disability Access Requirements & Services

CULTURAL COMPETENCY

Cultural Competency requires the tailoring of services and supports to meet the unique social, cultural, and linguistic needs of your patient.

Studies show that culturally diverse groups, those with limited English proficiency, and people with disabilities experience inadequate access to care, lower quality of care, and poorer health outcomes.

To help mitigate this reality, Buckeye maintains a Cultural Competency Plan that monitors the availability of the following services at the health plan and provider level:

- Language Services
- Transportation services; and
- Reasonable accommodations for members with disabilities to access services and/or facilities.

In addition, Buckeye and participating Providers share responsibility for:

- Informing patients of the availability of cultural, linguistic and disability access services, at no cost to Medicaid patients
- Providing diversity and cultural competency training to all staff; and
- Promoting a culturally, linguistically and disability diverse workforce that reflects the diversity of its patients.

Beginning on October 1, 2022, cultural competency information as well as languages spoken by office location will be collected in ODM's Provider Network Management (PNM) system and will be utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the managed care organizations on a weekly basis for them to align their directories with the information contained in the PROVIDER NETWORK MANAGEMENT (PNM).

LANGUAGE SERVICES

Effective communication with patients who have limited English proficiency or who are deaf, hard of hearing, or speech disabled is crucial to ensuring better health outcomes.

When working with an interpreter, the American Academy of Family Physicians recommends that practitioners:

- Use professional interpreters rather than family and friends
- Speak directly to the patient rather than the interpreter
- Keep sentences short and pause to allow time for interpretation

ACCOMODATING PEOPLE WITH DISABILITIES

The Americans with Disabilities Act (ADA) defines a person with a disability as:

A person who has a physical or mental impairment that substantially limits one or more major life activity, and includes people who have a record of impairment, even if they do not currently have a disability, and individuals who do not have a disability, but are regarded as having a disability.

People with disabilities are entitled, by law, to fair and equal access to healthcare services and facilities. Buckeye ensures equal access in partnership with participating providers by maintaining an ADA Plan. The ADA Plan monitors the following:

- Physical accessibility of Provider offices
- Quality of the Health Plan's free transportation services
- Complaints related to the Health Plan and/ or Provider's failure to offer reasonable accommodations to patients with a disability

Accommodations for people with disabilities include, but are not limited to:

- Physical accessibility
- Accessible medical equipment (e.g., examination tables and scales)
- Policy modification (e.g., to permit use of service animals)
- Effective communication (e.g., minimize distractions and stimuli for members with intellectual and developmental disabilities).

RESOURCES

Please contact Provider Services at 1-866-296-8731 for language or transportation services.

Member Services

The Buckeye is committed to providing Buckeye members with information about the health benefits that are available to them through the Buckeye program. Buckeye encourages members to take responsibility for their health care by providing them with basic information to assist them with making decisions about their healthcare choices.

Buckeye has developed targeted programs to address the needs of its members. Members may attend classes, receive specific disease management bulletins and treatment updates, appointment reminder cards, and informational mailings.

MEMBERCONNECTIONS™ PROGRAM

The MemberConnections™ Program provides a link between the member, PCP and Buckeye. Buckeye recognizes the special needs of the population it serves. In response to these special needs, the MemberConnections™ program has been developed to address the challenges in member outreach, member education, and in member's understanding of the managed care health system.

The MemberConnections™ program is an innovative community outreach program adopted by Buckeye. Representatives reach out to members providing them with basic information to assist them with understanding their available health benefits, and to understand how to access those healthcare benefits in an appropriate manner.

MemberConnections™ representatives will:

- Contact new members by telephone to welcome them to Buckeye Health Plan.
- Educate members on Buckeye benefits including (but not limited to): Transportation, NurseWise®, Pharmacy, and using Care Management to increase health awareness and prevention.
- Actively collaborate with Care Managers to identify the needs of members to be assessed at the time of referral. The Connections Representative will complete and/or educate members regarding:

    - o Non-Emergency Transportation NET
    - o Tokens/Travel training program
    - o PCP selection and appointments
    - o Assistance with transportation options as needed
    - o Connections Plus/Caring Voices telephones
    - o Participate in community activities centered on health education.

Watch for activities that MemberConnections™ may be hosting in the Buckeye provider mailings. Participating Buckeye providers may contact the Member Services Department or Care Management at 1-866-246-4358 to request a home visit be completed when a Buckeye member is found to be non-compliant, (i.e., medical appointments), with recommended medical treatment or has been identified as high-risk factors (i.e., frequent emergency room visits for routine medical care) which could negatively impact the member's health status.

MEMBER MATERIALS

Members will receive various pieces of information from Buckeye through mailings and through face-to-face contact. These materials are printed in English and Spanish and can be requested in Spanish or other languages identified by the state. These materials include:

- Transportation Information
- Targeted Disease Management Brochure
- Provider Directory
- NurseWise® information
- Emergency Room Information
- Member Handbook, which includes:
    - o Benefit information, i.e., pharmacy network information, transportation information
    - o Member rights and responsibilities

Providers interested in receiving any of these materials may contact:

Buckeye Provider Services
1-866-296-8731

Member Rights & Responsibilities

MEMBER RIGHTS & RESPONSIBILITIES

Following are the members' rights and responsibilities as listed in the Buckeye member handbook.

As a member of Buckeye, you have the following rights and responsibilities:

- To receive all services that Buckeye must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally okayed to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To be able to take part in decisions about your healthcare unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure that others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless Buckeye must by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or Buckeye must talk to you about what could happen, and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing.
- To be able to get all Buckeye written member information from Buckeye:
    - at no cost to you
    - in the prevalent non-English languages of members in Buckeye's service area
    - in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from Buckeye and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the healthcare provider is a student and to be able to refuse his/her care.
- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- A responsibility to supply information (to the extent possible) that the organization and its practitioners

and providers need to provide care.

- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See the pamphlet in your new member packet which explains about advance directives. You can also contact member services for more information.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP on Buckeye's panel at least monthly. Buckeye must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that Buckeye, Buckeye's providers or ODJFS will not hold this against you.
- To know that Buckeye must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider on Buckeye's panel for covered woman's health services.
- To be able to get a second opinion from a qualified provider on Buckeye's panel. If a qualified provider is not able to see you, Buckeye must set up a visit with a provider not on our panel.
- To get information about Buckeye from us.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses 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.
- To know that Buckeye Representatives do not discriminate against any potential Member because of race, creed, age, color, sex, religion, culture, national origin, ancestry, marital status, sexual orientation, physical or mental disability, health status, or requirements for health care services. Services shall provide individuals equal access to its health programs or activities without discrimination on the basis of sex and treat individuals consistently with their gender identity.

Bureau of Civil Rights
Ohio Department Medicaid
150 E. Gay Street, 18th Floor
Columbus, Ohio 43215
(614) 644-2703 / 1-866-227-6353/ 1-866-221-6700 TTY
Fax: (614) 752-6381

As a member of Buckeye, you also have several responsibilities. They are to learn and understand each right you have under the Medicaid program. That includes the responsibility to:

- Ask questions if you don't understand your rights.
- Make any changes in your health plan and primary care provider in the ways established by the Medicaid program and Buckeye.
- Keep your scheduled appointments.
- Have ID card with you.
- Notify PCP of emergency room treatment.
- Cancel appointments in advance when you can't keep them.
- If Buckeye is providing transportation for you to a medical appointment, you must provide a car seat for any child riding with you if the child is 4 years of age or younger, or if the child weighs less than 40 pounds.
- Always contact your PCP or Buckeye's NurseWise® first for your non-emergency medical needs.

- Only go to the emergency room when you think it is an emergency.
- Be sure you have approval from your PCP before going to a specialist except for self-referrals.
- To share information relating to your health status with your PCP and become fully informed about service and treatment options. That includes the responsibility to:
    - Tell your PCP about your health.
    - Talk to your providers about your healthcare needs and ask questions about the different ways your healthcare problems can be treated.
    - Help your providers get your medical records.
    - Actively participate in decisions relating to safe service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
        - Work as a team with your provider in deciding what healthcare is best for you.
        - Do the best you can to stay healthy.
        - Treat providers and staff with respect.

All Buckeye members have the right to ask and obtain information regarding Buckeye physician Incentive Programs by contacting Buckeye Member Services at 1-866-246-4358.

MEMBER GRIEVANCES AND APPEALS

A ***grievance*** is an expression of dissatisfaction with any aspect of Buckeye's or a provider's operation, provision of healthcare services, activities, or behaviors, other than an MCO's adverse benefit determination per OAC rule 5160-26-08.4.

Beginning on December 1, 2022, a member may file a grievance with the MCO or SPBM orally or in writing at any time. An authorized representative must have the member's written consent to file a grievance on the member's behalf. Buckeye will respond to all issues raised by members, current or former, regardless of the time that has passed.

An ***appeal*** is the request for the review of the following adverse benefit determination:

- The denial or limited authorization of a requested service, including the type or level of service.
- The reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or part of payment for a service.
- Failure to act within the time frames required to resolve grievances.
- Failure to provide services in a timely manner (i.e., failure to meet prior authorization decision time frames).

Beginning on December 1, 2022, if the member does not agree with the decision/action listed in a notice of action (NOA), they may contact us within **60** calendar days from the NOA issuance date to ask that we change our decision/action; this is called an appeal. Unless we tell the member a different date, we will give them an answer, in writing, within 15 calendar days from the date they contacted us or 72 hours for an expedited appeal.

Resolution means a final decision is made by the Buckeye and the decision is communicated to the member. Buckeye will provide members access to a grievance and appeal resolution process. Buckeye will respond to member grievances and appeals in a timely manner and attempt to resolve all issues to the member's satisfaction.

*For the purposes of filing grievances or appeals on behalf of a member under the age of eighteen, written consent to file is not required when the individual filing the grievance or appeal belongs to the member's assistance group.

To file a grievance or an appeal a member should:

- Call the Member Service Department at 1-866-246-4358 (TTY 1-800¬750-0750).
- Complete the Appeals and Grievances form in the Buckeye Member Handbook at https://www.buckeyehealthplan.com/members/medicaid/resources/handbooks-forms.html

Mail the form or letter to:

Buckeye Health Plan
Appeals and Grievances Department
4349 Easton Way Suite 400
Columbus, OH 43219

Buckeye will give an answer to the member's grievance by phone (or by mail if we are unable to reach them by phone) within the following time frames:

- Within two working days for grievances regarding not being able to access medical care.
- **30** calendar days for all other grievances except grievances that are about getting a bill for care the member received.
- **60** calendar days for grievances about getting a bill for care the member received.

Buckeye will respond to a written grievance or appeal in writing if we decide to:

- Approve a request to cover a service.
- Provide an answer to the member about something they were unhappy with.
- Deny the request to cover the service.
- Reduce, suspend, or stop care the member is already receiving.
- Deny payment for a service received that is not covered by Buckeye.

If the member expresses dissatisfaction with the grievance/appeal resolution, he/she can either write a grievance letter or call Buckeye Member Services at 1-866-246-4358.

MEMBERS RIGHT TO A STATE FAIR HEARING

The member will be notified in writing of their right to a state fair hearing. If a state hearing is requested, the member must sign and return the State Hearing Form to the address listed on the form within 90 calendar days from the mailing date on the form. A state hearing is a meeting with the member, a representative from the County Department of Job and Family Services, a representative from Buckeye and a hearing officer from ODJFS. Buckeye will explain why we made our decision, and the member will explain why they think Buckeye made the wrong decision. The hearing officer will listen and then decide who is right based upon the information given and whether Buckeye followed the rules.

Request a State Hearing at https://hearings.jfs.ohio.gov/SHARE.

SPECIAL SERVICES TO ASSIST WITH MEMBERS

Buckeye has designed its programs and trained its staff to ensure that each day individuals' cultural needs are considered in carrying out its operations. Providers should remain cognizant of the diverse Buckeye population. Patients' needs may vary depending on their gender, ethnicity, age, beliefs, etc. We ask that you recognize these needs in serving your patients. Buckeye is always available to assist your office in providing the best care possible to your patients.

There are several services that are also available to your patients to assist with their everyday needs. Please see the description below.

Transportation Services

For ambulance services, a member or member representative can call Buckeye at 1-866-246-4358, at least 24-hours in advance. For ambulette (wheelchair) or ambulatory transportation, a member or a member representative can call TMS at 1-866-531-0615 to request a ride to a healthcare appointment, at least 48 hours in advance except for urgent appointments. Urgent appointments will be verified with the provider before the transportation is scheduled. Members must provide their name, home address, home phone number or contact number, the date of the appointment, time, location of appointment and whether it is a regularly scheduled appointment or an urgent care appointment. The member must also inform the member services representative if a return ride is needed. It is important to inform the member services representative if extra riders are accompanying the member to the appointment, as these requests may not always be granted.

Interpreter/Translation Services

As a provider for Buckeye, please remember that it is your obligation to identify any Buckeye member who requires translation, interpretation, or sign language services. Buckeye will pay for these services whenever you need them to effectively communicate with a Buckeye member. Buckeye members are not to be held liable for these services. To arrange for any of the above services, please call the Buckeye Member Services Department at (866) 246-4358.

Buckeye is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. To meet this need, Buckeye is committed to the following:

- Having individuals available who are trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with members as needed.
- Providing Language Line services that will be available 24 hours a day, seven (7) days a week in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.
- In-person Interpreter services are made available when Buckeye is notified in advance of the members scheduled appointment to allow for a more positive encounter between the member and provider. Telephonic services are available for those encounters involving urgent/emergent situations, as well as non-urgent/emergent appointments as requested.
- Providing TTY access for members who are hearing impaired through the Ohio Relay service at 1-800-750-0750 Buckeye's medical advice line, NurseWise®, provides 24-hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line.
- Providing or making available Buckeye Member Services and Health Education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation. Alternative methods must be requested by the member or designee.

  To access interpreter services, contact Member Services at 1-866-246-4358.

  Providers must call Member Services if Interpreter services are needed. Please have the member's ID number, date/time service is requested and any other documentation that would assist in scheduling interpreter services.

NurseWise®

Our members have many questions about their health, their primary care provider and access to emergency care. Our health plan offers a nurse triage service to encourage members to talk with their physician and to promote education and preventive care.

NurseWise® is our 24-hour nurse line available for your patients. The Registered Nurses provide basic health education, nurse triage and answer questions about urgent or emergency access, all day long. The staff often answers questions about pregnancy and newborn care. In addition, members with chronic problems, like asthma or diabetes, are referred to care management for education and encouragement to improve their health.

Members may request information about providers and services available in your community after the health plan is closed. Providers can verify eligibility any time of the day. The NurseWise® staff is conversant in both English and Spanish and can offer the Language Line for additional translation services. The nurses document their calls using Barton Schmitt, M.D. and David A. Thompson, M.D. protocols in a web-based data system. These protocols are widely used in nurse call centers and have been reviewed and approved by physicians from around the country.

We provide this service to support your practice and offer our members access to an RN every day. If you have any additional questions, please call Member Services or NurseWise® at 1-866-246-4358 option #7.

Transportation services for members enrolled in OhioRISE

The MCO must arrange and provide transportation for members who are enrolled with the OhioRISE plan in a manner that ensures that children, youth, and their families served by the OhioRISE plan do not face transportation barriers to receive services regardless of Medicaid payer. The MCO is responsible for arranging transportation in cases where transportation of families, caregivers, and sibling(s) (other minor residents of the home) when needed to facilitate the treatment needs of the member and their family.

Provider Enrollment, Credentialing & Contracting

PROVIDER ENROLLMENT

Provider Enrollment (ODM Functions):

General Provider Information/Enrollment Information

- Pursuant to 42 Code of Federal Regulations (CFR) 438.602, the Ohio Department of Medicaid (ODM) is required to screen, enroll, and revalidate all managed care organization (MCO) network providers. This provision does not require MCO network providers to render services to fee-for-service (FFS) beneficiaries.
- There are many resources available on the Ohio Department of Medicaid website about the requirements to become a participating provider. Please visit https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support for several useful documents that answer relevant questions.
- Organizational provider types will be required to pay a fee. The fee does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFS 445.460 and in OAC 5160:1-17.8. The fee for 2022 is $631 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, Ohio Medicaid will require that the enrolling organizational providers submit proof of payment with their application. (See OAC 5160:1-17.8)

Termination, Suspension, or Denial of ODM Provider Enrollment

- For a list of termination, suspension and denial actions initiated by the state against a provider or applicant that allow for hearing rights, please refer to Ohio Revised Code 5164.38.
- For a list of termination, suspension and denial actions initiated by the state Medicaid agency against a provider or applicant that allow for reconsideration, please refer to Ohio Administrative Code 5160-70-02.

Loss of Licensure

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

Enrollment and Reinstatement After Termination or Denial

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

Provider Maintenance

- The PNM system serves as the source of truth for provider data for ODM and the MCOs. As a result, data in the PNM is used in both the plan's provider directory and ODM provider directory. To ensure provider information remains current it is important for providers to keep their information up to date in the PNM. Please remember, as an ODM provider and in accordance with your provider agreement, providers are responsible to notify ODM of changes within 30 days (see OAC 5160-1-17.2 F).
    - **Updating the PNM:** When there is a change in a provider's information, please log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update. Self-service functions include location changes, specialty changes, and key demographic (e.g., name, NPI, etc.) changes. This information is sent to the MCOs on a daily basis for use in their individual directories. The provider must update their information in the PNM system first. The MCOs are required to direct providers back to the PNM if there are changes.

Integrated Help Desk/ODM Provider Call Center

If you have questions or need assistance with your Ohio Medicaid provider enrollment, call the ODM Provider Hotline at 800-686-1516 through the interactive voice response (IVR) system. It provides 24 hour, 7 days a week access to information regarding provider information. Provider representatives are available via the IVR system weekdays from 8:00 a.m. through 4:30 p.m.

Helpful Information

- **Medicaid Provider Resources**
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support
- **Federal guidelines for enrollment and screening (42 CFR 455 Subpart E)**
  https://www.law.cornell.edu/cfr/text/42/part-455/subpart-E
- **Ohio Revised Code**
  https://codes.ohio.gov/ohio-revised-code/chapter-5160
  https://codes.ohio.gov/ohio-revised-code/chapter-3963
- **Ohio Administrative Code**
  https://codes.ohio.gov/ohio-administrative-code/5160

ENROLLMENT GUIDELINES FOR BUCKEYE PROVIDERS

Buckeye providers must adhere to enrollment/marketing guidelines as outlined by Ohio Department of Medicaid (ODM).

Those guidelines include the following:

Providers cannot:

- Influence a patient to choose one health plan over another
- Influence patients based upon reimbursement rates or methodology used by a particular plan

Providers may:

- Stock and distribute to Buckeye members only state approved Buckeye Member Educational Materials.
- Inform the patients of hospital services, specialists, or specialty care available in the Buckeye Plan.
- Assist a patient in contacting Buckeye to determine if a particular specialist or service is available
- Only directly contact Buckeye members with whom they have an established relationship
- Encourage pregnant Buckeye members to select a physician for their baby before the baby is born

PROVIDER CONTRACTING

Our members value the quality of the network providers we offer. The Buckeye Contracting Team's goal is to help you complete this process quickly and easily.

Please follow the step-by-step instructions listed below. Once you have submitted your enrollment request at the Ohio Department of Medicaid Provider Network Management (PNM) Module through the centralized credentialing platform you can complete our contract request by completing your Join Our Network (JON) Form, a Contract Negotiator will reach out to you shortly.

1. Access our provider pages of the website at https://www.buckeyehealthplan.com/providers.html
2. Select the "Become a Provider" in the left menu options.
3. On the Become a Provider page, select the blue 'access forms and information' link in the Joining our Network section.
4. On the Join Our Network page, you will answer a series of questions –
5. Select What type of provider are you? Click on Solo, Independent, Group or Facility
6. If selecting Group or Facility, please respond to the next question as "I do not have a contract and want to apply" option
7. Next, select the Networks or Services you wish to contract for: Behavioral, Medical or Waiver
8. Complete the boxes with demographic information. To prevent delays, please provide complete information.
9. Complete the forms listed below and upload. (Click on each form link, complete the form online, save them to your computer, then upload the completed forms.)
    - Contract Services Form
    - Disclosure of Ownership Form
    - W-9
10. Select 'Submit' to submit your Join Our Network (JON) form.

Sample Provider Agreement

The Provider Manual will be updated with additional details around the ODM NextGen contract as they become available.

Medicaid Addendum

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

The most current Medicaid Addendum is posted on the ODM website here: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda.

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

Termination, Suspension, or Denial of Contract

- Providers should refer to their Buckeye contract for specific information about termination, suspension, or denial of contract from Buckeye.
- Providers should refer to their Buckeye contract for specific information about appeals process for denial of contract from Buckeye.

Out-of-state Providers/Non-contracted Providers

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with Buckeye for payment of covered services. If you are an out-of-network provider seeking payment for claims for emergency, post-stabilization, and any other services authorized by Buckeye, please review these guidelines below. For detailed information, please call Buckeye's Provider Services Department at 1-866-296-8731.

It is important that providers ensure Buckeye has accurate billing information on file. Please provide accurate information as follows:

- Provider name (as noted on his/her current W-9 form)
- Physical location address
- Billing name and address (if different)
- Tax Identification Number

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member's contract on the date of service; and

- Referral and prior authorization processes were followed unless the service was an emergency service.

Payment for service is contingent upon the service being provided to treat an emergency, or the service was compliant with referral and prior authorization policies and procedures, as well as the billing guidelines.

Single Case Agreement and Out of Network Provider Agreement

Single Case Agreements and Out of Network Provider Agreements will include details that inform the provider their information will be submitted to ODM to be entered in the Provider Network Management (PNM) system. This becomes the only option that allows these providers to submit claims given ODM's Fiscal Intermediary (FI) is the single-entry point for all provider claims effective December 1, 2022.

Plan Provider Call Center

If you have questions or need assistance with your Buckeye enrollment, call Provider Services at 1-866-296-8731. Provider representatives are available Monday – Friday 8 a.m. - Noon and 1- 5 p.m.

Credentialing & Re-credentialing

Per ODM's request, Buckeye will discontinue all initial credentialing effective September 1, 2022.

CREDENTIALING REQUIREMENTS

The credentialing process exists to ensure that participating providers meet the criteria established by Buckeye, as well as government regulations and standards of accrediting bodies such as the National Committee for Quality Assurance (NCQA).

NOTICE: To maintain a current provider profile, providers are required to notify Buckeye of any relevant changes to their credentialing file in a timely manner.

Practitioners must submit the following information when applying for participation with Buckeye:

- Complete, signed, and dated Council for Affordable Quality Healthcare (CAQH) credentialing form as mandated by ORC 3963.03 and 3963.06
- Current Drug Enforcement Agency (DEA) Certificate and/or Controlled Dangerous Substance (CDS) certificate, if applicable
- Current professional liability insurance policy face sheet that includes expiration dates, amounts of coverage and practitioner's name
- Attestation of history of loss of license and/or felony convictions; history of loss or limitation of privileges or disciplinary actions; lack of present/current illegal drug use; reasons for inability to perform the essential functions of the position, with or without accommodation; current malpractice insurance coverage and to the correctness and completeness of the application
- Standard Care Arrangement, if applicable

Buckeye is a participating organization with CAQH. Practitioners registered with CAQH's Universal Provider Data source must ensure they have granted Buckeye Health Plan access to their information or have granted global access to all participating health plans on the CAQH website (www.CAQH.org). To prevent delays in the credentialing process, it is essential that all application information and supporting documents be kept up to date.

Once the application is completed and processed according to Buckeye Credentialing Policies and Procedures, the Buckeye Credentialing Sub-Committee will render a final decision following its next regularly scheduled meeting. Practitioners will be notified of the credentialing decision within sixty (60) days of the committee's decision.

A Primary Care Provider (PCP) cannot accept member assignments until they are fully credentialed. Specialists must be credentialed prior to becoming a participating network provider.

CREDENTIALING COMMITTEE

The Credentialing Committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination and direction of the credentialing procedures. Committee meetings are held monthly and more often as deemed necessary.

CRITERIA FOR PROVIDER PARTICIPATION

A set of minimum level criteria established by Buckeye will be used to determine physicians' and other professional providers' participation. The minimum criteria include:

- An active, valid license in the state where the practice is located.
- An individual Ohio Medicaid provider number or state Provider Reporting Number.
- Current admitting privileges in good standing at an in-network inpatient facility or written documentation from the practitioner attesting that another physician, group of physicians, or hospitalists with a similar or like specialty will assume the inpatient care of all the practitioner's Plan members who require admission and that they will do so at a participating facility.
- A current valid DEA Certificate and/or CDS Certificate, if applicable.
- Satisfactory review of a five-year work history via the Practitioner Application or curriculum vitae with no unexplained gaps of employment over six (6) months.
- Current professional liability insurance with minimum limits of $1,000,000 per occurrence/$1,000,000 per aggregate. Minimum limits for dental providers must be at least $200,000 per occurrence /$600,000 per aggregate. If the practitioner is practicing outside the state of Ohio, Buckeye accepts professional liability coverage minimums required by the state in which they practice, if applicable.
- Proof of formal education and professional training, including board certification status if applicable, in the specialty they wish to practice.
- ECFMG (Educational Commission for Foreign Medical Graduates) certification or equivalent if practitioner is a foreign medical graduate.
- History of professional liability claims/actions (pending, settled, arbitrated, mediated, litigated, etc.) within the last 10 years. When reviewing this history, the Credentialing Sub-Committee will consider the frequency of the cases(s) and their outcome.
- History of Medicare/Medicaid sanctions showing practitioner is currently in good standing and must not appear on the Medicare Opt-Out Provider List, if applicable.
- An agreement to abide by the applicable Participation Provider Services Agreement.
- Applicants applying for participation must include a signed application and in doing so:
    - Signifies his/her willingness to appear for interviews regarding his/her application.
    - Authorizes Buckeye representatives to consult with others who have been associated with him/her and/or who have information bearing on his/her competence and qualifications.
    - Releases from any liability all Buckeye representatives for their acts performed in good faith and without malice in connections with evaluation of his/her credentials.
    - Releases from any liability all individuals and organizations who provide, including otherwise privileged or confidential information, to Buckeye representatives in good faith and without malice about mental health, emotional stability, and other qualifications for purposes of evaluation and participation in plan.

The credentialing process will be completed within 90 days from receipt of a complete application.

Failure of an applicant to respond timely and adequately to a request for credentialing information may result in termination of the application process and a waiting period to reapply.

Any communication regarding credentialing between Buckeye and the provider, including submission of application documents, shall be electronically, by facsimile, or by certified mail, return receipt requested to comply with state requirements.

RECREDENTIALING

To comply with NCQA Standards, Buckeye conducts the recredentialing process for providers at least every thirty-six (36) months from the date of the previous credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status, which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners (primary care providers and specialists) and health delivery organizations previously credentialed to participate within the Buckeye network.

A Participating Provider's Service Agreement contract may be terminated if it is determined by Buckeye's Board of Directors or the Credentialing Committee that participation requirements are no longer being met or if a provider fails to comply with recredentialing requirements.

MID-LEVEL PRACTITIONER CREDENTIALING

Certified Nurse Practitioner: an advanced practice nurse who provides advanced levels of nursing client care in a specialty role and has passed the certifying examination. Most NPs function primarily as clinicians. NPs may diagnose and treat a wide range of acute and chronic illnesses and injuries, interpret lab results, counsel patients, develop treatment plans, and they may prescribe medication.

Certified nurse-midwife: a registered nurse who has graduated from a nationally accredited school of midwifery, has passed the National Certifying Examination given by the American College of Nurse-Midwives, and is licensed by the board to practice as a nurse-midwife.

Clinical Nurse Specialist: Clinical nurse specialists are expert clinicians with advanced education and training in a specialized area of nursing practice who work in a wide variety of health care settings. A CNS must obtain a master's or Doctoral degree from a clinical nurse specialist accredited program and pass a national CNS certification examination. A CNS is licensed by the Ohio Board of Nursing as an APRN.

Physician Assistant: medical professionals who diagnose illness, develop, and manage treatment plans, prescribe medications, and often serve as a patient's principal healthcare provider. PAs receive their master's degree from a nationally accredited program.

A mid-level practitioner must submit proof of his/her standard care arrangement with a licensed physician or podiatrist who is participating with Buckeye that sets forth the way the mid-level practitioner and licensed physician or podiatrist will cooperate, coordinate, and consult with each other in the provision of health care to patients.

CREDENTIALING AND RECREDENTIALING OF HEALTH DELIVERY ORGANIZATIONS

Prior to contracting with the external Health Delivery Organizations (HDOs) noted below, Buckeye must receive a complete and signed Ohio Department of Insurance Standardized Credentialing Form Part B (INS5036) to initiate the credentialing process.

As part of the credentialing process, Buckeye verifies organizations have been approved by a recognized accrediting body or meet Buckeye's standards for non-accredited organizations, are in good standing with state and federal regulatory bodies, and have current professional liability insurance with minimum limits of $1,000,000 per occurrence/$1,000,000 per aggregate or in accordance with state minimum requirements if located outside of Ohio, as applicable:

Health Delivery Organizations
Hospitals
Home Health Agencies
Skilled Nursing Facilities
Nursing Homes
Free-Standing Surgical Centers
Behavioral Health Facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting

Buckeye recognizes the following accrediting bodies: *

- AAAASF - American Association for Accreditation of Ambulatory Surgery Facilities.
- AAAHC - Accreditation Association for Ambulatory Healthcare.
- ABCPO - American Board for Certification of Prosthetics and Orthotics.
- ACR - American College of Radiology.
- ACHC - Accreditation Commission for Health Care
- AOA - American Osteopathic Association.
- CAP - College of American Pathologists.
- CARF - Commission on Accreditation of Rehabilitation Facilities.
- CHAP - Community Health Accreditation Program.
- CCAC - Continuing Care Accreditation Commission
- COLA - Commission on Office Laboratory Accreditation.
- DNV- Det Nortske Veritas Healthcare
- JCAHO - Joint Commission on Accreditation of Healthcare Organizations.
- NCQA - National Committee for Quality Assurance

** this list may not be inclusive of all accrediting organizations*

For those organizations that are not accredited, an on-site evaluation will be scheduled to review the scope of services available at the facility, physical plant safety, and the quality improvement program. A current Centers for Medicare and Medicaid Services (CMS) certificate or state review completed within the last three (3) years, or as applicable to state review periods will be accepted in lieu of a formal site visit and can be utilized to augment the information required to assess compliance with Buckeye standards.

HDOs are re-credentialed every three (3) years to assure that the organization is in good standing with state and federal regulatory bodies, has been reviewed and approved by an accrediting body (as applicable), and continues to meet Buckeye participation and Quality Improvement (QI) requirements.

RIGHT TO REVIEW AND CORRECT INFORMATION

All practitioners have the right to be informed of the status of their credentialing/recredentialing application by submitting a written request to the Credentialing Department at:

Buckeye Health Plan
Credentialing Manager
4349 Easton Way
Columbus, OH 43219

All practitioners participating with Buckeye have the right to review information obtained by the Plan to evaluate their credentialing and/or recredentialing application.

This includes information obtained from any outside primary source such as the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB), malpractice insurance carriers and the State Medical Board/Licensing Agency. This does not allow a practitioner to review references, personal recommendations or other information that is peer review protected.

Should a practitioner believe any of the information used in the credentialing/recredentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, he/she has the right to correct the erroneous information submitted by another party.

To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the practitioner will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to Buckeye. Buckeye's Credentialing Sub-Committee will then include this information as part of the credentialing/recredentialing process.

PROVIDER DIRECTORY

Contracted providers will be included in the provider directory upon completion of credentialing, as required.

**Hospital based providers will not be listed in the directory.*

Credentialing Process (on or after October 1, 2022)

OHIO DEPARTMENT OF MEDICAID (ODM) CREDENTIALING PROCESS

Credentialing will be done by ODM for any provider on or after October 1, 2022.

- Upon go-live of centralized credentialing, ODM is responsible for credentialing all Medicaid managed care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the Provider Network Management system. This process adheres to National Committee for Quality Assurance (NCQA) and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.

- Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled, and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.
- For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. Medical students, residents, fellows, and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with each managed care organization (MCO) you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOs.
- When you submit your initial application to be an Ohio Medicaid provider, you can designate managed care organization interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOs so they can start contracting with you.

Benefits Available to Buckeye Members

Buckeye is required to provide specific medically necessary services to its members. The following list provides an overview of Medicaid benefits. Please refer to the current Medicaid Provider Manual and ODM Bulletins for a more inclusive listing of limitations and exclusions. These services include, but may not be limited to:

- Acupuncture for pain management of headaches and lower back pain
- Ambulance and ambulette transportation
- Behavioral Health Services (including mental health and substance use disorder treatment services)
- Certified nurse midwife services
- Certified nurse practitioner services
- Chiropractic (back) services
- Dental services ((includes two child and adult periodic oral exams and cleanings per year)
- Developmental therapy services for children aged birth to six years
- Diagnostic services (x-ray, lab)
- Durable medical equipment
- Emergency services
- Family planning services and supplies
- Federally Qualified Health Center or Rural Health Clinic services
- Home health services
- Hospice care (care for terminally ill, e.g., cancer patients)
- Inpatient hospital services
- Medical supplies
- Nursing facility services for a short-term rehabilitative stay
- Obstetrical (maternity care - prenatal and postpartum including at risk pregnancy services) and gynecological services
- Outpatient hospital services
- Physical and occupational therapy
- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source
- Podiatry (foot) services
- Prescription drugs, including certain prescribed over-the-counter drugs
- Preventive mammogram (breast) and cervical cancer (pap smear) exams
- Primary care provider services
- Renal dialysis (kidney disease)
- Services for children with medical handicaps (Title V)
- Shots (immunizations)
- Specialist services
- Speech and hearing services, including hearing aids
- Telehealth Services
  Vision (optical) services, including eyeglasses and contact lenses
- Well-child (Healthchek) exams for children under the age of 21
- Yearly well adult exam

NON-COVERED SERVICES

Buckeye will not pay for services or supplies received that are not covered by Medicaid:

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

SERVICES NOT COVERED BY BUCKEYE UNLESS MEDICALLY NECESSARY

Buckeye will review applicable OAC rules (e.g., 5160-1-61) and conduct a medically necessity review if appropriate. If you have a question about whether a service is covered, please call Provider Services at 866-296-8731.

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Biofeedback services
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered)
- Plastic or cosmetic surgery that is not medically necessary
- Services for the treatment of obesity unless determined medically necessary
- Services determined by Medicare or another third-party payer
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure

This is not a complete list of the services that are not covered by Medicaid or Buckeye. If you have a question about whether a service is covered, please call Provider Services at 1-866-296-8731.

Value Added Services

TRANSPORTATION

Buckeye provides round trip coverage for covered services 30+ miles away. In addition, Buckeye offers up to 30 round-trip visits (60 one-way trips) per member per 12-month period to covered healthcare/dental appointments, WIC appointments, and redetermination appointments with their Ohio Dept of Job and Family Services (ODJFS) caseworker.

Members can schedule transportation to and from a medical visit. Call Member Services 2 business days in advance and ask for a transportation specialist, and they will arrange appropriate transportation.

Ambulance Services - a member or member representative can call Buckeye at 1-866-246-4358, at least 24-hours in advance.

Ambulette (wheelchair) or ambulatory transportation - a member or a member representative can call TMS at 1-866-531-0615 to request a ride to a healthcare appointment, at least 48 hours in advance except for urgent appointments.

Urgent appointments - will be verified with the provider before the transportation is scheduled.

Members must provide their name, home address, home phone number or contact number, the date of the appointment, time, location of appointment and whether it is a regularly scheduled appointment or an urgent care appointment.

The member must also inform the member services representative if a return ride is needed. It is important to inform the member services representative if extra riders are accompanying the member to the appointment, as these requests may not always be granted.

Transportation services for members enrolled in OhioRISE
The MCO must arrange and provide transportation for members who are enrolled with the OhioRISE plan in a manner that ensures that children, youth, and their families served by the OhioRISE plan do not face transportation barriers to receive services regardless of Medicaid payer. The MCO is responsible for arranging transportation in cases where transportation of families, caregivers, and sibling(s) (other minor residents of the home) when needed to facilitate the treatment needs of the member and their family.

24/7 NURSE ADVICE LINE

When our members have questions about their health, their primary care provider, and/or access to emergency care, we are here for them. Buckeye offers a 24/7 Nurse Advice Line service to encourage members to talk with their physician and to promote education and preventive care.

Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency

access. The staff often answers basic health questions but is also available to triage more complex health issues using nationally recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

We provide this service to support your practice and offer our members access to a registered nurse daily. If you have any additional questions, please call Provider Services or the Nurse Advice Line.

REWARDS PROGRAM

The goal of Buckeye's rewards program is to increase appropriate utilization of preventive services by rewarding members for healthy behaviors. The program encourages members to regularly access preventive services and promotes personal responsibility for the member's own healthcare.

My Health Pays™ Rewards
My Health Pays™ rewards program is offered to members in the Buckeye Health Plan. My Health Pays™ rewards members with a pre-paid debit card to purchase healthcare items, such as over-the-counter medications that they might otherwise not be able to afford. Preventive services that may qualify for rewards through the program include completion of annual well visits, certain disease-specific screenings, and completion of prenatal and postpartum care.

CELL PHONE PROGRAM

The cell phone program is where Buckeye connects qualifying high-risk members with access to a government phone benefit program. Members who qualify receive a pre-programmed cell phone with limited use. Members may use this cell phone to call their case manager, PCP, specialty physician, the 24/7 Nurse Advice Line, 911, or other members of their healthcare team.

MEMBERCONNECTIONS™ PROGRAM

The MemberConnections™ Program provides a link between the member, PCP and Buckeye. Buckeye recognizes the special needs of the population it serves. In response to these special needs, the MemberConnections™ program has been developed to address the challenges in member outreach, member education, and in member's understanding of the managed care health system.

The MemberConnections™ program is an innovative community outreach program adopted by Buckeye. Representatives reach out to members providing them with basic information to assist them with understanding their available health benefits, and to understand how to access those healthcare benefits in an appropriate manner.

CARE COORDINATION & DISEASE MANAGEMENT

As a part of Buckeye's services, disease management programs are offered to members. Components of the programs available include:

- Increasing coordination between medical, social, and educational communities.
- Severity and risk assessments of the population.
- Profiling the population and providers for appropriate referrals to providers.
- Ensuring active and coordinated physician specialist participation.
- Identifying modes of delivery for coordination care services such as home visits, clinic visits, and phone contacts depending on the circumstances and needs of the member and his/her family.

- Increasing the member's and member's caregiver ability to self-manage chronic conditions.
- Coordination with a Buckeye care coordinator for case management services.

The disease management programs target members with selected chronic diseases which may not be under control. The new members are assessed and stratified to accurately assign them to the most appropriate level of intervention. Interventions may include mailed information for low intensity cases, telephone calls and mailings for moderate cases, or include home visits by a health coach for members categorized as high risk.

OUR COMMUNITY CONNECTIONS

Buckeye is at work all across Ohio to help meet the needs of our members and the communities we are honored to serve. Where our members work, live and play can affect their health. Challenges like access to healthy food, affordable housing, childcare, education and living wage jobs can create barriers that drive as much as 80% of health outcomes.

Buckeye Community Connect at https://communityconnect.buckeyehealthplan.com/ is our comprehensive online directory of social service organizations and resources that meet our members' needs. Through this free database, Buckeye connects users with an ever-growing statewide network of thousands of community partners that can provide local resources and support.

Simply enter a ZIP code to search for help with food, housing, transportation, childcare, jobs and more!

Routine, Urgent & Emergency Services

ROUTINE, URGENT AND EMERGENCY CARE SERVICES DEFINED

Members are encouraged to contact their PCP prior to seeking urgent or emergent care, except in an emergency. The following are definitions for routine, urgent, and emergency care.

Routine care is designed to prevent disease altogether, to detect and treat it early, or to manage its course most effectively. Examples of routine care include immunizations and regular screenings such as Pap smears or cholesterol checks.

Urgent care is designed to treat a health condition, including an urgent behavioral health situation, which is not an emergency, but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the member's PCP or PCP designee to prevent serious deterioration of the member's condition or health.

Emergency care is designed to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care to result in:

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

The PCP plays a major role in educating Buckeye members about appropriate and inappropriate use of hospital emergency rooms.

The PCP is responsible for following up on members who receive emergency care from other providers.

Buckeye is not required to cover services to members outside the United States.

Healthchek/EPSDT

OHIO'S HEALTHCHEK/EPSDT PROGRAM

Members Healthchek, otherwise known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, is a program of comprehensive preventive health services available to Medicaid recipients from birth through 20 years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems. Healthchek is a preventive program that combines diagnostic screening and medically necessary follow-up care for dental, vision and hearing examinations for eligible Ohio enrollees under the age of 21.

PCPs are required to perform Healthchek Medical Check-ups in their entirety and at the required intervals. All components of exam must be documented and included in the medical record of each Healthchek eligible member.

The frequencies of these visits are as follows:

- Eight Healthchek exams should be provided from birth through 12 months of age. Children should have Healthchek exams at 15, 18, 24, and 30 months of age.
- After 30 months of age, and up to the day prior to the individual's 21st birthday, a Healthchek exam should be provided annually or one per calendar year.

Preventive health is a major principal on which managed care organizations are based, measured, and held accountable. It is the responsibility of Buckeye to encourage eligible covered Medicaid recipients to participate in the State of Ohio's preventive care program, Healthchek. Buckeye will send reminders of the need for a Healthchek examination to all Healthchek eligible members.

For the first birthday, a HealthChek reminder postcard will be sent advising of the two suggested exams before the child turns three.

For ages 2 through 20, reminders will be sent annually based on the month of the birth.

For additional information on the Healthchek program see Ohio Administrative Code Chapter 5160-14 or access the State of Ohio website at www.state.OH.us.

Prior authorization requests for members under age 21 for screening, diagnostic and treatment services that go beyond the coverage and limitations are reviewed for medical necessity as defined in OAC 5160-1-01.

Newborn Testing

The Ohio Newborn Screening program requires that all newborns delivered in the State of Ohio be screened for the following disorders, including but not limited to:

- Phenylketonuria (PKU)
- Homocystinuria
- Galactosemia
- Medium-chain Acyl-CoA Dehydrogenase Deficiency
- Sickle Cell Disease
- Maple Syrup Urine Disease
- Isovaleric Acidemia
- Propionic Acidemia
- Methylmalonic Acidemia
- Citrullinemia
- Argininosuccinic Acidemia

If you have additional questions regarding Ohio's newborn screening requirements, please contact:

Ohio Department of Health
Public Health Laboratory
Newborn Screening Program
1-888-634-5227 – option 1
http://www.odh.ohio.gov

Immunizations

Children must be immunized during medical checkups according to the EPSDT Routine Immunization Schedule by age and immunizing agent.
Buckeye requires all members under the age of 18 to be immunized by their PCP unless medically contraindicated or against parental religious beliefs.

Vaccines for Children (VFC)

The Vaccines for Children (VFC) program is a federally funded program. It supplies vaccines at no cost to public and private healthcare providers who enroll and agree to immunize eligible children in their medical practice or clinic.

Buckeye PCPs can receive vaccines for immunizations free of charge through the Ohio Department of Health (ODH). You must be enrolled in the Ohio VFC Program and have a provider identification number (PIN) to order vaccines. If you are not enrolled, contact the Ohio Department of Health at 1-800-282-0546 or 614-466-4643 for more information and to enroll.

Buckeye will reimburse for the vaccines in accordance with the current Ohio Medicaid Fee Schedule and will also reimburse an administration fee for each vaccine.

For additional information about vaccines, vaccine supply, and contraindications for immunization, please visit the Centers for Disease Control and Prevention Website at www.cdc.gov/vaccines or call (800) 232¬4636 (English and Spanish).

Blood Lead Screening

Physicians are required to perform a blood lead screening test on all 12- and 24-month-old Medicaid eligible children, (regardless of zip code or exposure to lead) as stated in the Ohio Administrative Code, rule 3701-30-02.

Domestic Violence
Buckeye's members may include individuals at risk for becoming victims of domestic violence. Thus, it is especially important that providers are vigilant in identifying these members. Member Services can help members identify resources to protect them from further domestic violence. Providers should report all suspected domestic violence.

For Ohio residents, you may refer victims of domestic violence to the Ohio Domestic Violence Network hotline, at 1-800-934-9840 for information about local domestic violence programs and shelters within the State of Ohio. The Ohio Domestic Violence Network help line operates 24 hours a day.

State law requires reporting by any person if he or she has "reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse". Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report any suspected child abuse or neglect immediately to Children's Services in the county in which the child lives or was abused.

The Ohio Department of Job and Family Services has launched 855-O-H-CHILD (855-642-4453), an automated telephone directory that will link callers directly to a child welfare or law enforcement office in their county.

DENTAL SERVICES

Buckeye's dental services include two periodic oral exams and cleanings per year.

Dental benefits are provided through Envolve Health who maintains a quality network of licensed providers. In addition, they also process claims for dental services.

To access Envolve Health for provider inquiries, please call 1-844-464-5634 or visit their website at https://www.envolvehealth.com/

VISION SERVICES

Buckeye provides annual eye exams for children AND adults. Eyeglasses are provided annually for children under the age of 21 and adults aged 60 or older and every two years for adults aged 21 through 59.

Vision services are provided through Envolve Health who maintains a quality network of licensed providers. In addition, they also process claims for vision services.

To access Envolve Health, please call 1-866-442-6173 or visit their website at https://www.envolvehealth.com/

Medical Management

OVERVIEW

Buckeye's Medical Management department hours of operation are 8:00 a.m. to 5:00 p.m. weekdays (excluding holidays).

Information necessary for authorization may include but is not limited to:

- Patient's name, ID number
- Patient's address and phone number
- Physician's name and telephone number
- Hospital name if the request is for an inpatient admission or outpatient services
- Reason for admission – primary and secondary diagnoses, surgical procedures, surgery date
- Relevant clinical information – past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed
- Admission date or proposed date of surgery if the request is for an inpatient admission
- Requested length of stay if the request is for an inpatient admission
- Discharge plans if the request is for an inpatient admission.

PRIOR AUTHORIZATION

Failure to obtain the required Prior Authorization for a service may result in administrative claim denials. Buckeye Health Plan providers are contractually prohibited from holding any Buckeye Health Plan member financially liable for any service administratively denied by Buckeye Health Plan for payment due to the provider's failure to obtain timely Prior Authorization.

Services That Require Prior Authorization

Prior Authorizations are required on some services for the provider to be reimbursed.

1. To determine if a service needs prior authorization, please use our Prior Authorization Prescreen Tool.
2. If a service requires prior authorization, please note:
   a. Standard prior authorization requests should be submitted for medical necessity review at least **five (5) business days** before the scheduled service delivery date or as soon as the need for service is identified.
   b. Beginning on December 1, 2022, authorization requests should be submitted to ODM through their Fiscal Intermediary (FI) and should include all necessary clinical information.

Requesting a Prior Authorization

To submit a Prior Authorization for approval.

1. Beginning on December 1, 2022, navigate to ODM's Provider Network Management (PNM) Module to request prior authorization and supply all appropriate/required information.

Emergency Room and Post Stabilization Services

Emergent and post-stabilization services do not require prior authorization. Urgent/emergent admissions require **notification within one (1) business day following the admit date.**

ODM will process most routine authorizations within five business days. If additional clinical information is needed or the case needs to be reviewed by the Medical Director, it may take up to 14 calendar days to be notified of the determination. Authorization determinations will be communicated to the provider via ODM's Fiscal Intermediary (FI).

REFERRAL PROCESS

As the Medical Home, PCPs should coordinate all healthcare services for Buckeye Health Plan members. PCPs are encouraged to refer members when medically necessary services are beyond their scope of practice. Paper referrals are not required to direct a member to a specialist within our participating network of providers. All out of network services (excluding ER and family planning) require prior authorization. PCPs should track receipt of consult notes from the specialist provider and maintain these notes within the patient's medical record.

INPATIENT NOTIFICATION PROCESS

Inpatient facilities are required to notify Buckeye for emergent and urgent admissions within two business days following the admission. The authorization is required to track inpatient utilization, enable care coordination, discharge planning, and ensure timely claim payment. All inpatient admissions require authorization.

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Faxes will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise® line at 866-246-4358 for after-hours urgent admission, inpatient notifications, or requests.

ADMISSION NOTIFICATION

When Buckeye receives notification for an inpatient admission past the contractual two (2) business days and the member is still in-house, Buckeye will accept the notification, but the reviews will begin with the date on which Buckeye was notified, unless the case meets retrospective criteria as defined in the OAC.

All prior days will be administratively denied due to untimely notification and will have to be appealed after the claim has been submitted.

(For example, Jane Doe was admitted on 4-1-06. Buckeye receives notification of this admission on 4-10-06 and Jane Doe is still in-house. Buckeye will begin reviews starting 4/10/06 the day we were informed. All prior days will be denied.) Providers must fax a copy of their facility's face sheet and discharge instructions once the member has been discharged from all inpatient stays at their facility.

PEER TO PEER REVIEW

In the event of an adverse determination, a physician involved with the patient's care or physician advisor from the facility may request a Physician to Physician (peer to peer) discussion with a Buckeye medical director by calling Utilization Management at 866-246-4356, extension 24084, or by secure email to Buckeye_peer_to_peer_notification@Centene.com within five (5) calendar days of receiving the notice of determination.

EXTERNAL MEDICAL REVIEW

- External medical review is available to any provider who is unsatisfied with Buckeye Health Plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity. Denials for lack of medical necessity include, but are not limited to:
    - Denials, limitations, reductions, suspensions, or terminations that required clinical documentation or medical record review in making the decision to deny (includes pre-service, concurrent, and retrospective reviews).
    - Denials, limitations, reductions, suspensions, or terminations that involved clinical judgment or medical decision making (i.e., request was referred to a licensed practitioner for review).
    - Denials, limitations, reductions, suspensions, or terminations based on not meeting a clinical standard or medical necessity requirement (e.g., Interqual®, MCG®, ASAM, or OAC 5160-1-01, including EPSDT criteria, and/or Buckeye Health Plan's clinical coverage or other internal utilization management policy(ies)).
- Denials, limitations, reductions, suspensions, or terminations subject to external medical review may be the result of service authorization requests or claim payment denials due to lack of medical necessity. Services that are denied for reasons other than lack of medical necessity and for which no clinical review was completed by the MCO are not subject to external medical review.
- Before you may request an external medical review, you must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using Buckeye Health Plan's internal provider appeals process. If the MCO does not issue a response to your internal appeal of Buckeye Health Plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity within the timeframes specified in ORC 5160.34(B)(12) for service authorizations you may request external medical review.
- The external medical review process does not interfere with your right to request a peer-to-peer review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions.
- You have the right to request an external medical review within 30 calendar days of Buckeye Health Plan's decision to uphold the denial, limitation, reduction, suspension, or termination a covered service for lack of medical necessity.
- The external medical review is available at no cost to you.

NOTIFICATION OF PREGNANCY

PRENATAL RISK ASSESSMENT FORM (PRAF) AND NOTIFICATION

A complete PRAF helps Moms receive the best support for a healthy pregnancy.
(You can download this PRAF information (PDF) if needed.)

Provider Benefits of submitting a PRAF
The electronic PRAF 2.0 has multiple benefits with one, simple submission:

- Automatically notifies the Ohio Department of Job and Family Services County Office, Managed Care Plan, and Home Health Care provider of the pregnancy, need for progesterone and any other need indicated on the form.
- Allows for an Ohio Board of Pharmacy approved Progesterone prescription to be printed and faxed to the appropriate pharmacy.
- Allows provider staff updates by multiple users prior to submission.
- Maintains a pregnant woman's Medicaid eligibility without disruption in coverage-equating to prompt provider payment for services throughout mom's pregnancy.

Payment for Completing the PRAF
After completing the PRAF, submit a claim based on the guidelines below.

Guidelines effective July 1, 2021

Code + modifier	Description	Fee Schedule Amount*
H1000 33	Electronic PRAF submission	$90.00
H1000	Paper/Faxed version	$12.11

*Providers contracted rate would be applied to the fee schedule amount to determine final payment. Health Plans will pay no additional incentives for PRAF submissions.

Note: The following codes are terminated as of June 30, 2021: 59899 U1, 59899 U2 and 59899 U3.

Ensuring Prompt Care
Every pregnant woman with Medicaid coverage should be linked to needed services on her very first prenatal visit. An online PRAF 2.0 submission ensures:
- Medicaid coverage for Mom and baby without disruption through the immediate post-partum period.
- Serves as pregnancy notification to managed care plans and initiation of timely health care and connection to added resources, like care management, important for at-risk pregnancies.

Submitting the PRAF 2.0 using NurtureOhio is Easy!
1. Open the NurtureOhio website to access the PRAF at NurturOhio.com
2. Instructions can be found at Medicaid.Ohio.Gov/Provider/PRAF
3. Users must be registered in the Medicaid Information Technology System (MITS). For username or password issues go to OHMITS.com
4. Difficulties with NurtureOhio, email: Progesterone_PIP@medicaid.ohio.gov

DELIVERY INFORMATION

When contacting Buckeye about deliveries, the following additional information is required:
- Location of baby i.e., well nursery or NICU
- Weight in grams
- EDC
- LMP
- Gestational age
- Apgar scores at 1 and 5 minutes
- If a C-section, is it initial or repeat AND reason

CONCURRENT REVIEW

The Buckeye Medical Management Department will concurrently review the treatment and status of all members who are inpatient through contact with the member's attending physician and the Hospital Utilization and Discharge Planning Departments. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's current status, proposed plan of care, discharge planning and any subsequent diagnostic testing or procedures. When appropriate, the Buckeye concurrent review staff may attempt to visit with the hospitalized member to provide the member with information on the care management program.

RETROSPECTIVE REVIEW

Buckeye Health Plan, as required by OAC rule 5160-26-03.1 (a) and ORC section 5160.34(C), recognizes that there are events that may result in the need for a retrospective medical necessity review. A retrospective review request that includes the clinical documentation to support the medical necessity for the services, can be submitted via fax to 1-866-529-0290.

The fax cover sheet should indicate that this is *Retrospective Review* for one of the following reasons:

- Retrospective member eligibility: the member's eligibility with Buckeye Health Plan was not known at the time of the services
- Retrospective knowledge of the Buckeye Health Plan eligibility: Member unable, at the time of the need for care, to report what health plan administers their Medicaid benefit
- Service/Procedure Change Due to Unavoidable Circumstances: Prior authorized services/procedures resulted in a change due to clinical findings or circumstances not known prior to the initiation of services/surgical interventions
- Urgent Services Required: not enough time to obtain prior authorization due to member's medical condition or circumstances

HOSPITAL-TO-HOSPITAL TRANSFERS

If a member is receiving inpatient services and needs to be transferred to another inpatient facility, approval of this transfer must be obtained from Buckeye PRIOR to the member being transferred. If this approval is not obtained prior to the member's transfer, the transfer to the new facility will be an administrative denial.

DISCHARGE PLANNING

Discharge planning activities are expected to be initiated upon admission. The Buckeye Medical Management Department will coordinate the discharge planning efforts of the member's attending physician/PCP and the hospital discharge-planning department to ensure that Buckeye members receive appropriate post hospital discharge care.

The Buckeye Medical Management Department may contact the member's admitting physician's office prior to the discharge date established during the authorization process, to check on the member's progress, and to make certain that the member receives medically necessary services.

OBSERVATION BED GUIDELINES

If a member's clinical symptoms do not meet the criteria for an inpatient admission, but the treating physician believes

that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period. Observation Bed Services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nurse or other staff. These services are reasonable and necessary to:

- Evaluate an acutely ill patient's condition
- Determine the need for a possible inpatient hospital admission
- Provide aggressive treatment for an acute condition

This observation may last for a period of up to 24 hours except when continued observation is clinically warranted, a maximum of 48 hours may be allowed.

In those instances that a member begins their hospitalization in an observation status and the member is upgraded to an inpatient admission, all incurred observation charges and services will be rolled into the acute reimbursement rate, or as designated by the contracted arrangement with Buckeye, and cannot be billed separately. It is the responsibility of the physician and/or hospital to notify Buckeye of the acute admission.

Providers should not substitute outpatient observation services for medically appropriate inpatient hospital admissions.

UTILIZATION MANAGEMENT CRITERIA

Buckeye has adopted utilization review criteria developed by McKesson InterQual Products. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services.

Criteria are established and periodically evaluated and updated with appropriate involvement from physician members of the Quality Improvement Committee. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment.

Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, considering special circumstances of each case that may require deviation from the norm stated in the screening criteria. Criteria are used for the approval of medical necessity but not for the denial of services. The Medical Director reviews all medical necessity denials.

Practitioners may obtain the criteria used to make a decision by contacting the Medical Management Department at 1-866-246-4359.

Appeals related to a medical necessity decision made during the authorization, pre-certification or concurrent review process can be made orally, submitted through the portal or in writing to:

Buckeye Health Plan
Appeals/Grievance Department
4349 Easton Way Suite 400
Columbus, OH 43219
1-866-246-4359

AFFIRMATIVE STATEMENT FOR UTILIZATION MANAGEMENT (UM)

All individuals involved in UM decision-making at the Plan are asked to sign an Affirmative Statement about Incentives and acknowledge that Buckeye makes UM decisions based on appropriateness of care and existence of coverage; Buckeye does not reward practitioners or other individuals for issuing denials of coverage or service care; and financial incentives for UM decision makers do not encourage decisions that result in underutilization. Staff receive this statement upon hire and annually thereafter. This statement is distributed upon initial contracting with practitioners and providers via the Provider Manual and annually thereafter to all network providers via our Provider Newsletter.

SECOND OPINION

Members may receive a second opinion from a qualified professional within Buckeye's network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network providers and in network providers on the prior authorization list will require prior authorization.

CONTINUITY OF CARE

In some instances, Buckeye will authorize payment for a provider other than the PCP to coordinate the member's care. The services initiated prior to the member's enrollment with Buckeye must have been covered under a prior carrier. These services shall be continued until the member is evaluated by his/her PCP and a new plan of care is established. For example, an existing out-of-network provider has been treating a new member, and Buckeye has been notified of the arrangement. The out-of-network provider must comply with the Buckeye Utilization Management Program. The out-of-network provider must transfer the patient's records to the Buckeye provider and will not be authorized for on-going care for more than 90 days or until the member is evaluated by his/her PCP and a new plan of care is established.

Buckeye collects data regarding the coordination of a member's care across all settings of care or a transition in care.

COMPLEX CARE MANAGEMENT (CM) SERVICES/BUCKEYE CARE

Definition of Care Management Services

Care management and care coordination are collaborative processes of assessment, planning, coordinating, monitoring, and evaluation of the services required to meet an individual's needs. Care management serves as a means for achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The goal of care management is provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the member's quality of life, and efficient utilization of patient care resources.

Although it is the Provider's responsibility to serve as the ongoing source of primary and preventive care, the care manager, working in collaboration with the Provider, helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner.

Buckeye members who are attributed to a CPC Practice shall receive their care coordination services, including coordination of behavioral, physical, and social needs, from the practice and/or Buckeye, depending on need and CPC readiness. The CPC practice shall be the member's primary care management entity. Buckeye plays a key role in

supporting the CPC practice to be successful in achieving optimal population-level health outcomes while decreasing duplication of services. The level of support provided by Buckeye shall be contingent on the CPC practice's infrastructure and capabilities (e.g., use of electronic health records, use of care management teams, etc.) to manage coordination responsibilities and share and/or integrate data with other providers and Buckeye.

Buckeye Thrive Care Management

Buckeye Thrive Care Management is Buckeye's complex care management program that supports provider care treatment plans for our high-risk, high-utilization care management members by having a high touch, face-to-face presence at the point of care.

Buckeye has developed a Population Health based Model of Care geared to all Medicaid who will be placed into a Care Management program tailored to their needs. All Medicaid recipients are in a Care Management program tailored to their needs.

Care Management still provides high touch, face-to-face presence at the point of care. Buckeye care managers are visible in our provider offices, facilities and community agencies and accompany our high-risk care management members on routine visits. Our Buckeye Thrive Care staff provides face-to-face education, advocacy and support to high-risk care management members and their providers.

Criteria for determining which members might benefit from complex, care management:

A key objective of Buckeye's Care Management program is early identification of those members who have the greatest need for care coordination and care management. This includes but is not limited to those who are classified as children or adults with special health care needs; have catastrophic, high-cost, and high-risk or co-morbid conditions; have been non-compliant in less intensive programs; or are frail and elderly, disabled, or at the end of life.

Identifying members for Buckeye's Care Management may be conducted through, but not limited to predictive modeling programs, claims or encounter data, hospital discharge data, pharmacy data, or data collected at any time through the UM process. Members may also be referred directly to the care management program through self or family, the disease management program, hospital discharge planner, Provider, hospital care management staff, Care Coordination Entity, OhioRISE, Care Management Entity, Buckeye concurrent review staff, or other Buckeye staff. These multiple referral avenues can help to minimize the time between need and initiation of care management services. The Provider maintains an ongoing responsibility in identifying members who may meet Buckeye's care management criteria and refer them to the Plan.

Buckeye members who are attributed to a CPC Practice that completed Care Management Transition, shall receive all their care management, including coordination of behavioral, physical, and social needs, from the CPC practice. The CPC practice shall be the member's primary care management entity. Buckeye plays a key role in supporting the CPC practice to be successful in achieving optimal population-level health outcomes. The level of support provided by Buckeye shall be contingent on the CPC practice's infrastructure and capabilities (e.g., use of electronic health records, use of care management teams, etc.) to manage coordination responsibilities and share and/or integrate data with other providers and Buckeye.

At Buckeye, the care manager is the accountable point of contact who can help the member obtain medically necessary care, assist with health-related services and coordinate care needs. Members of the Buckeye care management team include the care manager and other health care professionals such as licensed social workers, pharmacists, medical directors, licensed practical nurses, and care guides who are appropriately qualified for the member's health care condition, follows the state's licensure/credentialing requirements, and operates within the scope of practice as allowed by the State.

Health Risk Assessment and Care Plan

Once identified, the Buckeye Care team uses various health risk assessment tools to determine whether coordination of services will result in more appropriate and cost-effective care through treatment intervention. During this assessment of the member's risk factors, patient information including cultural and linguistic needs, current health status, potential barriers to complying with the care treatment plan, and other pertinent information may be obtained from the member, family support system, Provider, and other health care practitioners. Assessment, care plan, and all interaction with the member is documented in the TruCare Managed Care System which facilitates automatic documentation of the individual and the date and time when the Care Coordination team acted on the care or interacted with the member. TruCare supports evidence-based clinical guidelines to conduct assessment and management and allows the CM to generate reminder prompts for follow-up according to the care management care plan. This assessment is completed within 30 days of member identification as a candidate for the care management program.

The Care Manager develops a proposed care plan in conjunction with the member, the Provider, and authorized family members, care givers or guardians. This proposed care plan is based on medical necessity, appropriateness of the discharge plan, patient/family/support systems to assist the patient in the home setting, community resources/services available and patient compliance with the prescribed care treatment plan. This care plan includes prioritized short- and long-term goals with timeframes for completion, member level interventions, a plan to continuously review and re-evaluate member needs; identifies barriers to meeting goals, provides schedules for follow up and communication with members, includes self-management planning and an assessment of progress against the plans and goals, with modification as needed. The care plan is developed to support the Provider's plan for the member and the emphasis is on communication and feedback between the care manager, the member, other care entities, and the Provider.

When the Provider, patient, patient's representative, and family agree, the care plan is implemented. Checkpoints are put into place to evaluate and monitor the effectiveness of care coordination/care management services and the quality of care provided, and to trigger timely revisions to the care plan when necessary. Behavioral health care coordination is incorporated in the care plan. The care manager also assists the member in transitioning to other care when benefits end.

The care manager will send the Provider a copy of the care plan or bring the care plan to the point of care when accompanying a member for a face-to-face visit with the Provider. If the Provider agrees, we encourage the Provider to make additions or comments and then send the care plan back to Buckeye. A copy of it will be maintained in the patient's medical record. Care plans will be forwarded to the Provider when significant updates occur as well.

Referring a Member to Buckeye Care

Providers are asked to contact a Buckeye Care Manager to refer a member identified in need of care management intervention:

Medical Management/Care Management
1-866-246-4359

Special Needs Care Management Programs

In addition to general high risk care management services, Buckeye also provides special needs care management programs as follows:

- Asthma
- Diabetes
- CHF

- Children in Custody
- CAD
- Non-mild hypertension
- COPD
- HIV/AIDS
- Severe mental illness
- Severe cognitive and or developmental limitation
- Transplants
- Teen pregnancy
- High risk or high-cost substance abuse disorder
- Frequent admissions or preventable/avoidable/PCP treatable ED visits
- Start Smart for Your Baby® Program
- Children with Special Health Care Needs
- "Compassionate Connections" Palliative Care Program
- Sickle Cell
- “Addiction in Pregnancy" Program

Asthma Program

This program targets Buckeye members with asthma who are inappropriately using medications, who are having repeated visits to the ED, or are being admitted to the hospital for additional care management and support from the medical management department. Additional education and coordination of care with the member’s PCP are key factors in this program. The goals of this program include increasing positive clinical outcomes for the member and controlling the asthma to improve the quality of life for the member. Members may also be referred to disease management for asthma as well.

Children with Special Healthcare Needs

Buckeye believes that Children with Special Health Care Needs (CSHCN) should have the opportunity to participate in all aspects of a full and active life. With that goal in mind, we have developed a CSHCN program to ensure these children are receiving proper care and optimal coordination of their services. Aspects of our CSHCN Program include but are not limited to:

- Increasing coordination between the medical, social, and educational communities.
- Assurance referrals are made to proper providers, including dental and/ or behavioral health providers.
- Improving levels of screening at birth and more consistent referrals to and from Early Intervention Programs.
- Encouraging family participation.
- Ensuring active and coordinated physician/ specialist participation; and
- Identifying modes of delivery for coordinated care services such as, home visits, clinic visits, and phone contacts depending on the circumstances and needs of the child and his/her family.

Children in Custody (CIC)

Buckeye partners with PCSAO and local children’s services agencies to provide care coordination services to all children in custody. Buckeye assesses the physical, behavioral, and SDOH needs of the children and their families to provide resources, support current care, and assist with reunification, as appropriate. Buckeye also works to support youth getting ready to transition to adulthood by providing education on topics important to them such as life skills, finances, and more. Buckeye will partner closely with OhioRISE and other CCE entities to ensure the appropriate level of care coordination is provided. Buckeye will obtain appropriate authorizations from the children’s service agencies for care coordination activities with the children’s foster parents. Buckeye will also share required information related to the child via a secure portal.

Start Smart for Your Baby®

Start Smart for Your Baby® is our special program for women who are pregnant. This program provides educational materials that tackle the most critical issues affecting the child's development during pregnancy. Start Smart offers a preventive approach that encourages prenatal education for the expectant mother to achieve the best possible outcome.

Start Smart encourages pregnant women to keep their prenatal care appointments; educates members and their families about pregnancy; identifies members who may be at high risk for developing complications; and provides support in dealing with medical, socioeconomic, and environmental issues that may contribute to complications.

Identifying pregnant members as early as possible, providing them with adequate prenatal care and guidance as well as addressing complications as effectively as possible should result in improved outcomes for both the mother and the newborn.

New Leaf Program

Buckeye is responsible for the care management of those pregnant members identified with substance use disorder. Special efforts are made to identify pregnant members with substance abuse concerns who are early in their pregnancy and link them with Substance Use Disorder treatment and Medication Assisted Treatment. The goal is to keep members engaged in care management through 18 months post-delivery to ensure a healthy delivery and provide support throughout the baby's first year.

HIV/AIDS

The goals of Buckeye's HIV/AIDS Disease Management Program are as follows:

- To establish a process to enable Buckeye's members diagnosed with HIV+/AIDS to access medical services in a timely manner
- To educate and monitor pregnant women to reduce perinatal transmission of HIV from mother to infant
- To promote HIV prevention and early treatment of same by providing information to the Buckeye membership consistent with the member's age, sex, and risk factors as well as culturally and linguistically appropriate.
- To ensure that care plans are specifically developed for each member to ensure continuity of care among the various clinical and non-clinical disciples and services
- To assure the use of the most current diagnosis and treatment protocols and standards established by the DHSS and the medical community.

Teen Pregnancy

Buckeye care managers intervene as early as possible to provide care coordination and support for teen mothers. Identifying them as early as possible, providing them with adequate prenatal care and guidance as well as addressing social and emotional issues and complications as effectively as possible should result in improved outcomes for both the mother and the newborn.

Referring a Member to Buckeye Care Management:
Providers are asked to contact a Buckeye Care Manager to refer a member identified in need of care management intervention:

Medical Management/Care Management
1-866-246-4359

Sickle Cell Management

Specialized care management program to assist members with long-term management of sickle cell disease. Includes medication management and adherence, aids with hematology referrals, and referrals to behavioral providers if indicated.

Transplant Program

Members approved for transplants are placed in either intensive or high-risk care management and followed by a Care Manager for ongoing support, education, resources, and referrals. Members are followed pre- and post-transplant until medically stable and member has reached their baseline related to health and wellness.

Disease Management

Disease management (DM) is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management is based on evidence-based guidelines such as American Heart Association, American Diabetes Association, etc. Disease management programs generally are offered telephonically, involving interaction with a trained nursing professional, and require an extended series of interactions, including a strong educational element. Buckeye's Disease Management Program emphasizes prevention and members are expected to play an active role in managing their diseases. Buckeye may delegate management of specific disease management programs to an external vendor.

Disease Management Process

Buckeye's DM programs are disease specific and evaluated for relevance to Buckeye's membership demographics and utilization patterns. DM programs may include, but are not limited to: Asthma, Chronic Kidney Disease, COPD, Diabetes, Pregnancy Management, and Sickle Cell disease. The major components of each disease management program include:

1. Identification of members with specified diagnosis
2. Stratification or classification of these members according to the severity of their disease, the appropriateness of their treatment and the risk for complications and high resource utilization
3. Provision of proven interventions that will improve the clinical status of the member and reduce the risk for complications and long-term problems
4. Involvement of the member, family, and physician to promote appropriate use of resources
5. Education of patient and family to promote better understanding of disease and better self-management
6. Ongoing measurement of the process and its outcomes to document successes and/or identify necessary revisions of the program

Members with a potential diagnosis applicable to the specific DM program will be identified through various sources, including, but not limited to inpatient census reports, medical claims data (office, emergency room, outpatient, and inpatient levels of care), pharmaceutical claims data, HRA results, Laboratory reports, data from UM/CM process, new member welcome calls, member self-referral, and physician referral. Based on the data received during the identification phase, members will be stratified into risk groups that will guide the care coordination interventions provided. Members will be stratified into either Low Risk, Moderate Risk, or High-Risk categories. Definitions for each risk category are program specific and will be outlined in the program's description document. Members may change between risk groups based on data retrieved during each reporting period, as well as through collaboration/interaction with Care Manager, member, or PCP.

Members enrolled into a disease management program will receive some level of intervention from a multi-disciplinary team that includes specially trained nurses, dieticians, respiratory therapists, and certified diabetic educators. The interventions may include, but is not limited to identification, assessment, disease specific education, reminders about

preventive/monitoring services, assistance with making needed appointments and transportation arrangements, referral to specialists as needed, authorization for services and/or medical equipment, coordination of benefits, and coordination with community-based resources. Education is a crucial component of the disease management program. Education will be presented to members and their treating physician and may be provided through mailings, telephone calls, or home visits.

High-risk members will be referred to Buckeye's complex care management program for development of an individualized care plan. Both the member/family and the physician will be included in the development of the care plan. Including the member/family in the development of the individualized goals and interventions promotes ownership of the program and stimulates a desire for success. Care plan goals and interventions will be reviewed routinely, and the plan of care will be adjusted as necessary by the care coordinator to assure the best possible outcome for the member.

Behavior change is a critical piece of the disease management approach. Members are initially screened and their readiness to change is determined. Motivational interviewing techniques are utilized to engage and assist the member in moving toward a healthy lifestyle.

The Buckeye Disease Management program as provided by our external vendor receives oversight through the Buckeye Delegated Oversight Committee process.

New Technology

Buckeye evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and or Medical Management staff may identify relevant topics for review pertinent to our population. Centene Corporation's Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

In the instance where the request is made for coverage for new technology, which has not been reviewed by the CPC, the Buckeye Medical Director will review all information and make a one-time determination within two (2) working days of receipt of all information. This new technology request will then be reviewed at the next regular meeting of the CPC. If you are aware of a new technology and would like a benefit determination or have an individual case review for new technology, please contact the Medical Management Department at 1-866-246-4359.

Grievance & Appeals

INQUIRY, DISPUTE AND APPEAL OF CLAIM PAYMENT

To check the status of previously submitted claim(s), providers should contact the Buckeye Provider Services Department at 1-866-296-8731, Monday through Friday 8:00 AM – 5:00 PM Providers can also check claims status on our website portal at: www.buckeyehealthplan.com/providers.

Providers should have the servicing provider's name, member name, member ID number, date of birth, date of service and claim number, if applicable.

Buckeye offers providers the option to request payment evaluation/and or determination of a previously submitted claim(s) by means of a claims dispute.

Dispute the Claim
A dispute is a review of any provider inquiries, requests for reconsiderations, or complaints of a previously submitted claim(s) by the appropriate claims team. Use this method to have claims reviewed that do not require corrected billing and you either:

- Disagree with the current outcome of the claim(s) to include, but not limited to Eligibility, Other Insurance, LOC/Medical Necessity, Timely Filing, Failure to Obtain Prior Authorization and/or.
- Disagree with the current outcome of the claim(s) and additional documentation is needed by the claims team for review.

Claim Dispute

If a provider believes that an improper payment of a claim for covered Medicaid services has occurred through either the omission of information, submittal of incorrect claims data, and/or systems error, an adjustment may be requested by submitting a copy of the Explanation of Payment (EOP) along with a completed adjustment form that can be found on the Buckeye web site. Adjustments should be submitted within 12 months from the date of service or 60 calendar days from date of remittance, whichever is later through the web portal, a provider representative, the call center and/or to the mail center at the following address:

Buckeye Health Plan
P.O. Box 6200
Farmington, MO 63640-3800

Please do not send a copy of the disputed claim.

How to File a Medical Necessity Dispute

1. If submitting the dispute via paper to the mail center:
    - Complete a Medical Necessity Dispute Review Form.

- Send all required documentation and the dispute form to the mail center at:

Buckeye Health Plan
P.O. Box 6200
Farmington, MO 63640-3800

2. If submitting the dispute through the provider web portal:
    - Complete a Medical Necessity Dispute Review Form.
    - Go to our Provider Portal Login to submit your form and all additional documentation. Supported document types include: .jpg, tif, PDF, and tiff

Once Logged into the Portal:

1. Select the Claims tab at the top of the page.
2. Click on search and enter the claim # you want to dispute.
3. When the claim appears, click on it to bring up the Button Options.
4. Select the Dispute button.
5. To upload your documents:
    1. Click on the 'Browse' button.
    2. Find the document(s) you want to upload and attach, much like you were attaching a document to an email.
    3. Select 'Attachment Type' from the drop down. (See types listed above.)
    4. Select 'Attach.' This will attach the document to your appeal request.
    5. Continue the same process for all documentation you want to attach.
6. Select the 'Next' button to complete the process.
7. Review your claim information to ensure it is correct.
8. Select the 'Submit' button.
9. Once submitted, you will receive a notice of their successful submission and a Confirmation ID#.
10. On the main Claims screen, you click on the Submitted tab and see the submission of the dispute.

Note: If a dispute has already been submitted for a claim, you will see a message notifying you that a Claims Adjustment has been previously submitted and no further adjustment can be made today.
If you have questions, please contact Provider Services at 1-866-296-8731.

MEDICAL MANAGEMENT APPEAL DEFINITIONS FOR APPEALS AND DENIALS

The following options are available to providers who are unsatisfied with Buckeye Health Plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.

Pre-Service Member Appeal

(Effective December 1, 2022)
A submitted appeal by the member or provider on the member's behalf that requires review for medical necessity.

Post-Service Medical Necessity Claim Dispute

(Effective December 1, 2022)
A submitted dispute by the provider that requires review for medical necessity.

Pre- and Post-Service External Medical Review Request

(Effective December 1, 2022)

A request by the provider for a pre- and post-service External Medical Review for a claim that has previously been reviewed for medical necessity.

Medical Management Adverse Determinations

Buckeye will provide availability of an appropriate practitioner reviewer to discuss any UM adverse determination. Upon any adverse determination made by the Buckeye Medical Director or other appropriately licensed health care professional, a written notification, at a minimum, will be communicated to the member and requesting provider. The notification will include the specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process, and timeframes for appeal of the decision.

The Plan Medical Director may be contacted by calling Buckeye's main toll-free phone number at 1-866-246-4356 Monday through Friday between 8 a.m. and 5 p.m. and asking for Buckeye's Medical Director. A Plan Care Manager may also coordinate communication between the Medical Director and the requesting practitioner.

FAQs

Who Can File an Appeal?

Members or an authorized representative of a member may appeal an adverse determination. This can be the member, doctor, or other service provider like a physical therapist. A practitioner with knowledge of the member's condition may request an expedited appeal on a member's behalf. Written member consent is not required for expedited appeals requested by the provider. Providers may also submit a request for an expedited appeal orally or via fax.

What are the Timeframes?

The timeframe to file a standard appeal is no longer than **60** calendar days from the day following the mailing date of Buckeye's notification of adverse determination of the requested service. An expedited appeal is available for Medicaid members when the service is needed more quickly and for all urgent care requests. These expedited appeal decisions and notification will be no later than 72 hours after the appeal request is received by Buckeye. Therefore, it is important that if this type of request is made all documentation should be in order. Expedited appeals are not available for post-service requests.

REMEMBER: If an appeal is not filed in the timeframe outlined above, a request can be made to appeal but must be in writing and include information as to why the request was not submitted timely.

Helpful Tip
Always remember the documentation is KEY and should include records and other information relevant to the decision and especially address the reason it was denied.

Billing & Claims Submission

Buckeye Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with Buckeye for payment of covered services.

It is important that providers ensure Buckeye has accurate billing information on file. Please confirm with your Provider Relations Department that the following information is current in our files:

- Provider Name (as noted on his/her current W-9 form)
- Medicaid Number
- Physical location address
- Billing name and address (if different)
- Tax Identification Number

Buckeye will return claims when billing information does not match the information that is currently in our files. Such claims are not considered "clean" and therefore cannot be entered into the system. The claims are then returned to the provider, creating payment delays.

We recommend that providers notify Buckeye in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's Tax Identification Number and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member's contract on the date of service; and
- Referral and prior authorization processes were followed.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

CLEAN CLAIM DEFINITION

Clean claims are invoices properly submitted in a timely manner and in the required format that do not require Buckeye to investigate, develop or acquire additional information from the provider or other external sources. Such claims should have no defect or impropriety or particular circumstance requiring special treatment that prevents timely payments from being made, including any lack of required, substantiating documentation.

NON-CLEAN CLAIM DEFINITION

Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. These errors or omissions result in Buckeye requesting additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or access to

other information necessary to resolve discrepancies. In addition, claims with issues relating to payment including but not limited to, issues regarding medical necessity or claims not submitted within the identified filing limits are also defined as non-clean.

CLAIMS SUBMISSIONS

Providers may submit claims, prior authorizations, eligibility inquiries, claim status inquiries and associated attachments through the Provider Network Management (PNM) system.
https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

Claim Submission Time Frame

Timely filing requirements are currently 365 days from the date of service for all provider types with further details outlined in Appendix S of the provider agreement for the duration of the PHE. Once the PHE ends and Appendix S is terminated, providers will be subject to the timely filing requirements in rule 5160-1-19 of the Ohio Administrative Code.

The Provider Agreement can be found at: Managed Care Procurement | Ohio Medicaid Managed Care.

Disputes and Appeals must be submitted within 12 months from date of service or hospital discharge date or **60** days from date of electronic remittance whichever is greater.

Billing Methods

Effective December 1, 2022, first time claims and corrected billing claims must be submitted through ODM's Fiscal Intermediary (FI).

Providers will submit disputes through the Provider Network Management (PNM) system.
https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

RESUBMITTING CLAIMS

Electronic Submission

Effective December 1, 2022, corrected billing claims must be submitted electronically using the appropriate bill type in the designated field through ODM's Fiscal Intermediary (FI).

Paper Claims

Effective December 1, 2022, corrected billing claims will no longer be accepted via paper submission. Claims should be submitted electronically through ODM's Fiscal Intermediary (FI).

If you would like to dispute the prior outcome of a claim, which includes but is not limited to additional documentation needed, claim underpaid, or claim denied in error. Please refer to the Claims dispute section of this manual. The dispute process should be used if the claim does not require any corrected billing to be done.

Claim Payment Audits

Buckeye audit review nurses will perform retrospective review of claims paid to providers to ensure accuracy of the payment process. If a claim is found to be overpaid, the amount will be recouped against future claim payments. A letter will be sent to the provider notifying them of the reason for the recoupment and the amount.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Buckeye Health Plan auditors request medical records for a defined review period. Providers have 30 days to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Buckeye Health Plan will recover all amounts paid for the services in question.

Buckeye Health Plan auditors review cases for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

Buckeye Health Plan investigators consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Buckeye Health Plan will seek recovery of all overpayments. Depending on the number of services provided during the review period, Buckeye Health Plan may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

ELECTRONIC CLAIMS SUBMISSION

Electronic Data Interchange (EDI) is a computer-to-computer exchange of claims data in standardized formats. EDI transmissions must comply with the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA).

Buckeye encourages all providers to file claims/encounters electronically. The benefits of EDI submission include:

- Faster claims processing
- Ability to track and confirm submission and receipt
- Fewer errors related to missing data or incorrect formatting
- Reduced administrative expense
- Reduction in AR days from submission to payment
- Eliminate paper submission of secondary claims

Providers may submit claims, prior authorizations, eligibility inquiries, claim status inquiries and associated attachments using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP.
https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners

New Buckeye Payer IDs effective 12/1/22 as follow:
https://managedcare.medicaid.ohio.gov/managed-care/fiscal-intermediary
BUCKEYE Payer IDs
- 0004202 BUCKEYE OHIO MEDICAID (837 P & I ONLY)
- V004202 BUCKEYE/ENVOLVE VISION
- D004202 BUCKEYE/ENVOLVE DENTAL (837 Dental)
- T004202 BUCKEYE/ACCESS2CARE

Companion Guides

File Format

Centene Corporation has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, Centene Corporation has the capability to generate an ANSI X12N 835 electronic of payment (EOP). For more information on electronic filing, contact:

Centene EDI Department
1-800-225-2573, extension 6075525
or by e-mail at: EDIBA@centene.com

Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the claims and encounters.

EDI Vendors

Providers submitting electronic claims must have an established relationship with an electronic claim's clearinghouse. Please contact your preferred clearinghouse to confirm participation with Centene Corporation's/Buckeye's EDI program.

Ohio Medicaid Identification Number

Effective 1/1/2019, your Ohio Medicaid ID number is required for all claim submissions. Any claims not submitted with this information will be rejected.

NPI and Tax ID

Your NPI and Tax ID number are required for all claim submissions. Claims submitted without one or both required numbers will be rejected and will appear on your EDI Vendor Error Report.

ELECTRONIC REMITTANCE ADVICE (ERA) AND ELECTRONIC FUNDS TRANSFER (EFT)

Network providers may elect to receive Electronic Remittance Advice (ERA) files and Electronic Fund Transfers (EFT) through Buckeye's contracted vendor, PaySpan Health. Providers may access PaySpan Health at www.payspanhealth.com to request these services and to obtain additional information regarding set-up and administration.

ABORTION, STERILIZATION, AND HYSTERECTOMY BILLING

The use of federal funds to pay for abortion, sterilization, and hysterectomies is prohibited unless the specific criteria found in 42 CFR 441 and Ohio Administrative Code rules 5160-21-02.2 are met.

Claims for abortion, sterilization, or hysterectomy along with the appropriate consent form (see section to follow).

- Sterilizations do not require prior authorization.
- Prior authorization is required for abortions and hysterectomies.
- ODJFS mandated consents/attestations for all the procedures above must be submitted with the claim.
- Failure to submit a valid, signed consents/attestations will result in denial

Consent forms can be found online at:

https://www.buckeyehealthplan.com/providers/resources/forms-resources.html

Helpful Hints for the Abortion Certification Form JFS 01391:

- Abortions are only covered for limited instances, as indicated on the form.
- All areas on the form must be completed.
- Only one reason for the abortion can be selected.
- The physician's name must be typed, and the physician's signature must be in the physician's own handwriting.
- The patient's "Medicaid Billing Number" is the patient's 12-digit Medicaid billing number.
- The "Physician's Medicaid Provider Number" is the provider's 7-digit Medicaid provider number.

Helpful hints for the Consent to Sterilization Form JFS 3198 or Federal Form HHS-687

- All areas on the form must be completed.

- The patient must be 21 years old, mentally competent, and not in an institution at the time he/she signed the consent form.
- The patient's signature must be in the patient's own handwriting.
- The date the person obtains consent must be the same as the date the patient signed for consent.
- The date of sterilization must be 30 days after the date the patient signed the consent and is not to exceed 180 days.
- The physician's name must be typed, and the physician's signature must be in the physician's own handwriting.
- The date the physician signed the consent must be within 30 days after the surgery.
- The interpreter's section must only be completed if interpreter services were used for the patient.

Helpful hints for the Acknowledgement of Hysterectomy Form JFS 3199:

- Reimbursement cannot be made for hysterectomy procedures when the primary intent is for fertility control. Payment will only be made for hysterectomies performed for medical reasons, such as diseased uterus, and only if the patient has been advised orally and in writing prior to surgery that sterility will result.
- Section I: all areas must be completed. The physician's signature must be in their own handwriting. A stamp is not acceptable.
- Out of the next three sections (section II, III, or IV), ONLY one section must be completed.

COMMON BILLING ERRORS

To avoid rejected claims or encounters always remember to:

- Use specific CPT-4 or HCPCS codes. Avoid the use of nonspecific or "catch-all" codes (i.e., 99070).
- Use the most current CPT-4 and HCPCS codes. Out-of-date codes will be denied.
- Use the 4th or 5th digit when required for all ICD-10 codes.
- Submit all claims/encounters with the proper provider number.
- Submit all claims/encounters with the complete member's Medicaid ID (MMIS ID) or Buckeye ID number.
- Verify other insurance information entered on claim.
- Do not submit handwritten claims
- Original claim forms only, no photocopied or faxed claims
- Printing should be correctly aligned with information in correct fields

Billing Codes

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent denial of payment. payment. Submit professional claims with current, valid CPT-4, HCPCS and ICD-10 codes. Submit institutional claims with valid Revenue codes and CPT-4 or HCPCS (when applicable), ICD-10 and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a patient's diagnosis. We require the use of valid ICD-10 diagnosis codes, to the ultimate specificity, for all claims.

Code Auditing

Buckeye uses HIPPA compliant code-auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting. The code auditing software will detect, correct, and document coding errors on provider claims prior to payment. Our software will analyze HCPCS Level 1/CPT-4 codes (5-digit numeric coding system

which applies to medical services delivered); HCPCS Level II codes (alpha-numeric codes which apply to ambulance services, medical equipment, supplies, and prosthetics); CPT Category II ("F" codes used for tracking purposes) and CPT Category III ("T" codes or temporary codes used for new and emerging technologies) and healthcare industry standard modifiers against correct coding guidelines. These guidelines have been established by the American Medical Association (CPT, CPT Assistant, and CPT Insider View) and the Centers for Medicare and Medicaid Services (CMS).

Reimbursement/payment decisions will continue to be based on the fee schedules and contract agreements between the provider and the Plan. Furthermore, while the code-auditing software has been designed to assist in evaluating the accuracy of procedure coding; it will not evaluate medical necessity. Buckeye may request medical records or other documentation to assist in the determination of medical necessity, appropriateness of the coding submitted, or review of the procedure billed.

Claim Dispute:

A verbal or written expression by a Provider which indicates dissatisfaction or dispute of BHP's claim adjudication, to include the amount reimbursed or denial of a particular service.

Providers claim disputes are any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial. While these disputes can come in through any avenue (e.g., provider call center, provider advocates, BHP's provider portal), they do not include inquiries that come through ODM's Provider Web portal (HealthTrack). Provider claims disputes do not include provider disagreements with BHP's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity that are subject to external medical review as described in this appendix.

BHP will establish and maintain a provider claim dispute resolution process for its network and out-of-network providers to dispute adverse claims payment decisions made by BHP.

As part of the provider claim dispute resolution process, BHP will:

i. Allow providers to file a written claim dispute no later than **12 months from the date of service or 60 calendar days after the payment**, denial, or partial denial of a timely claim submission, whichever is later.
ii. Allow providers to submit claim disputes verbally and in writing. This includes disputes submitted through the provider portal.
iii. Convert a verbal dispute to writing and include a tracking number for the provider.
iv. Within five business days of receipt of a dispute, notify the provider (verbally or in writing) that the dispute has been received.
v. Thoroughly investigate each provider claim dispute using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying BHP's written policies and procedures.
vi. Resolve and provide written notice to the provider of the disposition of all claim disputes within 15 business days of receipt of the dispute. Written notice is not required if the claim dispute was resolved with an initial phone call or in-person contact. When required, the written notice will include:
    1. The nature of the dispute.
    2. The claim dispute tracking number.
    3. A summary of the pertinent facts and claim detail for claim related disputes.
    4. The specific statutory, regulatory, contractual, or policy references that support the resolution.
    5. Next steps if the provider disagrees with the resolution.
vii. If additional time to resolve a dispute is needed past 15 business days, BHP will provide a status update to the provider every 5 business days beginning on the 15th business day until the dispute is resolved.
viii. Reprocess and pay disputed claims, when the resolution determines they were paid/denied incorrectly,

within 30 calendar days of the written notice of the resolution unless a system fix is needed then additional time is allotted.

ix. Automatically apply the corrective action or claims resolution to correctly adjudicate all other provider claims affected by the same issue.

Billing the Patient

Buckeye reimburses only services that are medically necessary and covered through Medicaid. Contracted providers can bill a member only if the following conditions are met:

- The member was notified by the provider of the financial liability in advance of the service delivery.
- The notification by the provider was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose; and,
- The notification is dated and signed by the member.

Medical Records

Buckeye providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Buckeye to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Buckeye requires providers to maintain all records for members for at least seven years.

REQUIRED INFORMATION

Providers must maintain complete medical information for members in accordance with the following standards:

- Patient's name, and/or ID number on all chart pages or electronic file.
- Personal/biographical data is present (i.e., age, sex, address, employer, home and work telephone number, spouse, etc.).
- All entries must be legible to someone other than the writer. In states that mandate medical record reviews, a second surveyor examines any record judged to be illegible by one physician surveyor. All entries in the medical record contain the author's identification, which may be a handwritten signature, unique electronic identifier, or initials.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA or NKDA is documented.
- An immunization record is established for pediatric patients, or an appropriate history is made in chart for adults (full Healthchek documentation for pediatric patients).
- Evidence that preventive screening and services are offered in accordance with Buckeye's practice guidelines.
- Appropriate subjective and objective information pertinent to the patients presenting complaints is documented in the history and physical.
- Past medical history (for patients seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters. For children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses. For patients 10 and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, there is evidence of substance abuse query). Working diagnosis is consistent with findings. Treatment plan is appropriate for diagnosis.
- Encounter forms or notes have a notation regarding follow-up care, calls, or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- There is review for under-or over-utilization of consultants.
- If consultation is requested, there is a note from the consultant in the record.
- Consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.

- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere.
- Health teaching and/or counseling is documented.
- Evidence that an Advance Directive has been offered to adult patients.

Providers are required to have an organized medical recordkeeping system and have records available in the office. Confidentiality of patient information and medical records will be protected at all times.

MEDICAL RECORDS RELEASE

All medical records of covered persons shall be confidential and shall not be released without the written authorization of covered person or a responsible covered person's representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

Written authorization is required for the transmission of the medical record information of a current Buckeye member or former Buckeye member to any physician not connected with Buckeye.

Providers are required to make member records available to Buckeye as requested at no cost to Buckeye.

MEDICAL RECORDS TRANSFER FOR NEW PATIENTS

All PCPs are required to document, in the member's medical record, attempts to obtain old medical records for all new Buckeye members. If the member or member's guardian is unable to remember where they obtained medical care, or are unable to provide an appropriate address, then this should also be noted in the medical record. Providers are required to make medical records for Medicaid-eligible individuals available for transfer in a timely manner to new providers at no cost to the individual.

MEDICAL RECORDS AUDITS

Medical records may be audited to determine compliance with Buckeye's standards for documentation. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services may also be assessed during a medical record audit.

Eligibility

ELIGIBILITY FOR THE BUCKEYE PROGRAM

The local office of the County Department of Job and Family Services (CDJFS) is responsible for determining eligibility of persons applying for Medicaid coverage. Persons interested in applying for Medicaid coverage through Buckeye should be referred to the local county office of the CDJFS in the county in which the individual lives.

Applicants enroll in Buckeye by contacting the Ohio Selection Service Center at 1-800-605-3040. During the application process, the enrollee has an opportunity to select a primary care provider (PCP) with the assistance of a Selection Counselor. Individuals who do not make a voluntary PCP selection are assigned to a PCP via an automated assignment process that links the member with an appropriate PCP.

VERIFYING ENROLLMENT

Providers are responsible for verifying eligibility every time a member schedules an appointment, and when they arrive for services. PCPs should also verify that a patient is their assigned member.

To verify enrollment call Buckeye Provider Services at 1-866-296-8731 or go online at https://member.buckeyehealthplan.com/sso/login.

Buckeye has the capability to receive an ANSI X12N 270 health plan eligibility inquiry and generate an ANSI X12N 271 health plan eligibility response transactions through Centene Corporation. For more information on conducting these transactions electronically contact:

Centene EDI Department
1-800-225-2573, extension 6075525
or by e-mail at:
EDIBA@centene.com

Until the actual date of enrollment with Buckeye, Buckeye is not financially responsible for services the prospective member receives. In addition, Buckeye is not financially responsible for services members receive after their coverage has been terminated. However, Buckeye is responsible for those individuals who are Buckeye members at the time of a hospital inpatient admission and change health plans during that confinement.

MEMBER ID CARD

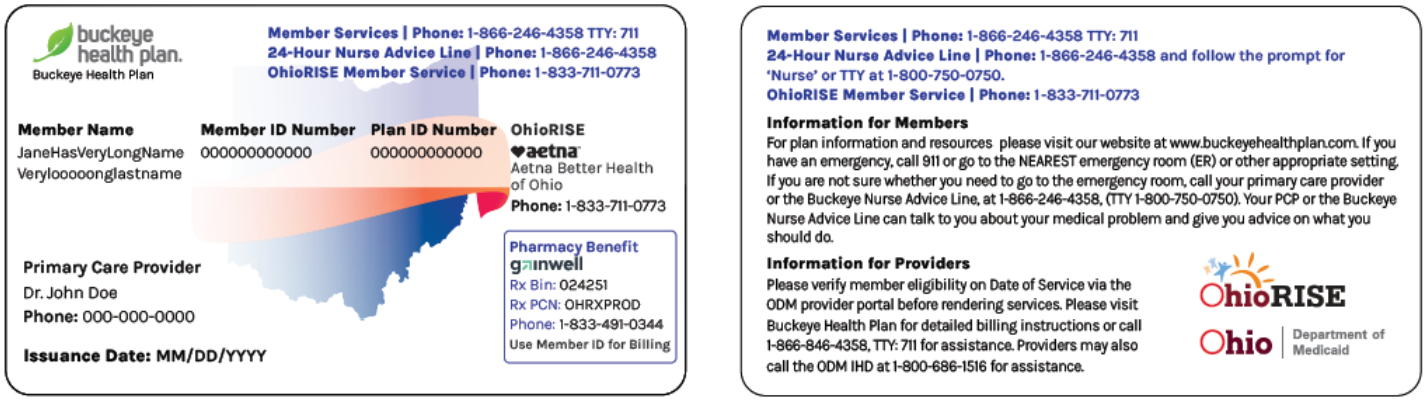
All Buckeye members receive an ID card (see samples below). Members should present their ID card at the time of service, but an ID card in and of itself is not a guarantee of eligibility; therefore, providers must verify a member's eligibility on each date of service.

The member ID number, effective date, contact information for Buckeye, and PCP information are included on the ID card. If you are not familiar with the member seeking care, please ask to see photo identification for confirmation. If you suspect fraud, please contact Provider Services immediately.

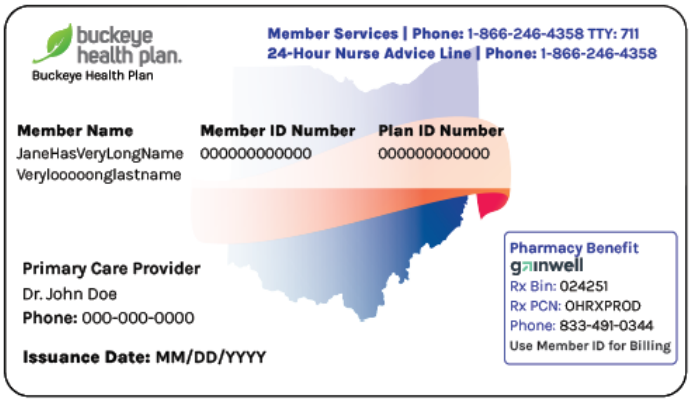
Buckeye Health Plan ID Cards:

OhioRISE with CSP

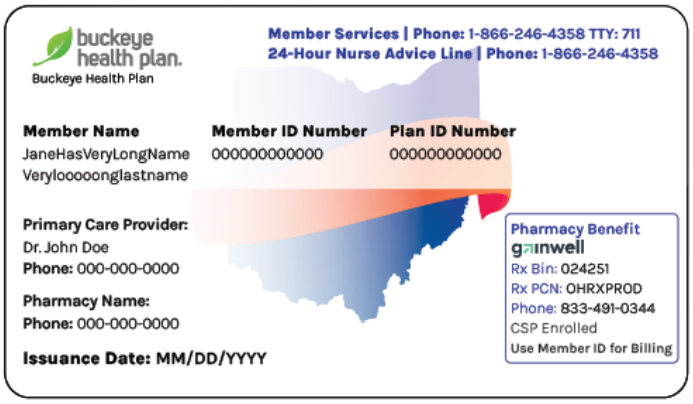
OhioRISE without CSP



NO OhioRISE without CSP



NO OhioRISE with CSP



NEWBORN ENROLLMENT

Providers are encouraged to refer the mother to Buckeye to select a PCP for their newborn. If the mother does not select a PCP after delivery, the mother's PCP will automatically be assigned to the newborn, unless the PCP is not accepting new patients, or the provider has age restrictions.

To make a PCP selection for the newborn, members should be referred to:

Member Services
1-866-246-4358

All providers are also encouraged to direct the mother to her county caseworker to ensure the newborn is officially deemed eligible for the Buckeye program.

Eligibility for newborns whose mothers are Buckeye members on the date of delivery are effective on the date of birth. Frequently, Buckeye receives a claim(s) for a newborn prior to the state sending the members' eligibility information.

Buckeye is committed to researching the newborn claims that are received to ensure that a claim is NOT denied for eligibility when the newborn is a Buckeye member.

The following guidelines are adhered to by Buckeye to ensure that newborn claims do not deny for payment:

1. When the claims department receives a claim, the members' eligibility is verified. If no member eligibility is found, the claim is pended for 120 days. The claims department will verify eligibility each day until the member

information is received from the state.

2. If after 120 days there is still no record of the member information, then the claims department will notify the Eligibility Specialist.
3. The Eligibility Specialist will contact the state to obtain the information on the member.
4. At that time one of the following actions will be taken:
   - If the member is eligible with Buckeye, then the Eligibility Specialist will enter the member information manually and instruct the claims department to process the claim.
   - If the member is NOT eligible with Buckeye, then the Eligibility Specialist will instruct the claims department to return the claim with a notice of member ineligibility.

Quality Program

QUALITY IMPROVEMENT PROGRAM

The scope of Buckeye's Quality Improvement Program (QIP) is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. The scope of the QIP ensures that all demographic groups, care settings, and services are included in QI activities.

The QIP is concerned with continual improvement in clinical care performance, including acute and chronic disease states, high-risk conditions, high volume care, inpatient care, ambulatory care, and preventive healthcare.

The various departments work together to identify enrollees/members with special health care needs, to identify, develop and implement appropriate health care services. Healthcare Effectiveness Data and Information Set (HEDIS®) measures are key monitors when considering future clinical studies and strategies.

Also, referenced are sources such as, but not limited to:

- Governmental agencies, such as the Centers for Disease Prevention and Control, the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the National Institutes of Health, etc.
- National physician professional organizations, such as the American Medical Association, the American Psychiatric Association, American College of Obstetricians and Gynecologists, etc.
- National health organizations, such as but not limited to the American Diabetes Association, National Cancer Institute and the American Heart Association, The National Heart Blood and Lung Institute, The Institute of Medicine, and the National Patient Safety Foundation.

Activities to Fulfill the Scope

- Annual Assessment of the Quality Improvement Program (QI)
- Assessment of Patient Safety
- Assessment of Member Satisfaction
- Assessment of Provider/Practitioner Satisfaction
- Assessment of Continuity and Coordination of Care
- Assessment of Provider/Practitioner Access and Availability
- Delegation Oversight
- QI Program Activities
- Ongoing Assessment of changes

Program Content/ Implementation

The goal of Buckeye's quality improvement program is to conduct meaningful quality improvement activities across all care settings aimed at improving member health status/outcomes, quality of care, services delivered, and overall customer satisfaction.

Patient Safety and Quality of Care

Patient Safety is a key focus of Buckeye Health Plan QM/QI program. Monitoring and promoting member safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member.

Buckeye Health Plan employees (including Medical Management, Member Services, Provider Services, Appeal Coordinators, etc.), panel providers, facilities or ancillary providers, members or member representatives, medical directors or the BoD may advise the Quality Management (QM) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee (Ad Hoc Committee) as indicated.

Per CMS Quality Improvement Organization Manual Chapter 5, Quality of Care Review, Section 5045.2, upon request by a QIO, a practitioner and/or provider must deliver all medical information requested within fourteen (14) calendar days of the request.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Quality Improvement

Buckeye's quality improvement efforts assess and improve the level of performance of key processes and outcomes within the organization. Opportunities to improve care and service are found primarily by examining the systems by which care, services are provided, and developing procedures and implementing corrective action plans to improve overall service and outcomes within the organization.

QI activities are coordinated with other performance monitoring activities and management functions including, but not limited to utilization/medical management, credentialing/recredentialing, EPSDT/HEALTHCHEK, patient safety, compliance, claims, member and provider services, network development, behavioral health, and disease management.

In addition, collaborative health performance improvement measures are developed by the Ohio Department for Jobs and Family Services.

Buckeye provides ongoing quality improvement through identification, implementation, analysis, evaluation, and re-measurement through:

- Adequate staffing and resources to support the QI functions
- Identification of opportunities for improvement and corrective action plans when opportunities are identified
- On-going monitoring and follow-up related to all quality improvement activities and the care and services members receive
- Maintain information systems that captures sound QI data required for reporting and analysis Identification and follow-up of issues identified by the Quality Improvement Committee and Sub-Committees

QI Process

Buckeye's Quality Improvement Committee (QIC) reviews and approves the annual QI Program, QI Evaluation and Work Plan. Buckeye utilizes traditional quality/risk/medical management approaches for identifying opportunities for improvement. Initiatives are selected based on information indicating the need for improvement in a particular clinical or non-clinical area having the greatest potential for improving health outcomes and reflecting the cultural and/or special needs of Buckeye's membership. Other initiatives can be selected to test an innovative strategy.

Once QI topics are selected, the QI Department, in conjunction with specific functional areas as appropriate, will present the proposed QI initiative to the QIC for approval. The QIC will select those initiatives that have the greatest potential for improving health outcomes or the quality of service delivered to Buckeye's members and network providers. Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines. QI initiatives are designed to allow for monitoring improvement over time.

Quality of Care and Service

Buckeye identifies quality of care and service issues through the following activities:

- Key indicators of care and service based on reliable data derived from claims, authorizations, inbound telephone calls, and internal tracking mechanisms, etc.
- Credentialing data
- Performance monitoring of contracted physicians/practitioners, facilities, ancillary providers, and organizational providers
- Provider office site review through member complaints
- Utilization data (under-over utilization) and performance indicator reports
- Issues identified during care coordination
- Referrals from sources indicating potential problems, including those identified by affiliated hospitals and contracted providers
- Quality of Care monitoring
- Trends in member grievance and appeals
- Care Management reports
- Pharmacy data and reports
- Member satisfaction survey
- Provider satisfaction survey
- Access and availability reports
- Utilization Review Activities
- Integration/collaboration of Quality Improvement (QI), Medical Management (MM), and Care Management (CM) processes Activities Designed to Improve Quality of Care and Service Buckeye's QI Department, QIC and subcommittees, as appropriate, continuously monitor various internal systems and administrative processes related to medical and behavioral health care for members.

A listing of key focus areas for quality improvement activities are:

Access and Availability

The QIC provides oversight to the provider network to ensure adequate numbers and geographic distribution of PCPs, specialists, hospitals, and other providers while taking into consideration the special and cultural needs of members. Provider Relations measure provider Access and Availability at least annually. Results are reviewed and recommendations are made to address any deficiencies in the number and distribution of Primary Care, Specialty, Behavioral Health, Dental, Hospitals, Pharmacy, and Ancillary providers.

The QIC sets standards for the number and geographic distribution of PCPs, Specialists, Dental Providers, Hospitals, Behavioral Health Providers, and Pharmacies in accordance with State contract requirements. Provider Relations analyzes practitioner appointment accessibility (Primary Care and Behavioral Health Care providers) at least annually and Member Services (telephone accessibility). Results are reviewed by the QIC to ensure compliance with contractual, regulatory and accreditation requirements as well as appropriate appointment and availability access.

Administrative and Customer Service

Buckeye measures its administrative and customer services performance by monitoring relevant indicators related to member and provider complaints, member, and provider satisfaction regarding administrative services, and member and provider call center performance. Buckeye collects and analyzes data to measure its performance against established benchmarks or standards, identifies and prioritizes improvement opportunities. Specific metrics are developed and implemented to improve performance, and the effectiveness of each metric is measured at specific intervals, depending upon the intervention.

Assessment of Utilization Patterns

To ensure appropriate care and service to members, an annual assessment of utilization data to identify potential under and over utilization issues or practices is completed. Data sources include medical service encounter data, pharmacy, dental and vision encounter. The MM Department, Case/Care Managers VPMM, VPMA, and Regional Medical Directors identify problem areas and provide improvement recommendations to the QIC for recommendation/approval. The MM Department implements approved actions to improve appropriate utilization of services. A minimum of four (4) data types are used for this analysis and at least one is related to behavioral health. Examples of possible data types are:

- Length of Stay (LOS) data
- Inpatient acute days or discharges
- Unplanned readmissions
- Rates of selected procedures
- Member satisfaction survey results
- Rates of referrals to specialists
- Ambulatory visit rates
- Rates of pharmacy use
- Rates of behavioral health utilization
- Rates of EPSDT/HEALTHCHEK screenings and subsequent treatment
- Member Grievances and requests for Administrative Review related to authorization denials

Continuity and Coordination of Care

Continuity of care is assessed via several different activities. Data from each activity is aggregated, reported, and reviewed at least annually. The following are examples of some of the Buckeye activities that monitor continuity and coordination of care:

Medical Care

- Surveying PCPs to assess their satisfaction with feedback from referred providers, including medical/surgical specialists, and other organizational providers.
- Assessing, through medical record review, the quality of the information exchange between medical providers, including the protection of privacy.
- Reviewing claims data to determine utilization patterns for specialty care referrals.
- Service to members with complex healthcare needs by case/care management teams.

Between Medical and Behavioral Health Care

- Assessing, through medical record review, the quality of the information exchange between medical and behavioral health providers.
- Utilizing pharmaceutical reports to assess the appropriateness of psychopharmacological medications prescribed by primary care physicians.
- Reviewing primary care providers' guidelines for assessment for behavioral health disorders in at-risk individuals and referral to behavioral health providers.
- Surveying PCPs to assess their satisfaction with feedback from referred behavioral health providers.
- Including a representative from Buckeye's behavioral health provider in UM rounds and QIC Committee.
- Reviewing claims data to determine utilization patterns for Behavioral Health referrals.
- Management of treatment access and follow-up for members with coexisting medical and behavioral disorders
- Collaborative approach to the development and adoption of primary and/or secondary prevention programs for behavioral healthcare.
- Collaboration on the use of the HEDIS Antidepressant Medication Management and Follow-Up Care for Children Prescribed ADHD Medication (ADD) measures

Key Quality Documents and Documentation Cycle

The QI Program Documentation Cycle is an ongoing sequence that applies a systematic process of quality assessment, identification of opportunities for improvement, action implementation, and evaluation. Several key QI instruments demonstrate Buckeye's continuous quality improvement cycle using a pre-determined documentation flow. Include but are not limited to the following:

- QI Program Description
- QI Work Plan
- QI Program Evaluation
- Performance Improvement Projects
- Focused Studies

Quality Improvement Work Plan (QI Work Plan)

To develop the comprehensive scope of the QIP, a QI Work Plan is developed that clearly defines the activities that must be completed within the measurement year. The annual QI Work Plan specifies the activities to be addressed, the person(s) responsible for each activity, the date of expected completion and the monitoring techniques that will be used to ensure completion within the established timeframe. The QI Work Plan is reviewed/ evaluated and approved by the

QIC and BOD at least annually. The QI Work Plan is presented to the QIC for review and updates quarterly.

Quality Improvement Program Evaluation (QI Evaluation)

The QI Department completes an annual evaluation of the QI Work Plan. As part of this evaluation, compliance with external accreditation and regulatory standards are assessed. After completing the annual evaluation of the QI Program, its findings and the QI Work Plan, the QI Department formulates a written report outlining the findings and provides recommendations for improvement to the QI Program. The VPMA presents the findings and recommendations to the QIC within ninety-days (90) after year-end for review and approval. The QI Evaluation is reviewed/evaluated and approved by the QIC and BOD at least annually.

Quality Improvement Committee Structure

Buckeye's Board of Directors (BOD) has the ultimate authority and accountability for the QIP. The Board of Directors delegates it's authority of the QIP to Buckeye's President/CEO who delegates the daily operations of the QIP to the Vice President of Medical Affairs (VPMA).

Nine committees support the QI Program. The structure and need for each committee are developed based on the ability of the QI Program to operate within the Organization. Each committee meets monthly, bi-monthly, and/or quarterly, may call special meetings on an as needed basis, a chairperson is identified for each committee. The chairperson and/or designated staff are responsible for leading the meeting, developing agendas, and maintaining the minutes. The minute's list attendees, issues presented key points of discussion, decisions, planned actions and assigns appropriate responsibility for each communication, action or follow-up.

Sub-Committees include but are not limited to the following:

- Medical Management Committee
- Pharmacy & Therapeutics Committee
- Grievance & Appeals Committee
- Credentialing Committee
- Peer Review Committee
- HEDIS/STARS Program Committee
- Member Advisory Committee
- Delegated Vendor Oversight
- Cultural Competency Committee

Notification to Providers

Upon request, Buckeye provides information regarding the QI Program Description and QI Program goals and objectives to providers/practitioners.

DATA COLLECTION

Buckeye is required to maintain a health information system that collects, analyzes, and integrates all data necessary to aggregate, evaluate and report certain statistical data related to cost, utilization, quality, and other data requested by CMS. As a Buckeye provider, you are required to submit all data necessary to fulfill these requirements in a timely manner and participate in Buckeye data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow the use of provider performance data for quality improvement activities. You are required to certify, in writing, that the data submission to Buckeye is complete and accurate, and truthful. This includes all data, including encounter data, medical records, or other information required by CMS.

PRACTITIONER INVOLVEMENT

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in Buckeye's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow Buckeye Health Plan the use of their performance data for quality improvement activities.

Billing Error Abuse and Fraud (BEAF) System

Buckeye takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a BEAF program that complies with state and federal laws. Any information related to BEAF, embezzlement or theft will be reported to the appropriate authorities. These are the primary agencies to which incidents or practices of abuse and/or fraud are to be reported:

Billing Errors, Abuse, and Fraud (BEAF) Hotline
1-866-685-8664

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, OH 43215
1-614-466-4693

Authority and Responsibility

The President/CEO of Buckeye has overall responsibility and authority for carrying out the provisions of the compliance program.

Buckeye is committed to identifying, investigating, sanctioning, and prosecuting suspected fraud and abuse.
The Buckeye provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations, at Buckeye or the subcontractor's own expense.

To report potential fraud and abuse, contact:

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, OH 43215
1-614-466-4693

SUPPLEMENTAL DATA ELECTRONIC DATA INTERCHANGE (EDI) FEED OVERVIEW

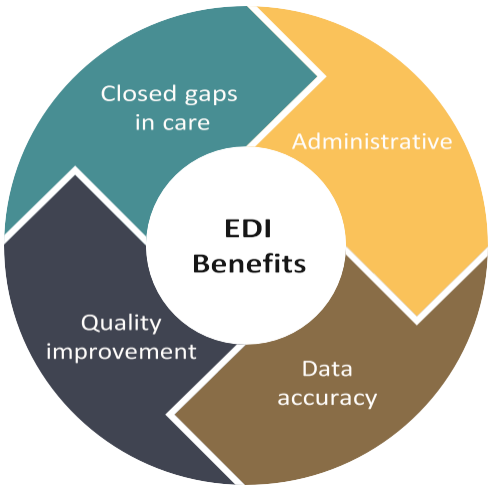
The Future of Healthcare

The Healthcare Industry is moving toward being completely electronic to foster better health outcomes, increase patient satisfaction, and meet contract requirements. Buckeye Health Plan is here to support you in adapting to the changes necessary to take advantage of the opportunity to share supplemental data. Supplemental data is member- specific information shared electronically by providers that impacts HEDIS® and improves care coordination. Here are the facts about Buckeye's supplemental data electronic data interchange (EDI) opportunity:

- Over 20 HEDIS® measures are reportable via EDI, including many within Buckeye quality-based provider incentive programs
- In 2020, over 60 sub measures showed an increase attributed to supplemental data received via EDI reducing the need for administrative support to provide medical records
- EDI facilitates higher performance in value-based agreements by picking up HEDIS® numerator hits missed by claims

Benefits of EDI

Closed gaps in care: For some measures, it is easier to report via the EDI feed versus claims submission. This is because some measures are based on the patient's vitals or measurement at the time of the appointment.
In 2020, HEDIS® measures like these showed an increase of over 14% for some instances.



Administrative: When measures are reported via EDI, it reduces the potential burden provider offices may face by minimizing the need to produce medical records. By reducing the number of manual transactions, staff can be more efficient and focus on patients rather than processing requests.

Data accuracy: Data submitted via EDI reduces the amount of human errorthat can occur upon review of medical records or claims submission.

Quality improvement: Supplemental data that is provided to Buckeye can enhance Care Coordination and potentially minimize adverse events and preventable health issues; mergingclinical with claims provides a better picture of patient health.

Examples of Standard Supplemental Data Files

- Laboratory Result Files
- EHR Output Files
- Continuity of Care Documents
- Encounter Data Files
- Pharmacy Data Files
- Admission Discharge Transfer Files
- Electronic Medical Records
- State Registries - Immunizations and Blood Lead

Contact Us Today

Want to sign up? Have questions about our Buckeye quality-based provider incentive programs? Have questions about EDI? Contact your local Provider Network Development Representative or call 866-296-8731.

Pharmacy

Buckeye Health Plan is committed to providing appropriate, high-quality, and cost-effective drug therapy to all Buckeye Health Plan members. Buckeye Health Plan covers prescription medications and certain over-the-counter medications with a written order from a Buckeye Health Plan provider. The pharmacy program does not cover all medications. Some medications may require prior authorization, and some may have limitations. Other medically necessary pharmacy services are covered as well.

SINGLE PHARMACY BENEFIT MANAGER (SPBM)

In 2019, the Ohio Legislature directed ODM to make a shift in the Medicaid pharmacy program and select and contract with a single pharmacy benefit manager (PBM). ODM's goals for the single pharmacy benefit manager (SPBM) are to improve management and administration of pharmacy benefits for managed care recipients. Through SPBM, ODM will gain increased financial accountability and ensure alignment with our clinical and policy goals, while also improving transparency. ODM selected Gainwell Technologies as the SPBM for Ohio Medicaid.

On October 1, 2022, the SPBM will begin providing pharmacy services across all managed care plans and members. Until the SPBM goes live on October 1, 2022, there is no change to the current process for submitting pharmacy claims or pharmacy prior authorizations. Through SPBM, pharmacists and prescribers will see benefits from streamlining and consolidation of processes currently provided by multiple, individually contracted PBMs. The SPBM will be responsible for maintaining the Unified Preferred Drug List (UPDL) and will also include implementation of a single set of clinical and prior authorization policies and claims process, and provide a standard point of contact, reducing the administrative burden on providers.

For Medicaid managed care members, the SPBM will provide more choice in selecting their pharmacy due to fewer out-of-network restrictions. In addition, members will no longer need to consider pharmacy benefits as a decision-making factor when selecting a managed care plan. The SPBM can also incentivize member-valued services and benefits like home delivery, 90-day refills, and adherence programs.

UNIFIED PREFERRED DRUG LIST (PDL)

The Preferred Drug List (PDL) is the list of drugs covered by Buckeye Health Plan. The Ohio Department of Medicaid, in partnership with the Medicaid managed care plans (MCPs), has created a unified preferred drug list (UPDL). All Ohio Medicaid MCPs will prefer the same medications and use the same prior authorization criteria for the majority of drug categories. This unified list of drugs will help you know which drugs are covered with or without prior approval. Prior approval is also called prior authorization.

Providers may refer to the ODM Pharmacy website under "Unified PDL" for more information and to view the UPDL document. Providers may also refer to Gainwell Technologies (the SPBM) portal for more information: https://spbm.medicaid.ohio.gov.

PRIOR AUTHORIZATION

Providers may determine if a prior authorization is required by reviewing the Unified Preferred Drug List (UPDL) located on the ODM Pharmacy website or Gainwell's portal, https://spbm.medicaid.ohio.gov.

The UPDL may also be utilized to review the criteria that must be met in order for a prior authorization to be approved. When a PA is required, it must be submitted to and approved by Gainwell before the medication is dispensed. A PA must be submitted by the prescribing provider or an authorized member of the prescribing provider's staff.

These requests can be submitted utilizing general and drug-specific prior authorization forms specified by Ohio Department of Medicaid (ODM) which will be available via the Gainwell public portal at https://spbm.medicaid.ohio.gov/ or fax-on-demand.

Next Generation of Ohio Medicaid Managed Care

The focus of the next generation Ohio Medicaid program is on the individual with strong cross-agency coordination and partnership among MCOs, vendors, sister state agencies & ODM to support specialization in addressing critical needs.

With the next generation managed care program, ODM will work in collaboration with the Ohio Department of Job and Family Services (ODJFS), County Departments of Job and Family Services (CDJFS), Mental Health Addiction Services (MHAS), Department of Developmental Disabilities (DODD), Ohio Department of Aging and other agencies to support a more seamless and individualized experience for individuals and providers.

OhioRISE

OhioRISE (Resilience through Integrated Systems and Excellence) is a specialized managed care program for youth with complex behavioral health and multi-system needs. ODM selected Aetna Better Health of Ohio to serve as the new OhioRISE specialized managed care organization. OhioRISE expands access to in-home and community-based behavioral health services and supports.

Aetna contracts with regional care management entities (CME) to ensure OhioRISE members and families have the resources they need to navigate their interactions with multiple state and local systems such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others. An individual who is enrolled in the OhioRISE program will keep their managed care enrollment for their physical health benefit. The managed care organization also will be included in the individual's care management.

OhioRISE Eligibility

- Enrolled in Ohio Medicaid – either managed care or fee for service
- Be twenty years of age or younger at the time of enrollment
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment tool, or the following:
    - an inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder;
    - An inpatient in a psychiatric residential treatment facility (PRTF)
- Not be enrolled in a MyCare Ohio plan as described in Chapter 5160-58 of the Administrative Code

OhioRISE Services

In addition to the behavioral health services provided through chapter 5160-27 of the Administrative Code, the following new services available through OhioRISE include:

- Care Coordination at three different levels:
  - Tier 1: Limited Care Coordination (LCC) delivered by Aetna for youth needing lower intensity care coordination
  - Tier 2: Moderate Care Coordination (MCC) will be consistent with principles of High-Fidelity Wraparound and will be delivered by a CME - qualified agency for youth with moderate behavioral health needs
  - Tier 3: Intensive Care Coordination (ICC) will be consistent with principles of High-Fidelity Wraparound and will be delivered by a CME - qualified agency for youth with the greatest behavioral health needs
- Intensive Home-Based Treatment (IHBT): OhioRISE will make changes to existing IHBT services and align with the Family First Prevention Services Act (FFPSA). As of July 1, 2022, IHBT will be exclusive to OhioRISE.
- Psychiatric Residential Treatment Facility (PRTF): Available as a designation in Ohio in 2023, this service is aimed at keeping youth with the most intensive behavioral health needs in-state and closer to their families and support systems.
- Mobile Response and Stabilization Service (MRSS): provide youth in crisis and their families with immediate behavioral health services to ensure they are safe and receive necessary supports and services (this new service will also be available to children who are not enrolled in OhioRISE).
- Behavioral Health Respite: provides short-term, temporary relief to the primary caregiver(s) of an OhioRISE plan enrolled youth, to support and preserve the primary caregiving relationship.
- Flex Funds: provides services, equipment, or supplies not otherwise provided through the Medicaid state plan benefit or the OhioRISE program that address a youth's identified need as documented in the child and family-centered care plan. These are intended to enhance and supplement the array of services available to a youth enrolled on the OhioRISE program.
- For additional services available for youth enrolled in the OhioRISE waiver see Ohio Administrative Code Rule 5160-59-05.

Additional information on the OhioRISE services is available in chapter 5160-59 of the Ohio Administrative Code.

Additional information regarding who to bill for behavioral health services provided to youth who are enrolled in the OhioRISE plan is located in the OhioRISE Mixed Services Protocol on the OhioRISE website (https://managedcare.medicaid.ohio.gov/managed-care/ohiorise/6-Community+and+Provider+Resources). The OhioRISE *resources for community partners and providers* website also contains helpful billing information for providers: https://managedcare.medicaid.ohio.gov/managed-care/ohiorise/6-Community+and+Provider+Resources Aetna Better Health of Ohio can be reached by calling 833-711-0773 or e-mailing OHRise-Network@aetna.com.

Single Pharmacy Benefit Manager (SPBM)

The Single Pharmacy Benefit Manager (SPBM) is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that will provide pharmacy benefits for the entire Medicaid managed care population (excluding MyCare Ohio members). ODM selected Gainwell Technologies to serve as the SPBM. An additional integral component to the new pharmacy model is the Pharmacy Pricing and Audit Consultant (PPAC), which will conduct actual acquisition cost surveys, cost of dispensing surveys, and perform oversight and auditing of the SPBM. ODM has selected Myers and Stauffer, LC as the PPAC vendor.

The SPBM will consolidate the processing of pharmacy benefits and maintain a pharmacy claims system that will integrate with the Ohio Medicaid Enterprise System (OMES), new MCOs, pharmacies, and prescribers. The SPBM also will work with pharmacies to ensure member access to medications, supporting ODM's goals of providing more pharmacy choices, fewer out-of-network restrictions, and consistent pharmacy benefits for all managed care

members. SPBM will also reduce provider and prescriber administrative burden, by using a single set of clinical policies and prior authorization procedures, as well as a single pharmacy program point of contact for all members.

All Medicaid managed care members will be automatically enrolled with the SPBM under a 1915(b) waiver. Additionally, Gainwell Technologies will be required to contract with all enrolled pharmacy providers that are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that will ensure access for all members statewide. SPBM will provide coverage for medications dispensed from contracted pharmacy providers. Provider-administered medications supplied by non-pharmacy providers (such as hospitals, clinics, and physician practices) will continue to be covered by the MCOs or the OhioRISE plan, as applicable.

For more information about the SPBM or PPAC initiatives, please email: MedicaidSPBM@medicaid.ohio.gov or visit the SPBM website at https://spbm.medicaid.ohio.gov.