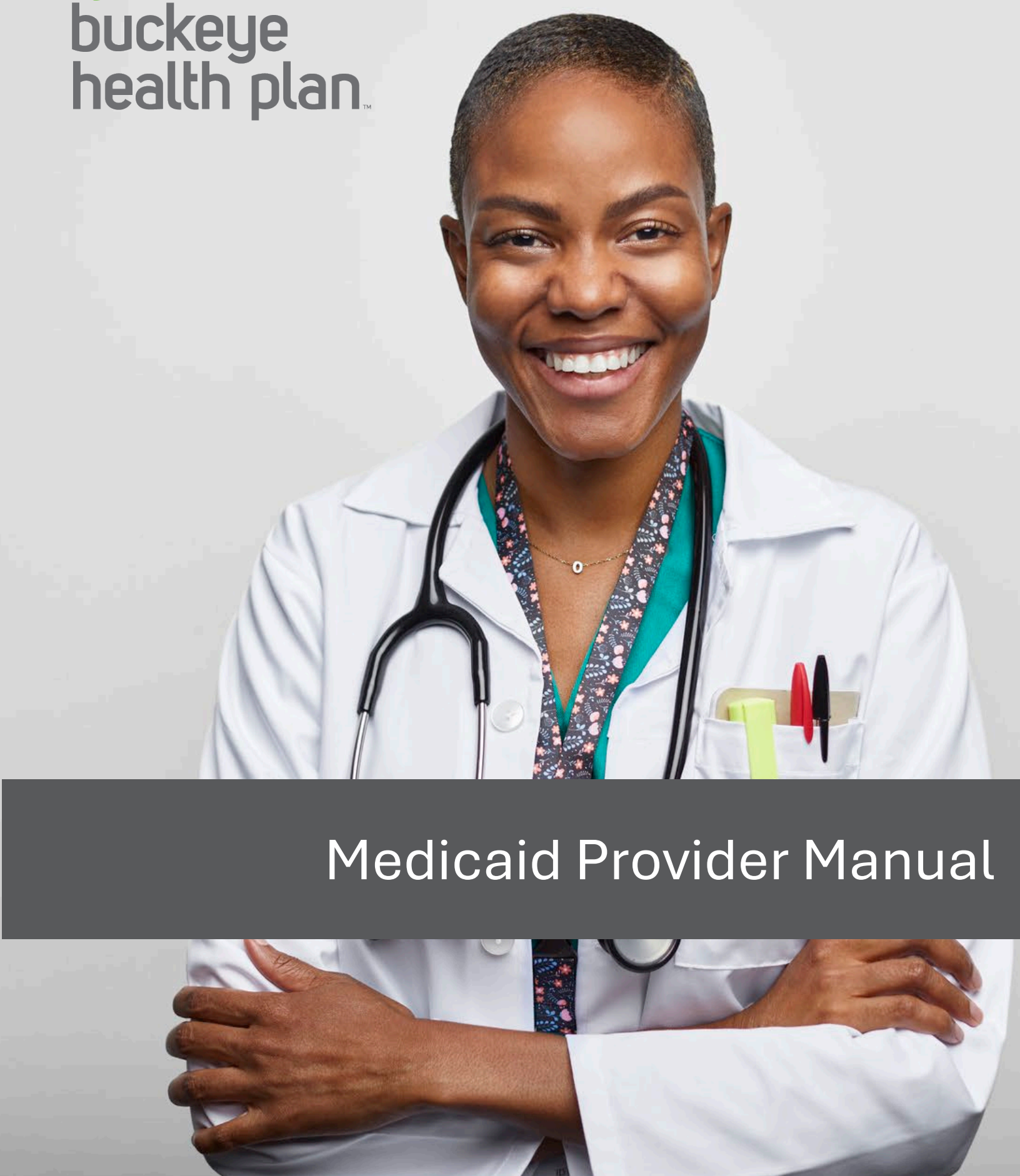
buckeye health plan™



Medicaid Provider Manual

Table of Contents

*Buckeye delivers updates to our provider network via our monthly Provider Update Newsletter and other email communications, as needed. Providers should **sign up** to receive our **Provider Communications** for the most up-to-date information.*

Section I – Introduction

WELCOME

Welcome to Buckeye Health Plan! Thank you for being part of our network of healthcare professionals. We look forward to working with you to improve the health of our communities, one person at a time.

About Us

Buckeye Health Plan, Inc. (Buckeye) is a managed care organization (MCO) contracted with the Ohio Department of Medicaid (ODM) to serve Medicaid 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/member communication regarding appropriate treatment alternatives. Buckeye does not penalize practitioners for discussing medically necessary or appropriate care with the member.

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 members, 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 details related to topics within this handbook, please call **Provider Services** at **1-866-296-8731** to receive additional information upon request.

You may access most of Buckeye's information/forms/etc. on our website at **Provider Home Page**.

How to Use this Manual

This Manual is designed to be a user-friendly informational tool. Buckeye's information is divided into sections, including a master Table of Contents and a separate Table of Contents for each section.

To access information quickly, please follow these steps:

- Locate the section or topic in the master Table of Contents
- Identify the Section Number
- Tab to the appropriate section's Table of Contents
- Find the page number in that section that is associated with the topic of interest

You may also access a copy of the Provider Manual on Buckeye's website at **Provider Home Page**.

Updates and Revisions

The Provider Manual is a dynamic tool and will continue to evolve with Buckeye's expansions and changes. Minor updates and revisions will be communicated to providers via *Provider Bulletins*. Information delivered in *Provider Bulletins* replaces the information found in the body of the existing Provider Manual.

Major revisions of the information in the Provider Manual will result in the publication of a revised edition that will be distributed to all providers, replacing older versions of the Manual. The most current version of the Manual is always available on Buckeye's website at: **Provider Home Page**.

Section II - Basic Plan 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

Provider Services	
Provider Services Telephone Number	1-866-296-8731
Hours of Operation	Monday - Friday 7 a.m. to 8 p.m. (EST)
Website	**https://www.buckeyehealthplan.com/providers.html**

Member Services		
Member Services Telephone Number	1-866-246-4358 TTY: 1-800-750-0750	Monday – Friday 7 a.m. to 8 p.m. (EST)
NurseWise® 24 Hour Nurse Advice Line	1-866-246-4358 and follow the prompt for 'Nurse' or TDD/TTY: 1-800-750-0750	24/7 Availability

Phone

Department	Telephone Number
Provider Services	1-866-296-8731
Member Services	1-866-246-4358 TTY: 1-800-750-0750
Member Eligibility	1-866-246-4358
Prior Authorizations	1-866-246-4359
Concurrent Review	1-866-246-4359
Care Management	1-866-246-4359
Centene Vision Services **https://visionbenefits.envolvehealth.com/**	1-866-442-6173
Centene Dental Services **https://www.envolvedental.com/**	1-844-464-5634
24 Hour Nurse Advice Line (24/7 Availability)	1-866-246-4358 and follow the prompt for 'Nurse' or TDD/TTY: 1-800-750-0750
National Imaging Associates (NIA) **www.radmd.com**	1-800-642-6551
Non-Emergency Medical Transportation (NEMT)	1-866-531-0615
Ohio Medicaid Provider Hotline **Integrated Helpdesk**	800-686-1516
Ohio Medicaid Consumer Hotline **Contact Us**	800-324-8680 (Toll Free)

Department	Telephone Number
Buckeye Admissions	1-866-246-4358
To report suspected waste, fraud, and abuse to Buckeye	1-866-296-8731
Interpreter Services	1-866-296-8731

Mail

Department	Telephone Number
Main Address	Buckeye Health Plan 4349 Easton Way Columbus, OH 43219
Appeals and Grievances	Buckeye Health Plan Appeals/Grievances Coordinator 4349 Easton Way, Suite 120 Columbus, OH 43219
Medical Paper Claims Submission	Buckeye Health Plan Ohio Claims Medical P.O. Box 6200 Farmington, MO 63640
Behavioral Health Paper Claims Submission	Buckeye Health Plan Ohio Claims Behavioral Health P.O. Box 6150 Farmington, MO 63640
Medical Claim Dispute	Buckeye Health Plan Attention: Dispute Department P.O. Box 6200 Farmington, MO 63640-3800
Behavioral Health Claim Dispute	Buckeye Health Plan Attention: BH Dispute Department P.O. Box 6150 Farmington, MO 63640-3800

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 Eligibility

Buckeye's providers should verify member eligibility before every service is rendered, using one of the following methods:

- **Log on to our Secure Provider Portal or Availity**. Using our secure Provider Portal, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of birth.

- **If you cannot confirm a member's eligibility using the method above, call our toll-free number at 1-866-296-8731 to speak to a live representative.** Follow the menu prompts to speak to a Provider Services Representative to verify eligibility prior to rendering services. Provider Services will need the member's name, member Medicaid ID, and member date of birth to check eligibility. Possession of a Buckeye's member ID card is not a guarantee of eligibility. Use one of the above methods to verify member eligibility on the date of service.

Buckeye's Secure Provider Portal allows Primary Care Providers (PCPs) to access a list of eligible members who have selected their services or were assigned to them. The list of eligible members also provides other important information, including indicators for members whose claims data shows a gap in care, such as the need for an adult BMI assessment. To view this list, log on to our **Secure Provider Portal or Availity**. Eligibility changes can occur throughout the month, and the member eligibility list does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on the date of service.

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.

Availity
Buckeye Health Plan has chosen **Availity Essentials** as its new, secure provider portal. Starting January 20, 2025, you can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access Buckeye Health Plans payer resources via **Availity Essentials**.

If you are already working in Essentials, you can log in **Availity** to enjoy these benefits for Buckeye's members beginning January 20, 2025:

- Use Availity Essentials to verify member eligibility and benefits, submit claims, check claim status, currently submit authorizations, and more.
- Look for additional functionality in Buckeye's payer space on Essentials and use the heart icon to add apps to **My Favorites** in the top navigation bar. Our current **Secure Provider Portal** will still be available for other functions you may use today.
- Access Manage My Organization – Providers to save provider information. You can then auto-populate that information repeatedly to eliminate repetitive data entry and reduce errors.

If you are new to Availity Essentials, getting your Essentials account is the first step toward working with Buckeye Health Plan on Availity.

Getting started: Designate an Availity administrator for your provider organization
Your provider organization's designated Availity administrator is the person responsible for registering your organization in Essentials and managing user accounts. This person should have legal authority to sign agreements for your organization.

Check out some of the time-saving tools that come with an Availity Essentials account:

- Verify member eligibility and benefits, submit claims, check claim status, and currently submit authorizations.
- Look for additional functionality in Buckeye's payer space and use the heart icon to add apps to **My Favorites** in the top navigation bar.
- Save provider information in Essentials and auto-populate it to save time and prevent errors.

Join one of our upcoming free webinars, *Availity Essentials Overview for Buckeye*, to learn additional tips for streamlining your workflow. We'll show you how to verify eligibility and benefits, submit claims, check claim status, submit authorizations, and more.

We're excited to welcome you to Availity Essentials, helping you transform the way you impact patient care with Buckeye Health Plan. If you need additional assistance with your registration, please call Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday, 8 a.m. – 8 p.m. ET. For general questions, please reach out to your Buckeye Health Plan Provider Relations Administrator.

Member Identification 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.

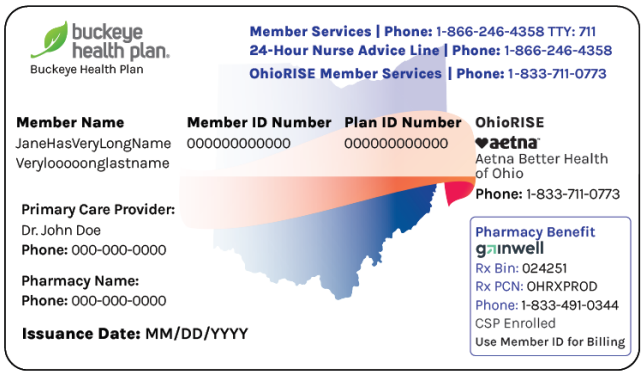
The member ID number, effective date, contact information for Buckeye, and PCP information are included on the ID card.

Members should present both their Buckeye member ID card and a photo ID each time they seek services from a provider. 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** toll-free at **1-866-296-8731** immediately.

View our Medicaid Member ID Cards on our website **here**.

OhioRISE with Coordinated Services Program (CSP)


buckeye health plan.
Buckeye Health Plan

Member Services | Phone: 1-866-246-4358 TTY: 711
24-Hour Nurse Advice Line | Phone: 1-866-246-4358
OhioRISE Member Services | Phone: 1-833-711-0773

Member Name
JaneHasVeryLongName
Veryloooonglastname

Member ID Number
000000000000

Plan ID Number
000000000000

OhioRISE
aetna
Aetna Better Health of Ohio
Phone: 1-833-711-0773

Primary Care Provider:
Dr. John Doe
Phone: 000-000-0000

Pharmacy Name:
Phone: 000-000-0000

Issuance Date: MM/DD/YYYY

Pharmacy Benefit
gainwell
Rx Bin: 024251
Rx PCN: OHRXPROD
Phone: 1-833-491-0344
CSP Enrolled
Use Member ID for Billing

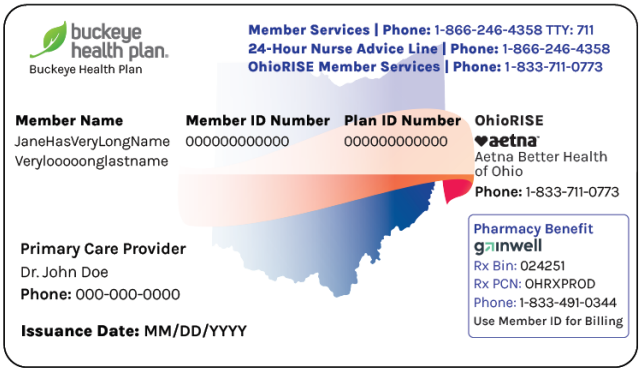

Member Services | Phone: 1-866-246-4358 TTY: 711
24-Hour Nurse Advice Line | Phone: 1-866-246-4358 and follow the prompt for 'Nurse' or TTY at 1-800-750-0750.
OhioRISE Member Services | Phone: 1-833-711-0773

Information for Members
For plan information and resources please visit our website at www.buckeyehealthplan.com. If you have an emergency, call 911 or go to the NEAREST emergency room (ER) or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your primary care provider or the Buckeye Nurse Advice Line, at 1-866-246-4358, (TTY 1-800-750-0750). Your PCP or the Buckeye Nurse Advice Line can talk to you about your medical problem and give you advice on what you should do.

Information for Providers
Please verify member eligibility on Date of Service via the ODM provider portal before rendering services. Please visit Buckeye Health Plan for detailed billing instructions or call 1-866-846-4358, TTY: 711 for assistance. Providers may also call the ODM IHD at 1-800-686-1516 for assistance.

OhioRISE
Ohio | Department of Medicaid

OhioRISE without Coordinated Services Program (CSP)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OhioRISE
Ohio | Department of Medicaid

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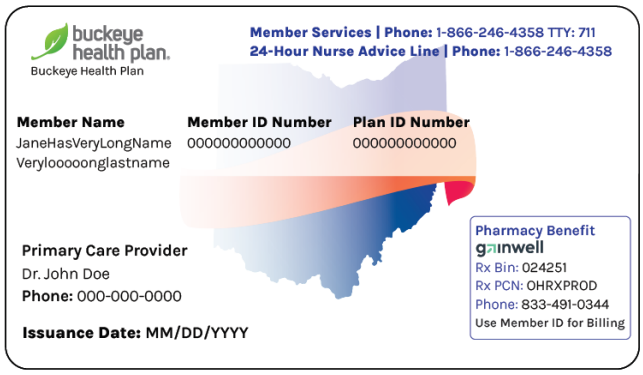
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Ohio | Department of Medicaid

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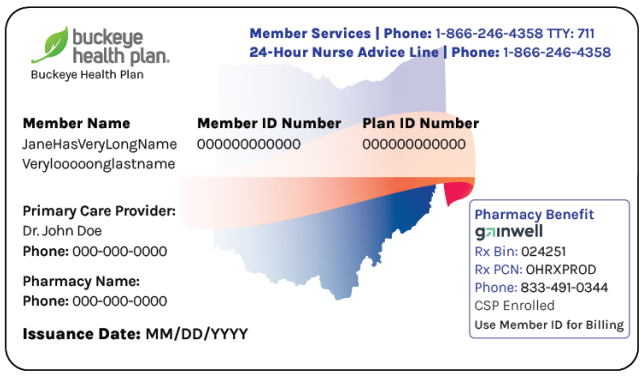
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Ohio | Department of Medicaid

PROVIDER REPRESENTATIVE INFORMATION

Provider Engagement

The Provider Engagement Department is dedicated to making your experience with Buckeye a positive one by serving as your advocate within the organization. Provider Engagement 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 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.

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Buckeye enrolled membership.

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

You can view the Provider Engagement Representative Territory Assignment Map on our **Provider Engagement** page.

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 members, respond to your Buckeye Plan inquiries, connect you to the Buckeye Provider Relations Specialist for your area, etc.

Provider Services and Provider Engagement 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.

Buckeye's Provider Services hours of operation are Monday - Friday 7 a.m. to 8 p.m. (EST) excluding holidays.

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

Section III - 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 as their main source of information related to our plan and products. Providers can access the following information at **Provider Home Page**:

- 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.
- And more!

We are continually updating our website with the latest news and information, so save the **Provider Home Page** to your Internet “Favorites” list and check our site often!

PROVIDER PORTAL

Buckeye offers time-saving tools through 24/7 access to our secure portals to manage administrative tasks. To make it easier to work with us, Buckeye began transitioning to **Availity Essentials™** in late 2024 and expects the migration to be complete in 2026. Our current **secure provider portal** is still available during the transition.

Availity Essentials™
Utilize **Availity Essentials** for the following operational tasks:

- Validate eligibility and benefits
- Submit authorization requests and attachments
- Check authorization status
- Submit batch claims
- Check claim status (24 months from date of service)
- View payment history and Explanation of Payment
- View member gaps in care with the Risk Condition Validation (RCV) and Clinical Quality Validation (CQV) tools
- Receive PCP notifications

Providers working in Availity with other payers can use their existing credentials to access resources for Buckeye members. New users must register and create an account. Training resources are available. For assistance, contact **Availity Client Services at 1-800-AVAILITY**.

Secure Provider Portal
Providers can also utilize the Buckeye **secure provider portal** for the following administrative tasks:

- Validate eligibility and benefits
- Submit authorization requests and attachments
- Check authorization status
- Submit claims
- Check claim status (24 months from date of service)
- Correct and resubmit claims
- View payment history and Explanation of Payment
- View member gaps in care with the Risk Condition Validation (RCV) and Clinical Quality Validation (CQV) tools
- Receive PCP notifications
- View and download a PCP panel (patient list)
- Update and edit authorization requests
- Submit administrative denial and provider claim disputes
- Check quality scorecards
- Access the Pay for Performance (P4P) program
- Refer members to care management
- Complete patient assessments
- Secure messaging with the health plan
- Waiver provider billing

For additional questions about Availity or the Buckeye secure provider portal, contact your Provider Engagement representative.

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 Buckeye Provider Communications email address: **Buckeye_Provider_Communications@CENTENE.COM**

CLAIMS PAYMENT SYSTEMIC ERROR (CPSE) REPORT

A claims payment systemic error (CPSE) is defined as the MCOP's claim's 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 here on our website under Provider Resources > Manuals, Forms and Resources at **Provider Home Page.**

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

Buckeye encourages you to review this log often and prior to contacting Buckeye 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 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 the issues identified. Ultimately improving the health care delivery system and improving outcomes for their members/our members.

The Provider Advisory Council will be chaired by the Chief Medical Officer, as designated by the CEO, for Buckeye. 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.

PROVIDER POLICIES

Clinical and Payment Policies are found on our website under Provider Resources at **Clinical & Payment Policies**.

PROVIDER SERVICES CALL CENTER INFORMATION

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.

Buckeye's Provider Services hours of operation are Monday - Friday 7 a.m. to 8 p.m. (EST) excluding holidays.

Buckeye will be closed on the following holidays:

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

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

PROVIDER TRAININGS

Provider Training and Webinars are found on our website under Provider Resources at **Training and Education**.

FORMS

ODM and Managed Care Policy Forms Page

Managed Care Policy Forms
Primary Care selection/change and Authorization forms.

Medicaid Forms
Ohio Department of Medicaid Forms Library

Hysterectomy, Abortion, or Sterilization Form(s)

The appropriate sterilization/abortion forms can be located at:

Consent for Sterilization (English)
Consent for Sterilization (Spanish)

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

For a Pre-Service Appeal (when the provider is submitting on behalf of the member), the link below must be used to obtain the required form, which must be submitted along with the appeal request:

Appointing a Representative

Provider Claim Dispute – Medical Necessity Review Form

A dispute may be submitted if the provider disagrees with Buckeye's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity or level of care.

Visit the link below to obtain the appropriate Medical Necessity / LOC review form based on the claim's date of service: **Dispute-Appeals Process**

SUD Residential Treatment (ODM)

Resources for Providers – Behavioral Health

Behavioral Health Provider Manual, Rates, and Resources

Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the MCOP 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 the MCOP contract that are identified in the PNM system.

- Attachment A is needed for all primary care providers (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 agree to provide services under this plan contract.

- Attachment C is only required when the contract between the MCOP 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:
Medicaid Managed Care Provider Addenda.

The Medicaid Addendum must be completed along with the MCOP provider contract.

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.

Become a Provider

Enrollment with Ohio Medicaid is required for both fee-for-service and managed care participation and payment.

Ohio Medicaid Online Application

MANAGED CARE ENTITY (MCE) OUT-OF-NETWORK PROVIDER APPLICATION (ODM 10282)

MANAGED CARE ENTITY (MCE) OUT-OF-NETWORK AND SINGLE CASE AGREEMENT PROVIDER APPLICATION (ODM 10295)

Ohio Medicaid Provider Agreement

Ohio Medicaid Provider Agreement for Managed Care Organization

Ohio Medicaid Provider Agreement

Prior Authorization

Use our **Pre-Auth Check** tool to see if a pre-authorization is needed. It's quick and easy. If an authorization is needed, you can access our login to submit online.

Section IV – Provider Responsibilities

Provider Rights

Buckeye providers have the **right** to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments.
    - Provide information regarding the nature of treatment options.
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered.
    - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment, as well as the benefits of such treatment options.
- Be treated by their patients and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for members' care.
- Have their patients act in a way that supports the care given to other patients and does not interfere with their operations.
- Expect other network providers to act as partners in members' treatment plans.
- File a dispute with Buckeye for payment issues and/or utilization management, or a general complaint with Buckeye and/or a member.
- File a grievance or an appeal with Buckeye on behalf of a member, with the member's written consent.

- Have access to information about Buckeye Quality Management/Quality Improvement (QM/QI) programs, including program goals, processes, and outcomes that relate to member care and services.
- Contact Buckeye Provider Services with any questions, comments, or problems.
- Collaborate with other healthcare professionals who are involved in the care of members.
- Not be discriminated against by Buckeye based solely on any characteristic protected under state or federal non-discriminate laws. Buckeye does not, and has never had a policy of terminating a Provider who:
    - Advocated on behalf of a member
    - Filed a complaint against us
    - Appealed a decision of ours
- Not be discriminated against by Buckeye in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. This does not require Buckeye to contract with providers beyond the number necessary to meet the needs of members, preclude Buckeye from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude Buckeye from establishing measures that are designed to maintain quality of services and control costs, or consistency with responsibilities to members.
- Not be discriminated against for serving high-risk populations or specializing in the treatment of costly conditions; for filing a grievance on behalf of and with the written consent of a member or helping a member to file a grievance; for protesting a plan decision, policy or practice the healthcare provider believes interferes with its ability to provide medically necessary and appropriate healthcare.
- Not be discriminated against based on any of the following: race/ethnicity, color, national origin, gender, age, lifestyle, disability, religion, sexual orientation, specialty/licensure type, geographic location, patient type in which the practitioner specializes, financial status, or on the basis of the providers association with any member of the aforementioned protected classes.

Provider Responsibilities

Buckeye providers have the **responsibility** to:

- Treat members with fairness, dignity, and respect.
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- 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.
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records, and be able to request that they be amended or corrected as specified in 45 CFR §164.524 and §164.526.

- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Respect members' Advance Directives and include these documents in the members' medical record.
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Participate in Buckeye data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- Review clinical practice guidelines distributed by Buckeye.
- Comply with Buckeye Medical Management program as outlined in this handbook.
- Disclose overpayments or improper payments to Buckeye.
- Not deny services to a member due to inability to pay the copayment if the household income is at or below 100% FPL.
- Reimburse copayments to members who have been incorrectly overcharged.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtain and report to Buckeye information regarding other insurance coverage.
- Notify Buckeye in writing if the provider is leaving or closing a practice.
- Update their enrollment information/status with the Ohio Medicaid program if there is any change in their location, licensure or certification, or status via the Ohio Medicaid's Provider Web Portal.
- Contact Buckeye to verify member eligibility or coverage for services, if appropriate.
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems they may have and to develop mutually agreed upon treatment goals, to the extent possible.
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- Office hours of operation offered to Medicaid members will be no less than those offered to commercial members.
- Not be excluded, penalized, or terminated from participating with Buckeye for having developed or accumulated a substantial number of patients in the Buckeye with high-cost medical conditions.
- Coordinate and cooperate with other service providers who serve Medicaid members, such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships, and school-based programs as appropriate.

- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
- Disclose to Buckeye, on an annual basis, any Physician Incentive Plan (PIP) or risk arrangements the Provider or Provider Group may have with providers either within its group practice or other providers not associated with the group practice even if there is no substantial financial risk between Buckeye and the provider or provider group.
- Provide services in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the Participating Provider Agreement.
- Allow Buckeye direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.
- Review and follow clinical practice guidelines distributed by Buckeye.
- Develop report based on Buckeye specification to submit monthly clinical data feed from the Electronic Medical Record (EMR) system within one year of enrolling in the Buckeye Provider Network.
- Comply with Ohio Risk Adjustment programs rely on complete and accurate diagnosis coding and reporting according to the ICD-10-CM coding guidelines.
- Report all suspected physical and/or sexual abuse and neglect.
- Report Communicable Disease to Buckeye.
- Buckeye must work with DHS State and District Office epidemiologists in partnership with the designated county or municipal health department staffs to appropriately report reportable conditions.

HIPAA and PHI

At Buckeye, we take the 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 1-866-296-8731.

Notification of Changes to Provider Practice

Providers must give Buckeye adequate notice of changes to provider practice following the terms of their participating agreement with our health plan.

How to Submit Changes

Providers submit updates and changes on the **Buckeye Provider Home Page** under Provider Resources > **Manuals, Forms and Resources** > Forms > Provider Update and Change Forms.

Notification of Change in Member Circumstance

Providers are required to promptly notify Buckeye Health Plan of a member's death by contacting Provider Services at 1-866-296-8731. When reporting such events, providers should be prepared to supply essential details including the member's full name, Medicaid ID, and the date of death. Additionally, for any changes in member contact information such as address, phone number, or other pertinent details, providers may submit these updates by contacting our Provider Services department at 1-866-296-8731. This ensures accurate and current member records, facilitating effective communication and care coordination.

Notification Of Pregnancy

Members that become pregnant while covered by Buckeye may remain a Buckeye member during their pregnancy. The managing Physician should notify the Buckeye prenatal team by completing the **Prenatal Risk Assessment Form (PRAF)** and Notification. A complete PRAF helps Moms receive the best support for a healthy pregnancy.

Provider Benefits of submitting a PRAF

- 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.

Code + modifier	Description	Provider Type	Fee Schedule Amount*
H1000 33	Electronic PRAF submission	Ob-Gyn	$90.00
H1000	Paper/Faxed version	Ob-Gyn	$12.11
T1023	Electronic Report of Pregnancy	Non Ob-Gyn/PCP	$30.00

**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.*

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!

- Open the **NurtureOhio** website to access the PRAF: **http://www.nurtureohio.com**
- Non OBGYN Providers can receive $30.00 by using the **NurtureOhio** website to submit the Report of Pregnancy (ROP).

PRIMARY CARE PROVIDER (PCP)

The Primary Care Provider (PCP) is a specific provider operating under the scope of his or her licensure, who is responsible for supervising, prescribing, and providing primary care service; locating, coordinating, and monitoring other medical care; rehabilitative service; and maintaining continuity of care on behalf of a member.

PCPs are the cornerstone of Buckeye service delivery model. The PCP serves as the "Medical Home" for the member. The Medical Home concept assists in establishing a member/provider relationship, supports continuity of care, and patient safety. This leads to elimination of redundant services, cost effective care, and better health outcomes.

Provider Types That May Serve as PCPs

A PCP shall be a medical Practitioner in our network including:

- Family Practitioner
- General Practitioner
- Internal Medicine
- Pediatrician
- Advanced Registered Nurse Practitioner (ARNP)
- Obstetrician or Gynecologist (OB/GYN)
- Physician Assistant

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 members. 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 member office visit. Injectable drugs provided during a covered member office visit costing over $100 require a Prior Authorization. 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 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

Type of Visit	Description	Minimum Standard
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 member'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.

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 members 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

Buckeye recognizes that the specialty provider is a valuable team member in delivering care to Buckeye's Ohio Medicaid members.

Selected specialty services may require authorization. The specialist must abide by the prior authorization requirements when ordering diagnostic tests or rendering services. All non-emergency inpatient admissions require prior authorization. To determine if services require an authorization, please use our **prior authorization check tool**.

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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 as needed before providing services.
- Coordinate the member'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 member care.
- Maintain the confidentiality of medical information.

HOSPITAL RESPONSIBILITIES

Buckeye utilizes a network of hospitals to provide services to Buckeye members. Hospital Services Providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the participating provider agreement.

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.

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 members, 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.

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.

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.

CLINICAL PRACTICE AND PREVENTIVE HEALTH GUIDELINES

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 adopts preventive and clinical practice guidelines that:

- are published by nationally recognized organizations or government institutions, as well as statewide collaboratives and/or a consensus of health care professionals in the applicable field;
- consider member needs;
- are reviewed and updated quarterly, or more frequently if needed; and
- are presented quarterly for approval by Buckeye's Quality Improvement Committee.

Buckeye provides quarterly notice of these guidelines via fax, website, and/or mail.

For more information, visit the **Provider Home Page** under **Quality Programs > Practice Guidelines.**

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

NON-COMPLIANT MEMBERS

There may be instances when a PCP feels that a member should be removed from his or her panel. All requests to remove a member 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 member 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 member's enrollment in the Program.*

CULTURAL COMPETENCY AND LINGUISTIC SERVICES

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

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 PNM.

Language Services

Effective communication with members 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 member rather than the interpreter
- Keep sentences short and pause to allow time for interpretation

Accommodating 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 members 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

Buckeye is committed to providing 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.
- 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., 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

Buckeye expects providers to respect and honor members' rights, including the right to:

- Receive information about Buckeye, its services, its providers.
- Be treated with respect and with due consideration for his or her dignity and privacy, including but not limited to the right to fully participate in the community and to work, live and learn to the fullest extent possible.
- Receive information on available treatment options and alternatives that are presented in a manner that the member is able to understand.
- Participate in decisions about their healthcare. This includes the right to refuse treatment.
- A right to get care right away for an Emergency Medical Condition.
- A right to decide about their healthcare and to give permission before the start of diagnosis, treatment, or surgery.
- Request and receive a copy of his or her medical records, and to request that they be amended or corrected.
- A right to have personal information in medical records kept private.
- A right to report any complaint or grievance about a provider or their medical care.
- A right to file an appeal of an action that reduces or denies services based on medical criteria.
- A right to express a concern or appeal to the Ombudsman's office.
- A right to receive interpretation services.
- A right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- A right to not be discriminated against due to race, color, national origin or health status or the need for healthcare services.
- A right to request a second opinion.

- A right to be notified at the time of enrollment and annually of disenrollment rights.
- A right to make an Advance Directive and to file a complaint with the Ohio DHS if they feel it is not followed.
- A right to choose a provider who gives care whenever possible and appropriate.
- A right to receive accessible healthcare services equivalent in amount, duration, and scope to those provided under Medicaid FFS and sufficient in amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished
- A right to receive appropriate services not denied or reduced solely because of diagnosis, type of illness or medical condition.
- Freedom to exercise the rights described herein without any adverse effect on the treatment by the Ohio Department of Human Services, Buckeye, its providers, or contractors.
- A right to receive all written member information from Buckeye:
    - At no cost to the member.
    - In the prevalent non-English languages of members in the service area.
    - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- A right to receive oral interpretation services free of charge for all non-English languages, not just those identified as "prevalent" and how to access them.
- A right to get help from both Ohio Department of Human Services and its Enrollment Broker in understanding the requirements and benefits of Buckeye.

Member Responsibilities

Members have certain responsibilities to:

- Inform Ohio Department of Job and Family Services of changes in family size.
- Inform Ohio Department of Job and Family Services if the member moves out of the Region, out-of-state or have other address changes.
- Inform Buckeye if the member obtains or has health coverage under another policy, other third party, or if there are changes to that coverage.
- Allow Buckeye direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.
- Take actions toward improving their own health, their responsibilities and any other information deemed essential by Buckeye.
- Keep appointments and follow-up appointments.
- Access preventive care services.
- Receive Information on any of cost-sharing responsibilities.
- Learn about Buckeye coverage provisions, rules, and restrictions.
- Choose a PCP.
- Treat providers and staff with dignity and respect.
- Inform Buckeye of the loss or theft of a member ID card.
- Present member ID card(s) when using healthcare services.
- Call or contact Buckeye to obtain information and have questions clarified.
- Provide providers with accurate and complete medical information.
- Follow prescribed treatment of care recommended by a provider or let them know the reason(s) treatment cannot be followed, as soon as possible.
- Ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives and make care decisions after weighing all factors.
- Understand health problems and participate in developing mutually agreed upon treatment goals with their provider to the highest degree possible.

- Make their PCP aware of all other providers who are treating them. This is to ensure communication and coordination in care. This also includes Behavioral Health Providers.
- Follow the grievance process established by Buckeye (and as outlined in the Member Handbook) if there is a disagreement with a provider.

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. Member's 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 for 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

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 Provider Services Department at 1-866-296-8731.

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 member's 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 Provider Services at **1-866-296-8731**.

Providers must call Provider 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.

Nurse Advice Line

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 answer 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 and follow the prompt for 'Nurse' or TDD/TTY: 1-800-750-0750.

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.

Section V - Provider Enrollment, Credentialing & Contracting

PROVIDER ENROLLMENT

Administered by the Ohio Department of Medicaid

Overview

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 CFR 455.460 and in OAC 5160-1-17.8. The fee for 2025 is $730 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(A)(1))

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 system of record for provider data for ODM and the MCOs. As a result, data in the PNM system is used in both claims payment, the MCO'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 system. 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 system:** 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, but are not limited to: location changes, specialty changes, and key demographic (e.g., name, NPI, etc.) changes. Once information is accepted into the PNM system, accepted information is sent to the MCOs daily 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 system if there are changes.

ODM Provider Call Center

If you have questions or need assistance with your Ohio Medicaid provider enrollment, call the ODM Integrated Helpdesk 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 member to choose one health plan over another
- Influence a member 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 members of hospital services, specialists, or specialty care available in the Buckeye Plan
- Assist a member 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

Administered by Buckeye Health Plan

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

Upon initiating your enrollment application through the Ohio Department of Medicaid Provider Network Management (PNM) system, visit Buckeye's **Provider Home Page** → **"Become a Provider"** to submit a contract request.

If any additional information is required or missing in order to complete the contract request, a Buckeye contract representative will reach out to you.

Upon approval, your contract information will be loaded into our internal systems as a participating provider. **Please allow 30 to 45 days for the loading process to be completed.**

Sample Network Provider Agreement

OH Participating Provider Agreement (PDF)

- NextGen Buckeye Medicaid Base Provider Agreement. This is to give providers who are not currently contracted with Buckeye an idea of our participation requirements.

OH Provider Product Attachment (PDF)

- Regulatory Amendment adding new NextGen required contract language to provider agreements. This is to give providers who are currently contracted with Buckeye an idea of the new NextGen participation requirements.

If you would like to complete and submit a request to participate, please see our **Become a Provider** section.

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: **Medicaid Managed Care Provider Addenda**.

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

Termination, Suspension, or Denial of Contract

In the event Buckeye denies a provider's request to join our Medicaid provider network, the provider will be notified in writing via email. The written notice will inform the provider of the right to appeal the decision to Buckeye's Contracting and Network Development Leadership (Senior Director/ and VP), as well as the relevant contact information to do so. Network Leadership will review the provider's request, along with the rationale from the assigned negotiator for denying the contract request and will respond to the provider within 10 business days. If the provider wants further review, they may appeal to the Network Steering committee, an interdisciplinary committee comprising senior leaders across the Buckeye Organization, who will review the denied request and respond within 10 business days.

Non-contracted or Unenrolled Providers

Contracting and enrollment are two separate processes. Both should be completed if you want to provide services to managed care enrolled Medicaid beneficiaries. Contracting is the process a provider completes with the MCO whereas enrollment is a process completed with the ODM.

All providers who are billing for services for Medicaid managed care enrolled beneficiaries should enroll with ODM through our PNM system. 42 CFR § 438.602 requires ODM to "screen and enroll, and periodically revalidate, all network providers of MCOs".

Federal regulations allow for a 120-day temporary agreement for providers who require more time to enroll in the PNM System. To complete the temporary 120 agreement while you wait for your ODM enrollment to process you must complete the **ODM 10295 form**.

Provider education and training resources for PNM, including how to enroll, are located here:
PSE Provider Registration Portal - Resources (maximus.com)

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.

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 7 a.m. - 8 p.m. EST.

CREDENTIALING/RECREDENTIALING PROCESS

Administered by the Ohio Department of Medicaid

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.

Section VI – Covered Services

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
- 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)
- ABA 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
- 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

Buckeye is not required to cover behavioral health services for members enrolled in the OhioRISE Plan, except for certain behavioral health services in accordance with the OhioRISE Mixed Services Protocol developed by ODM.

Buckeye is not required to cover pharmacy services other than the limited pharmacy services described in this manual. All other pharmacy benefits are covered by ODM's single pharmacy benefit manager (SPBM).

REFERRALS

As the Medical Home, PCPs should coordinate all healthcare services for Buckeye 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 member's medical record.

Member Self-Referrals

Family Planning
Family planning services are any medically approved means, including diagnostic evaluation, drugs, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, or for the detection or treatment of sexually transmitted diseases (STDs). These services are to be provided in a confidential manner to individuals of childbearing age, including minors who may be sexually active, who voluntarily choose not to risk initial pregnancy, or who wish to limit the number and spacing of their children.

Treatment for infertility is not included under the family planning benefit.

All Buckeye members have full freedom of choice of family planning providers, both in and out of the Buckeye network. The PCP should work with the member in providing for family planning services or assisting them in selecting a provider, as requested.

Members may also contact Member Services at **1-866-246-4358** for additional assistance with family planning referrals or family planning information.

Women's Health
Members 16 years and older may self-refer to the network OB/GYN of her choice for routine annual exams and female preventive screens (Pap smear, chlamydia, and mammogram). She may also refer to the in-network OB/GYN of her choice for prenatal/perinatal care.

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

FQHCs and RHCs are important community providers and all Buckeye's members have access to them if the member resides in a community where FQHC or RHC services are available. The Member Handbook outlines the member's rights to access an FQHC or RHC in their service area if they so desire.

For additional information and assistance in accessing a FQHC or RHC, members should be advised to contact Member Services at **1-866-246-4358**.

TRANSPORTATION

Buckeye will assure that non-emergency transportation and travel expenses determined to be required for members to secure medically necessary medical examinations and treatment are readily available and accessible.

This non-emergent transportation is available for all medical and health services deemed medically necessary by the member's primary care provider, including End Stage Renal Disease services (hemodialysis), prenatal care, preventive services, mental health services, obtaining prescription medicine and DME supplies.

Buckeye has contracted with a transportation agency that has a network capable of providing non-emergent transportation to the entire Buckeye member geographic coverage area. Information on how and when members can access non-emergent transportation is available in the Member Handbook or by calling Member Services at **1-866-246-4358**.

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 County Department of Job and Family Services (CDJFS) caseworker, as well as pharmacies following a doctor appointment.

Transportation Procedure

To arrange for these services, the member, PCP, or a Buckeye representative should call for non-emergent transportation at 1-866-531-0615 or Member Services at 1-866-246-4358.

The Non-Emergent Transportation Vendor will transport the following individuals:

- Members: All Buckeye members for all covered outpatient services
- Parents and Guardians: Parents or legal guardians of minor or incompetent members when they accompany the member to their appointment
- Others: Transportation of other family members, such as siblings, to the appointment may be allowed

Transportation will be to and from participating providers, or if explicitly directed by Buckeye, to and from non-participating providers.

Members can call directly 48 hours (two business days) in advance at 1-866-531-0615 (TDD/TTY: 1-855-823-8587) to schedule transportation.

Ambulance Services - a member or member representative can call Buckeye at 1-866-246-4358 (TDD/TTY: 1-800-750-0750), at least 24-hours in advance.

Ambulette (wheelchair) or ambulatory transportation - a member or a member representative can call the Non-Emergent Transportation Vendor at 1-866-531-0615 (TDD/TTY 1-855-823-8587) 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) is needed to facilitate the treatment needs of the member, even when the member is not being transported.

EMERGENCY SERVICES

Emergency Care Services must be accessible 24 hours a day, seven days a week. They are provided in a hospital or comparable facility in order to stabilize the member and determine the severity of the condition and the appropriate treatment of acute symptoms.

Members may access emergency services at any time without Prior Authorization from Buckeye.

Emergency services are covered by Buckeye when provided by a qualified provider, including out-of-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Buckeye.

Buckeye will not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition; or

- A representative from the Plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, Buckeye requires notification for hospital admission or Prior Authorization for follow-up care, as noted elsewhere in this manual.

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

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 5160-1-14 or access the State of Ohio website at **http://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)	Dehydrogenase Deficiency	Propionic Acidemia
Homocystinuria	Sickle Cell Disease	Methylmalonic Acidemia
Galactosemia	Maple Syrup Urine Disease	Citrullinemia
Medium-chain Acyl-CoA	Isovaleric Acidemia	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
https://odh.ohio.gov/

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.

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.

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).*

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 program is offered to members in the Buckeye. 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.

For youth enrolled in the OhioRISE program, Buckeye, in collaboration with the OhioRISE care team, will take an active role in the Child and Family-Centered Care Plan and Child and Family Team as requested.

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.

COMMUNITY CONNECTIONS

Buckeye is at work 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 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.

PHARMACY

Buckeye is committed to providing appropriate, high-quality, and cost-effective drug therapy to all Buckeye members. Pharmacy benefit coverage is through the Single Pharmacy Benefit Manager (SPBM), which is currently Gainwell. 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)

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/**.

Unified Preferred Drug List (PDL)

The Preferred Drug List (PDL) is the list of drugs covered by Buckeye. 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 MCOs 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/**. For more information, please utilize Gainwell's portal **https://spbm.medicaid.ohio.gov**.

BENEFIT MANAGER

Dental Services

Buckeye's dental benefits include:

- Extractions and fillings
- $0 copays for services
- Braces covered under the age of 21
- Two oral exams and cleanings per year
- Partials, dentures, crowns (prior authorization is required)

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

To access Centene Dental Services for provider inquiries, please call 1-844-464-5634 or visit their website at **Centene Dental Services**.

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 Centene Vision Services, who maintains a quality network of licensed providers. In addition, they also process claims for vision services.

To access Centene Vision Services, please call 1-866-442-6173 or visit their website at **Centene Vision Services**.

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.

MEMBER GRIEVANCE AND APPEALS PROCESSES

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.

A member, a member's authorized representative, or a member's provider (with written consent from the member to act on their behalf), may file a grievance with the MCO or SPBM verbally or in writing at any time. Buckeye will respond to all issues raised by members, current or former, regardless of the time that has passed.

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 for grievances about getting a bill for care the member received.
- **60** calendar days for grievances about getting a bill for care the member received.

The member also has the right at any time to file a complaint by contacting the:

Ohio Department of Medicaid
Bureau of Managed Care
P.O. Box 182709
Columbus, OH 43218-2709
1-800-605-3040 or 1-800-324-8680
TTY: 1-800-292-3572

OR

Ohio Department of Insurance
50 W. Town Street, 3rd Floor, Suite 300
Columbus, OH 43215
1-800-686-1526

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).

If a 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 respond, in writing, within 15 calendar days from the date they contacted us or **72 hours** from initial receipt for an expedited appeal.

The provider can participate in these processes on behalf of the member to challenge the failure of the MCO to cover a specific service. The member should appoint a representative to file an appeal or grievance on their behalf by submitting an Appointment of Representative Form with the request.

Members may file an appeal by doing the following:

- Call the Member Services department at 1-866-246-4358 (TDD/TTY: 1-800-750-0750), or
- Complete the Appeals and Grievances form in the Buckeye Member Handbook at **Member Handbooks and Forms**, or
- Call the Member Services department to request they mail a form, or
- Visit our website at **www.buckeyehealthplan.com** to submit via the member portal, or
- The member has the right to appoint a representative to file an appeal or grievance on their behalf. If the member desires to exercise this right they will be required to complete and submit an **Appointment of Representative Form** with their request.
- Write a letter telling us what they are unhappy about. The member must include their first and last name, the number from the front of their Buckeye member ID card, and their address and telephone number in the letter so that we can contact them, if needed. The member should also send any information that helps explain their problem.

Mail any forms/letters to:

Buckeye Health Plan
Appeals/Grievance Coordinator
4349 Easton Way, Suite 120
Columbus, OH 43219

Buckeye will send the member something in writing if we make a decision to:

- deny a request to cover a service for them
- reduce, suspend or stop services before they receive all of the services that were approved
- deny payment for a service they received that is not covered by Buckeye

We will also send something in writing if, by the date we should have, we did not:

- make a decision on whether to okay a request to cover a service for them
- give them an answer to something they told us they were unhappy about

In the event a decision cannot be made within **15 calendar days** from the date the appeal was received, the member or Buckeye may request a **14-calendar day** extension. Access **Dispute-Appeals Process** for additional information on pre-service appeals.

If we have made a decision to reduce, suspend or stop services before the member receives all of the services that were approved, their letter will tell them how they can keep receiving the services if they choose and when they may have to pay for the services.

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.

Non-Urgent Pre-Service Appeal

Members have 60 days to file an appeal from the date of the denied service. All written or verbal communication by a member regarding dissatisfaction with a decision to deny, reduce or terminate a clinical service based on medical necessity or on benefit determination is to be considered an appeal.

A provider or other authorized representative of the member such as family member, friend or attorney may file an appeal on the member's behalf with the member's written permission. The member must submit written permission to Buckeye for an authorized representative to appeal on their behalf.

Members can appeal by writing to the Buckeye Appeals Coordinator or by calling Member Services toll free at 1-866-246-4358. If members write to us, they must include a phone number where they can be reached so we can let them know that their appeal has been received.

The address to file an appeal is:

Buckeye Health Plan
Appeals Department
4349 Easton Way, Suite 120
Columbus, OH 43219

Within three days of receiving the appeal, Buckeye will notify the member of all the information that is needed to process the appeal. We will decide within 30 days of receiving the member's appeal request. We will decide within 10 calendar days for members enrolled in the Children's Special Health Care Service program. Members and their PCP, as well as any other provider involved in the appeal, will be notified of the outcome of the appeal in writing.

A provider with the same or like specialty as the treating provider will review the appeal. It will not be the same provider as the one who made the original decision to deny, reduce, or stop the medical service.

Expedited Appeals

A member or their provider may call Member Services at 1-866-246-4358 to file an expedited appeal if they think that their situation is clinically urgent and reviewing the appeal in the standard timeframe could:

- Seriously jeopardize the life or health of the member or the member's ability to regain maximum function based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the member's medical condition
- Would subject the member to severe pain that cannot be adequately managed without the care or treatment

The member will need confirmation from their provider that the appeal is urgent. Within 24 hours of receiving the appeal, Buckeye will notify the member of all the additional information that is needed to process the appeal. We will decide about the appeal within 72 hours of receiving the expedited appeal request.

The member and their PCP, as well as any other provider involved in the appeal, will be notified verbally of the outcome of the appeal. A written notification will follow.

State Fair Hearing

Buckeye will notify the member of their right to request a state hearing when:

- a decision is made to deny services
- a decision is made to reduce, suspend, or stop services before all of the approved services are received
- a provider is billing them because Buckeye has denied payment of the service
- a decision is made to propose enrollment or continue enrollment in the Buckeye Controlled Substances and Member Management (CSMM) program
- a decision is made to deny their request to change their Buckeye Controlled Substances and Member Management (CSMM) provider

At the time Buckeye makes the decision or is aware that the provider is billing the member for payment, we will mail the member a state hearing form. If the member wants a state hearing, they must request a hearing within **90** calendar days. The 90-calendar day period begins on the day after the mailing date on the hearing form. If we have made a decision to reduce, suspend, or stop services before all of the approved services are received and the member requests the hearing within **15** calendar days from the mailing date on the form, we will not take the action until all approved services are received or until the hearing is decided, whichever date comes first. The

member may have to pay for services they receive after the proposed date to reduce, suspend, or stop services if the hearing officer agrees with our decision.

State hearing decisions are usually issued no later than **70** calendar days after the request is received. However, if the MCP or Bureau of State Hearings decides that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed, but no later than **3** working days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

To request a hearing, the member can sign and return the state hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748, or submit their request via e-mail at **bsh@jfs.ohio.gov**. A state hearing is a meeting with the member, someone from the County Department of Job and Family Services, someone from Buckeye and a hearing officer from the Ohio Department of Job and Family Services. Buckeye will explain why we made our decision, and the member will tell why they think we made the wrong decision. The hearing officer will listen and then decide who is right based upon the information given and whether we followed the rules. If the member wants information on free legal services but doesn't know the number of their local legal aid office, they can call the Ohio State Legal Services Association at 1-800-589-5888, for the local number.

Continuation of Services

When an appeal or state fair hearing is requested, we will automatically continue the members' benefits if all of the following occur:

- The member files the request for an appeal timely.
- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired; and
- The member timely files for continuation of benefits.

Section VII - Utilization Management

OVERVIEW

Buckeye's Utilization Management (UM) program is designed to ensure members receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members, age categories, and range of diagnoses. It provides for aggregate and individual analysis and feedback of providers and plan performance in providing access to care, the quality of care provided to members, and utilization of services. Buckeye incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, maternity care, and ancillary care.

Buckeye seeks to optimize a member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. Buckeye aims to provide services that are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and that meet professionally recognized standards of care.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under- utilization.
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.

- Identification and provision of care and/or population management for members at risk for significant health costs or ongoing care.
- Development of an infrastructure to ensure members establish relationships with their PCPs to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self-management.
- Creation of partnerships with members/providers to enhance cooperation and support for UM goals.

Access to the Utilization Management Staff

For Utilization Management inquiries, you may call during normal business hours Monday through Friday between 8 a.m. and 5 p.m. at 1-866-246-4359. The provider portal is available 24/7 to view status authorization requests and submit new requests.

Medically Necessary

Medically Necessary means a service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability such that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.
- Will, or is reasonably expected to, reduce, or ameliorate the physical, mental, or developmental effects of an illness, condition or disability.
- Will assist the member in achieving or maintaining maximum functional capacity in performing daily activities, taking into account both the functional capacity or the member and those functional capacities are appropriate for members of the same age.

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caretaker, and the PCP, as well as any other providers, programs, and agencies that have evaluated the member.

All such determinations must be made by qualified and trained healthcare providers.

Review Criteria

Utilization decisions are based on appropriateness of care and service, as well as the member's eligibility. Buckeye does not specifically reward our providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

Utilization Management staff refer to plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by Buckeye's medical directors. These guidelines include McKesson InterQual® criteria, Buckeye's Medical Review Criteria (developed by Buckeye's medical directors in conjunction with community providers), and applicable federal and state benefit guidelines.

Buckeye's Medical Necessity Guidelines are based on current literature review, consultation with practicing providers and medical experts in their particular field, government agency policies, and standards adopted by national accreditation organizations. It is the responsibility of the attending provider to make all clinical decisions regarding medical treatment. These decisions should be made consistent with generally accepted principles of professional medical practice and in consultation with the member.

Copies of the criteria utilized in decision-making are available free of charge upon request by calling the Utilization Management department at **1-866-246-4359**. In certain circumstances, an external review of service requests is conducted by qualified, licensed providers with the appropriate clinical expertise.

Utilization management decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the member's eligibility and benefits at the time the services are rendered. Previously approved prior authorizations can be updated for changes in dates of service, CPT/HCPCS codes, or physician within 30 days of the original date of service prior to claim denial.

PRIOR AUTHORIZATIONS

Failure to obtain the required prior authorization for a service may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions, as described in applicable plan coverage guidelines. All out-of-network services require prior authorization (excluding ER and family planning).

Buckeye providers are contractually prohibited from holding any Buckeye member financially liable for any service administratively denied by Buckeye for payment due to the provider's failure to obtain timely Prior Authorization.

Services Requiring Prior Authorization

Prior Authorizations are required on some services for the provider to be reimbursed. Please visit the **Provider Home Page** and use the Prior Authorization **Pre-Auth Check** tool to determine if a service requires prior authorization. **Please verify requirements at the time of the request.**

Buckeye verifies benefit eligibility and medical necessity for select services at the time of the request and is not a guarantee of coverage or payment. Payment is determined by the member's eligibility and benefits at the time of service.

Classifying Your Prior Authorization Request

Standard Organization Determination (Non-urgent Preservice Request): Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than 7 calendar days after Buckeye receives the request for service.

Expedited Organization Determination (Urgent/Expedited Preservice Request): Expedited organization determinations are service request made when the member or the provider believes that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The service request will be made as expeditiously as the Member's health condition requires, but no later than 48 hours after Buckeye receives the request for services.

Expedited requests will require provider attestation as to the urgency of the request.

Inpatient Review

Our nurse reviewers are assigned to follow members at specific acute care facilities to promote collaboration with the facility's review staff and management of the member across the continuum of care. Buckeye nurse reviewers assess the care and services provided in an inpatient setting and the member's response to the care by applying InterQual® criteria. Together, with the facility's staff, Utilization Management's clinical staff coordinates the member's discharge needs.

Buckeye nurse reviewers' interface with the hospital/facility discharge planners to:

- Obtain the member's discharge planning needs
- Identify the member's discharge planning needs
- Facilitate the transition of the member from one level of care to another level of care
- Obtain clinical information and facilitates the authorization of post discharge services, such as DME, home health services, and outpatient services

Providers must notify Buckeye within **one business day** of admission.

Inpatient Psychiatric Prior Authorization

Inpatient psychiatric prior authorization requests for members under the age of 21 should be submitted to the OhioRISE Plan. Buckeye will deny these authorization requests because this service is covered by another payer.

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.

What Services Require Authorization?

The Prior Authorization **Pre-Auth Check** tool located on Buckeye's website at **Provider Home Page** may be used to assist providers in understanding what services require authorization.

1. All Inpatient admission or inpatient procedures require a Prior Authorization.
2. To determine if an outpatient service needs prior authorization use Buckeye's **Prior Authorization Prescreen Tool** on our website at **Provider Home Page.**
3. 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. Authorization requests should be submitted via our **Secure Provider Portal** or **Availity** beginning **July 1, 2025**, and should include all necessary clinical information.
    c. For Medicaid **Urgent requests** for prior authorization can be entered in the portal or faxed in as soon as the need is identified at **866-529-0291**.
4. All Continued stay Inpatient clinical and discharges can be faxed to **866-529-0290**.
5. All **SNF, LTAC and Rehab requests** should be submitted via our **Secure Provider Portal** or **Availity** beginning **July 1, 2025**, and should include all necessary clinical information. All continued stay clinical and discharges can be faxed to **866-529-0291**.

When submitting a Prior Authorization request, please include the following information:

- Member's name and date of birth
- Member's identification number
- Requesting Provider & NPI Number
- Servicing Provider & NPI Number
- Servicing Facility & NPI Number
- Place of Service
- Date(s) of service
- Procedure Code(s)
- ICD-10 Diagnosis Code(s)

Clinical Information

Clinical information should be provided at time of submission of the request. The provider or facility is responsible for ensuring services are authorized prior to service delivery. Buckeye provides a reference number for all authorizations. To ensure a timely decision, make sure all supporting clinical information is included with the initial request:

Clinical information includes relevant and current information regarding the members':

- History of presenting problem
- Physical assessment
- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Member's response to treatment

Requesting Prior Authorization

Authorization requests should be submitted via our **Secure Provider Portal** or **Availity** beginning **July 1, 2025**, and should include all necessary clinical information.

Medicaid **Urgent requests** for prior authorization can be entered in the portal or faxed in as soon as the need is identified at **866-529-0291**.

All continued stay inpatient clinical and discharges can be faxed to **866-529-0290**.

All **SNF, LTAC and Rehab requests** should be submitted via our **Secure Provider Portal** or **Availity** beginning **July 1, 2025**, and should include all necessary clinical information. All continued stay clinical and discharges can be faxed to **866-529-0291**.

Prior Authorization requests may take 24-48 hours to display on the Authorization list.

Submitted authorizations display for 90 days.

Prior Authorization Determination Timeframes

Buckeye medical Prior Authorization decisions are made as expeditiously as the member's health condition requires but shall not exceed the timeframes listed below in accordance with OAC rule 5160-58-03.1 and ORC 5160.34.

Type	Timeframe	Extension
Expedited Preservice/Urgent	48 hours after receipt of the request	May be extended up to 14 additional calendar days
Standard Preservice/Non-Urgent	Within 7 calendar days following receipt of the request	May be extended up to 14 additional calendar days

Evolent Authorizations

Evolent is partnering with Buckeye to provide several specialty programs for prior authorization review. Evolent now contains two legacy partners: New Century Health (NCH) and National Imaging Associates, Inc. (NIA).

The former NIA delegation will include the following programs: Advanced Diagnostic Imaging, Physical Medicine, Interventional Pain Management (IPM), and Musculoskeletal Care Management (MSK).

The former NCH delegation will include the following programs: Interventional Cardiology and Oncology (both medical and radiation oncology)

For Evolent / NIA prior authorization requests **RadMD.com** should be used to obtain on-line authorizations. For urgent authorization requests please call **1-800-424-5388**.

For Evolent / NCH prior authorization requests, please route all requests to **my.newcenturyhealth.com** or by calling **1-800-424-5388**, option 1.
For more information call our Provider Services department at **1-866-296-8731**.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Buckeye is using Evolent (formerly NIA) to provide prior authorization services and utilization management for advanced imaging and radiology services. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MRI/MRA
- PET

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization;
- It is the responsibility of the ordering physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

To reach Evolent and obtain authorization, please call **1-800-642-6551** and follow the prompt for radiology authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations.

Please visit **RadMD.com** for more information or call our Provider Services department at **1-866-296-8731**.

Cardiac Solutions

Buckeye, in collaboration with Evolent, will launch a cardiac imaging program to promote health care quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts.

Our guidelines are transparent and available throughout our programs. Evolent also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?
Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed
- Quality assessment of imaging providers to ensure the highest technical and professional standards

How the Program Works
In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through Evolent:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call **1-800-642-6551** and follow the prompt for radiology and cardiac authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit **RadMD.com** for more information.

Physical Medicine Program

To help ensure that physical medicine services (physical and occupational therapy) provided to our members are consistent with nationally recognized clinical guidelines, Buckeye has partnered with Evolent (formerly NIA) to implement a prior authorization program for physical medicine services. Evolent provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Buckeye members.

How the Program Works
Outpatient physical, occupational and speech therapy requests are reviewed by Evolent's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through Evolent.

Home Health providers submitting claims using codes other than the designated initial evaluation CPT codes for the initial evaluation should request an authorization within Buckeye's retro authorization guidelines. There is no need to send patient records in advance. Evolent will contact the provider via phone and fax if additional clinical information is needed to complete the request. If clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under the terms of the agreement between Buckeye and Evolent, Buckeye oversees the Evolent Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the patient will receive notice of the coverage decision. Should you have questions, please contact Buckeye Provider Services at **1-866-296-8731.**

Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through Buckeye. To obtain authorization through Evolent, visit **RadMD.com** or call **1-800-424-5388**.

Musculoskeletal (MSK) Management Program

The MSK program currently requires prior authorization for non-emergent outpatient, interventional spine pain management services (IPM), and will be expanded to include spinal cord stimulators, and inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries for our members. The decision to implement this latest program is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Under the terms of this agreement:

- We will oversee the MSK program and continue to be responsible for claims adjudication and medical policies.
- Evolent will manage IPM services*, and inpatient and outpatient MSK surgeries through the existing contractual relationships with us.

It is the responsibility of the ordering physician to obtain prior authorization for all IPM procedures and MSK surgeries managed by Evolent. Evolent does not manage prior authorization for emergency MSK surgery cases that are admitted through the emergency room or for MSK surgery procedures outside of those procedures listed above.

The ordering physician must obtain prior authorization with Evolent prior to performing the surgery/procedure. Facility admissions do not require a separate prior authorization. However, the facility should ensure that an Evolent prior authorization has been obtained prior to scheduling the surgery/procedure.

MSK surgeries other than those outlined above will continue to follow prior authorization requirements for hospital admissions and elective surgeries as outlined for the Buckeye line of business.

SECOND OPINION

Members or a healthcare professional, with the member's consent, may request and receive a second opinion from a qualified professional within the Buckeye 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 and in-network providers require Prior Authorization when performing second opinions.

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 the Buckeye population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management Department at 1-866-246-4359.

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.

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.

RETROSPECTIVE REVIEW

Buckeye, as required by OAC rule 5160-26-03.1and ORC section,3923.041(B)(9)(a) 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 was not known at the time of the services
- Retrospective knowledge of the Buckeye 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.

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 member 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 member'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*.**

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.

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 member'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.

PEER TO PEER CONSULTATIONS

Providers may request a peer-to-peer consultation when the MCO denies a prior authorization request. The peer-to-peer consultations will be conducted amongst health care professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. The peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines.

In the event of an adverse determination, a physician involved with the member'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.

PROVIDER APPEALS

Providers may request a provider appeal if the MCO denies a prior authorization request in accordance with ORC 5160.34. The provider appeal is separate from the peer-to-peer or member appeal processes. Provider appeals will be responded to within forty-eight hours for urgent care services and within ten calendar days for all other matters.

Providers may request preservice appeals or Medical Necessity/Level of Care Disputes regarding Buckeye's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of Medical Necessity or Level of Care. The provider appeal is separate from the peer-to-peer or member appeal process.

Any preservice provider appeals should include supporting member and clinical information/documentation and can be made through the Buckeye **Secure Provider Portal**, by fax, verbally or by mail to:

Buckeye Health Plan
Appeals/Grievance Department
4349 Easton Way Suite 120
Columbus, OH 43219
1-866-246-4358 (TTY: 711) phone
1-866-719-5404 fax

For medical necessity/level of care disputes, please see the Claim Dispute **Section VIII** of the provider Manual.

Medical Management Appeal Definitions for Appeals and Denials

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

Pre-Service Provider Appeal

A pre-service appeal is the request for review of a "Notice of Adverse Action."
A "Notice of Adverse Action" is the denial or limited authorization of a requested service, including the:

- Type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or part of payment for a service excluding technical reasons.
- Failure to render a decision within the required timeframes.
- Denial of a member's request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the Buckeye network.

A pre-service appeal should not have a previously submitted claim to Buckeye that has been paid or denied. Pre-service appeals are items that require clinical review, and no claim has yet to be submitted.

Post-Service Medical Necessity Claim Dispute

A Post Service Medical Necessity Claim Dispute is available to the provider when they disagree with Buckeye's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity or level of care.

A post-service medical necessity claim dispute should have a previously submitted claim to Buckeye that has either been paid or denied. Please see **Section VIII** of the provider manual for additional provider dispute guidelines.

External Medical Review

A provider who disagrees with Buckeye's determination on a dispute to deny, limit, reduce, suspend, or terminate a covered service for lack of Medical Necessity or Level of Care may request an External Medical Review with **Permedion.** Refer to the **External Medical Review** Section below.

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?

For pre-service member appeals, a member or an authorized representative of a member may appeal an adverse determination. This can be the member, doctor, or other service provider such as a physical therapist.

Written consent is required if the provider is appealing on behalf of the member or assisting the member in the appeals process. If the provider is assisting a member to file a pre-service appeal, please visit: **Appointing a Representative**.

For additional information on member appeals, please refer to the **Member Grievance and Appeals Processes** within this manual.

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 by phone 866-246-4358 (TTY: 711) or by fax 866-719-5404.

For pre-service provider appeals, requesting providers can appeal on their own behalf without written consent from the member.

What are the Timeframes?

Time Limit for Provider to Request a Pre-Service Appeal

The appeal review may be requested in writing or verbally within 60 calendar days from date of the Notice of Adverse Action. Members may request Buckeye to review the "Notice of Adverse Action" to verify if the right decision has been made.

Resolution Timeframes for Pre-Service Provider Appeals (without Appointment of Representative)

- **Standard Provider appeal** decisions are issued within 10 days from date of receipt of the appeal request.

- **Expedited Provider appeal** decisions are issued as expeditiously as the member's health condition requires, to not exceed 48 hours from the initial receipt of the appeal.
    - **Expediting Provider pre-service appeal** is when either Buckeye or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. If the request for expedited appeal is denied, the appeal must be transferred to the timeframe for standard appeal resolution.

- **14 Calendar Day Extension** may be added by Buckeye is applied for both standard and expedited pre-service appeals:
    - If the member or provider requests the extension, or
    - If Buckeye provides evidence satisfactory to the Ohio Department of Medicaid that a delay in rendering the decision is in the member's interest.
    - For any extension not requested by the member:
        - Buckeye will provide written notice of the reason for delay to the member.
        - Buckeye will make reasonable efforts to provide the member with prompt verbal notice of any decisions not resolved wholly in favor of the member and will follow-up in writing within two calendar days of action.

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.

EXTERNAL MEDICAL REVIEW

External Medical Review (EMR) –The review process conducted by an independent, external medical review entity that is initiated by a provider who disagrees with a managed care organizations (MCO's) decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.

In the Next Generation Medicaid managed care program, the EMR will be conducted by Permedion. This vendor has a contract with ODM to perform the EMR.

To request an EMR, providers must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the MCO's internal provider appeal or claim dispute resolution process. Failure to exhaust the MCO's internal appeals or claim dispute resolution process will result in the provider's inability to request an EMR.

EMR is only available to providers for services delivered to members enrolled in Medicaid managed care and/or OhioRISE. The EMR process is not currently available in the MyCare Ohio and Single Pharmacy Benefit Manager (SPBM) programs.

An EMR can be requested by a provider as a result of:

- An MCO's service authorization denial, limitation, reduction, suspension, or termination (includes pre-service, concurrent, or retrospective authorization requests) based on medical necessity; or
- An MCO's claim payment denial, limitation, reduction, suspension, or termination based on medical necessity.

Denials, limitations, reductions, suspensions, or terminations based on lack of medical necessity include, but are not limited to decisions made by the plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent, and retrospective reviews).
- Clinical judgement or medical decision making (i.e., referred to a licensed practitioner for review) is involved.
- A clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC 5160-1- 01, including EPSDT criteria, and/or the MCO's clinical coverage or utilization management policy or policies) is not met.

MCOs are required to notify providers of their option to request an EMR.

Requesting EMR:

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or provider claim dispute process has been exhausted.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located at **www.hmspermedion.com** (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from MCO (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing case.

Providers must upload the request form and all supporting documentation to Permedion's provider portal located at **https://ecenter.hmsy.com/** (new users will send their documentation through secured email at **IMR@gainwelltechnologies.com** to establish portal access).

Note: When requesting an EMR, providers may submit new or other relevant documentation as part of the EMR request.

If the MCO determines the provider's EMR request is not eligible for an EMR and the provider disagrees, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with the provider's 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.

Once the provider has submitted the EMR request, they do not need to take further action.

The EMR Review:

After the EMR request has been submitted, Permedion will share any documentation from the provider with the MCO. Following its review of this information the MCO may reverse its denial, in part or in whole. If the MCO reverses any part of its decision the provider will receive a written decision within one business day for expedited prior authorization requests and 5 business days for standard prior authorization requests and notify the EMR entity. If the MCO decides to reverse its decision in part, the remaining will continue as an EMR.

Permedion has 30 calendar days for a standard request and three business days for an expedited request to perform its review and issue a decision.

- If the decision reverses the MCO's coverage decision in part or in whole, that decision is final and binding on the MCO.
- If the decision agrees with the MCO's decision to deny, limit, reduce, suspend, or terminate a service, that decision is final.

For reversed service authorization decisions, the MCO must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the MCO receives the EMR decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the MCO must pay for the disputed services within the timeframes established for claims payment in Appendix L of the **Provider Agreement**.

For more information about the EMR, please contact Permedion at 1-800-473-0802, and select Option 2.

Section VIII - Claims Information

Buckeye Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with Buckeye for claims processing and payment.

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.

It is important for providers to ensure Buckeye has accurate billing information on file. Please confirm with Provider Services at **1-866-296-8731** that the following information is current in our files:

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

Buckeye will return claims when billing information does not match the information 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.

Providers are encouraged to notify Buckeye in advance of billing information changes. Please submit updated information on a W-9 form. Changes to a Provider's Tax Identification Number and/or address are **not acceptable** when conveyed via claim form or dispute.

CLAIMS SUBMISSION

ODM Provider Network Management System Direct Data Entry

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

Electronic Data Interchange (EDI) Submission of Provider Claims

Providers may submit claims, 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

PNM System Consistency

ODM expects that for each Medicaid provider, Buckeye's system and data are current and consistent with ODM's system of record, the PNM system. Therefore, it is important that providers keep their records up to date in ODM's PNM system. With the PNM system as the ODM's system of record, MCOs have been instructed to direct providers to update their ODM record in the PNM system when discrepancies are identified between the MCO's data and the PNM PMF. Buckeye is instructed by ODM to not accept changes from providers into their own systems that are inconsistent with PNM system data shared through the PNM for their Medicaid line of business.

Submission Methods

On February 1, 2023, the Electronic Data Interchange (EDI) launched along with the **Fiscal Intermediary (FI)** as part of the Next Generation of Ohio Medicaid program. The EDI is the exchange point for trading partners on all claims-related activities, providing transparency and visibility regarding care and services. The FI facilitates the processing of claims via the EDI. Any new or corrected billing claims should be submitted via ODM's FI/OMES system to be routed to Buckeye for processing, adjudication, and payment.

If the provider does not have access to the FI/OMES system, they may still submit the claims via direct data entry through Buckeye's **Secure Provider Portal** or **Availity**.

Claims must include the Medicaid Member ID (MMIS) and should be obtained for each encounter.

For professional claims, only one rendering provider is allowed per claim. Individual claims must be submitted for services rendered by different providers.

ODM Fiscal Intermediary / OMES System

First-time or corrected billing claims may be submitted through ODM's **Fiscal Intermediary** (OMES) system to one of the following Payer IDs (**Preferred/Fastest Option**)

PAYER ID
0004202 – Buckeye Ohio Medicaid (837 P & I only)
V004202 – Buckeye / Envolve Vision
D004202 – Buckeye / Envolve Dental (837 Dental)

Note: Per ODM, Buckeye will not accept claims via 837I or 837P batch submissions. Batch claims must be submitted through ODM's Fiscal Intermediary/OMES system.

Secure Provider Portal or Availity

Providers may submit individual first-time or corrected billing claims via the Buckeye **Secure Provider Portal** or **Availity**.

Paper Claims

Effective January 1, 2026, Buckeye will no longer accept paper claims for the Medicaid product.

ELECTRONIC CLAIMS SUBMISSION

Electronic Claims and EDI Information

Electronic Data Interchange (EDI) is a computer-to-computer exchange of claims data in standardized formats that comply with HIPAA requirements.

Benefits of EDI Submission

- Faster claims processing
- Ability to track and confirm submission and receipt
- Fewer errors and reduced administrative expense
- Reduced accounts receivable days
- Elimination of paper secondary claims

File Format and Support

Centene Corporation can receive ANSI X12N 837 professional, institutional, or encounter transactions and generate ANSI X12N 835 electronic remittance advices (EOP).
For questions about electronic claim rejections, contact:

Centene EDI Department
1-800-225-2573 ext. 6075525
EDIBA@centene.com

Providers billing electronically must monitor error reports and payment files to ensure all claims appear on the reports. Providers are responsible for correcting and resubmitting any errors.

EDI Vendors

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

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

Buckeye (in partnership with PaySpan®) has implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

Once a Provider has registered, this no-cost secure service offers Providers a number of options for viewing and receiving remittance details. ERAs can be imported directly into practice management or patient accounting systems, eliminating the need to rekey remittance data. Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

EOPs can be viewed and/or downloaded and printed from PaySpan's website, once registration is completed. Providers can register using PaySpan's enhanced Provider registration process at **payspanhealth.com**.

Providers can access additional resources by clicking *Need More Help* on the PaySpan homepage. PaySpan Health Support can be reached via email at **Providersupport@payspanhealth.com**, or by phone at **1-877-331-7154** or on the web.

Clean and Non-Clean Claims

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 external sources. Such claims have no defect, impropriety, or missing documentation that prevents timely payment.

Non-Clean Claims require further investigation or development beyond the information contained therein. Examples include missing or invalid data, required medical records, or payment issues related to medical necessity or filing limits.

Identification and Coding Requirements

Buckeye requires the payer-issued Tax Identification Number (TIN) and National Provider Identifier (NPI) on all claim submissions, except for atypical providers (providers that do not provide healthcare services and instead provide services such as home and vehicle modifications, taxi services, and respite care). Atypical providers must pre-register with Buckeye before submitting claims to avoid NPI rejections.

Claims without the TIN or NPI will be rejected and will not qualify as clean claims.
Your Ohio Medicaid ID number is required for all claim submissions. Any claims not submitted with this information will be rejected.

Common Billing Errors

- Use specific CPT-4 or HCPCS codes (avoid nonspecific or "catch-all" codes).
- Use current CPT-4 and HCPCS codes.
- Use required 4th or 5th digits on ICD-10 codes.
- Submit claims with complete member Medicaid ID (MMIS).
- Verify other insurance information.
- Do not submit handwritten, photocopied, or faxed claims.

Billing Codes

Providers must bill with codes applicable to the date of service. Billing with obsolete codes will result in claim denial. Professional claims must include current CPT-4, HCPCS, and ICD-10 codes; institutional claims must include valid revenue codes and DRG codes when applicable.

TIMELY CLAIMS SUBMISSION

Providers will have **365 days** to timely file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19.

Unless otherwise stated in the Provider Agreement, participating providers must submit clean claims (initial, corrected, and voided) within 365 days from the date of service or discharge.

Buckeye may deny payment for claims that fail to meet these requirements. A provider whose claim is denied as described in this paragraph must not bill or accept payment from the member.

Special Billing Circumstances

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/attestation will result in denial

Consent forms can be found on our **Provider Home Page** under:
Manuals, Forms and Resources > Forms.

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 member's "Medicaid Billing Number" is the member'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 member must be 21 years old, mentally competent, and not in an institution at the time he/she signed the consent form.
- The member's signature must be in the member's own handwriting.
- The date the person obtains consent must be the same as the date the member signed for consent.
- The date of sterilization must be 30 days after the date the member 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 member.

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 member 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.

Code Auditing

Buckeye uses HIPAA-compliant code-auditing software to improve accuracy and efficiency in claims processing, payment, and reporting. The software detects, corrects, and documents coding errors on provider claims prior to payment.

The software analyzes:

- HCPCS Level I/CPT-4 codes – 5-digit numeric codes for medical services.
- HCPCS Level II codes – alpha-numeric codes for ambulance services, medical equipment, supplies, and prosthetics.
- CPT Category II codes ("F" codes for tracking purposes).
- CPT Category III codes ("T" codes for new and emerging technologies).

All are compared against coding guidelines established by the American Medical Association (CPT, CPT Assistant, CPT Insider View) and the Centers for Medicare & Medicaid Services (CMS).

Reimbursement decisions continue to be based on fee schedules and contract agreements between the provider and Buckeye.

While the code-auditing software is designed to evaluate the accuracy of coding, it does **not** evaluate medical necessity. Buckeye may request medical records or other documentation to determine medical necessity or to review procedure billing accuracy.

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 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 will recover all amounts paid for the services in question.

Buckeye 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 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 will seek recovery of all overpayments. Depending on the number of services provided during the review period, Buckeye 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).

Prompt Payment

Buckeye will process claims in accordance with the terms of your Provider agreement. We make it a top priority to process claims within 30 calendar days.

Rate Updates

Buckeye implements and prospectively applies changes to its fee schedules and CMS changes to Medicare fee schedules as of the later of:

- The effective date of the change; or
- Forty-five (45) days from the date CMS publishes the change on its website; or
- Twenty (20) calendar days of being notified by ODM of the change.

Rate changes are not applied retroactively to claims that have already been processed.

Payment In Full Information

*(OAC 5160-1-13.1 – link: **https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-13.1**)*

(A) In accordance with 42 CFR 447.15, the Medicaid payment for a covered service constitutes **payment-in-full**. It shall not be construed as partial payment even when the amount is less than the provider's charge.

1. The provider shall not collect or bill a Medicaid recipient for any difference between the Medicaid payment and the provider's charge, nor charge any deductible, coinsurance, co-payment (other than as defined in OAC 5160-1-09), missed-appointment fee, or other similar charge.
2. The provider shall not charge a Medicaid recipient any down payment, refundable or otherwise.
3. Should an individual become eligible for Medicaid after the date of service and the eligibility span includes that date, the individual is not financially responsible.

(B) A Medicaid recipient cannot be billed when a Medicaid claim has been denied for any of the following reasons:

1. Unacceptable or untimely submission of a claim;
2. Failure to request prior authorization; or
3. A retroactive finding by a peer review organization that a rendered service was not medically necessary.

(C) A provider may bill a Medicaid recipient in lieu of submitting a claim to ODM only if all of the following conditions are met:

1. The provider explains that the service is covered by Medicaid and that other Medicaid providers may render the service at no cost;
2. Prior to each date of service, the provider notifies the recipient in writing that the provider will not submit a claim to ODM;
3. The recipient agrees in writing to be liable for payment of the service before the service is rendered; and
4. The covered service is not a prescription for a controlled substance.

(D) Services that are not covered by Medicaid, including those requiring prior authorization that have been denied by ODM, may be billed to the recipient when the conditions in paragraphs (C)(2) to (C)(4) are met.

(E) Any individual not covered by Medicaid on the date of service is financially responsible for those services unless the individual qualifies for the Hospital Care Assurance Program (HCAP).

Billing the Member

Except for member co-payments, Buckeye has elected to implement in accordance with OAC rules 5160-26-05 and 5160-26-12, that Buckeye will make a payment for any covered services that constitutes payment-in-full, and the providers are not to charge members or ODM any additional co-payment, cost sharing, down payment, or similar charge, refundable or otherwise.

Pursuant to OAC rule 5160-26-05, any subcontractors and providers are not to bill members any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing).

CLAIMS PAYMENT DISPUTES

Provider claim disputes are any provider inquiries, complaints, appeals, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial.

Providers may file a claim dispute within 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.

Providers may submit claim disputes verbally or in writing, including through the provider portal.

Provider Claim Dispute Process

Buckeye has established a Provider Claim Dispute Process which offers a method for providers to appeal or dispute a denial or underpayment of services rendered to Buckeye members. This includes denials or underpayments related to an authorization denial, or the reduction, suspension, or termination of a previously authorized service.

This process is available to all providers, whether participating (in-network) or non-participating (out-of-network).

Types of Provider Disputes

The Provider Claim Dispute process may be used for the following three main types of issues. The appropriate issue should be indicated on the cover form to ensure proper routing and processing.

Post-Service Provider Appeal
An appeal of services denied or reduced because they did not meet a specific clinical criterion, policy, or guideline and have a denied authorization on file. Example: The provider disagrees with a Buckeye determination combining two inpatient stays as a 15-day readmission. The provider should submit additional supporting documentation (such as medical records).

Administrative Appeal
An appeal of services denied for failure to obtain prior authorization within required timeframes. The provider must explain the circumstances and provide justification for why an exception should be considered.

Claim Dispute
A dispute of a payment determination after a claim has been adjudicated, which is not related to medical necessity or denial of authorization. Examples include disputes related to timely filing, coding denials, or payment amount.

Timelines for Filing

First-Time Claims or Corrected Billing Claims
Providers will have 365 days from the date of service to file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code rule 5160-1-19.

Claim Disputes
Must be submitted within 12 months from the date of service or hospital discharge, or 60 days from the date of the electronic remittance (EOP)—whichever is later.

Eligibility for a Claim Dispute

To qualify as a valid claim dispute, a claim must have been previously submitted and either paid or denied. Claims that have never been submitted do not qualify for dispute.

Provider disputes do not include inquiries submitted through ODM's Provider Web Portal (HealthTrack).

How to File a Provider Appeal or Dispute

For the fastest turnaround times and real-time tracking, providers are strongly encouraged to submit claim disputes through the **Secure Provider Portal**.

Option 1 – Secure Provider Portal (Preferred/Fastest Method)

Providers may submit individual claim disputes directly through the Secure Provider Portal by selecting **"Dispute Claim."**

To submit a claim dispute via the Secure Provider Portal:

1. Navigate to the **Secure Provider Portal**.
    - New users can create an account using the *Create Account* link on the login page.
2. Once logged in, select the **"Claims"** tab located at the top of the page.
3. Search for the relevant claim number and select the claim from the results list.
4. Click **"Dispute Claim."**
5. Select one of the following options based on the type of dispute:
    - **Option 1:** Disputes **not related to Medical Necessity or Level of Care**.
    - **Option 2:** Disputes **requiring review for Medical Necessity or Level of Care**. These must include the appropriate appeal form based on the claim's Date of Service.

Forms are available under **Provider Resources > Forms** on Buckeye's **Provider Home Page**.

Option 2 – Phone

Providers may also contact **Buckeye Provider Services** to submit a dispute or request assistance at: **1-866-296-8731** Monday through Friday, 8:00 a.m. to 8:00 p.m. (EST)

Option 3 – Mail

Providers preferring to submit a paper dispute may mail documentation to the appropriate address listed below:

Medical Dispute Address:

Buckeye Health Plan
Attention: Dispute Department
P.O. Box 6200
Farmington, MO 63640-3800

Behavioral Health Dispute Address:

Buckeye Health Plan
Attention: BH Dispute Department
P.O. Box 6150
Farmington, MO 63640-3800

Information Required for a Dispute Submission

Providers should include or have available:
- Servicing provider's name
- Member name and ID number
- Date of birth
- Date of service
- Claim number
- Supporting documentation (medical records, EOBs, or appeal forms as applicable)

Dispute Review and Resolution Process

Buckeye will thoroughly investigate each provider claim dispute using applicable statutory, regulatory, and contractual provisions, collecting all relevant facts from all parties and applying written policies and procedures.

Buckeye will provide written notice to the provider of the disposition of all claim disputes once a resolution has been determined, but no later than 30 business days after receipt.

Written notice will not be sent if the dispute is resolved during an initial phone call or in-person contact.

Once a resolution has been determined, Buckeye will reprocess and uphold or pay the associated claim as needed within 30 calendar days from written notice of resolution.

Providers can view and track disputes through the **Secure Provider Portal**, which displays the date received, claim details, member and provider data, previous outcomes, and status of the dispute.

Corrected Billing Claims

Any new or corrected billing claims should be submitted via ODM's FI/OMES system to be routed to Buckeye for processing, adjudication, and payment.

If the provider does not have access to the FI/OMES system, corrected claims may be submitted via the Buckeye **Secure Provider Portal**.

To submit a corrected claim via the Portal:

1. Go to the **Secure Provider Portal** (create an account if new).
2. Once logged in, select the "Claims" tab.
3. Search for the original claim number and open the claim details.
4. Select "Correct Claim" to replace the original claim and resubmit it for processing.

Claim Status Inquiries

Providers may check the status of previously submitted claims by:

- Contacting Buckeye Provider Services at 1-866-296-8731 (Mon–Fri, 8 a.m.–8 p.m. EST); or
- Checking claim and dispute status via the **Secure Provider Portal** or **Availity**.

External Medical Review

After exhausting Buckeye's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of this manual.

Section IX – Care Coordination/Care Management

Buckeye uses a multi-disciplinary Integrated Care Team to offer and coordinate care. Our staff coordinates care with all the necessary individuals on the member's care team, including the member's primary and specialty providers, other care team members, and those identified as having a significant role in the member's life, as appropriate.

Our goal is to help each, and every Buckeye member achieve the highest possible levels of wellness, functioning, and quality of life, while demonstrating positive clinical results. Integrated care is an integral part of the range of services we provide to all members. Through this, we continually strive to achieve optimal health status through member engagement and behavioral change motivation using a comprehensive approach that includes:

- Strong support for the integration of both physical and behavioral health services.
- Assisting members in achieving optimum health, functional capability, and quality of life.
- Empowering members through assistance with referrals and access to available benefits and resources.
- Working collaboratively with members, family and significant others, providers, and community organizations to assist members using a holistic approach to care.
- Maximizing benefits and resources through oversight and cost-effective utilization management.

- Rapid and thorough identification and assessment; especially members with special healthcare needs.
- A team approach that includes staff with expertise and skills that span departments and services.
- Information technologies that support care coordination within plan staff and among a member's providers and caregivers.
- Multifaceted approach to engage members in self-care and improve outcomes.
- Continuous quality improvement processes that assess the effectiveness of integrated care and identify areas for enhancement to fully meet member priorities.
- Assessment of member's risk factors and needs.
- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members understand treatment recommendations.
- Active coordination of care for members with coexisting behavioral and physical health conditions; residential; social and other support services where needed.
- Development of an integrated plan of care.
- Referrals and assistance to community resources and/or behavioral health providers.

The model emphasizes direct member contact (i.e., telephonic out-reach; face-to-face meetings; and written educational materials). In some circumstances, face-to-face education is preferred because it more effectively engages members, allows staff to provide information that can address member questions in real time and better meets member needs. Participating members also receive preventive care and screening reminders, invitations to community events, and can call any time regarding healthcare and psychosocial questions or needs.

CARE MANAGEMENT PROGRAM

Buckeye will assign a specific Care Manager to each member who, when determined by assessment, would benefit from such services. A member may be assigned to Care Coordination, Care Management, or Disease Management, as applicable.

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 member 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 members who will be placed into 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.

Key Indicators 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

Once identified, the Buckeye Care Management team uses various health risk assessment (HRA) 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, member 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 our clinical documentation system, TruCare®, 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.

Care Plan

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 member in the home setting, community resources/services available and member 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, member, member'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 member's medical record. Care plans will be forwarded to the provider when significant updates occur as well.

Referring a Member to Buckeye Care Management

Buckeye's goal is to ensure that all members have access to comprehensive Care Management services.

Providers are encouraged to refer any member who may benefit from care management support or intervention by contacting a Buckeye Care Manager.

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 the OhioRISE Plan 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® Program (Start Smart) 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.

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.

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.

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 member 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 member 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.

Members with Mental Health and Substance (Alcohol and Drug) Use Disorders

Buckeye uses an intensive Care Management (CM) Program to address the unique needs of members related to Mental Health and Substance Use Disorders (SUD), including frequent co-morbid and co-occurring conditions which require an integrated approach to all aspects of care coordination and treatment. The program incorporates interventions such as structured post-discharge telephone or in-person contact; assessing satisfaction with outpatient providers; careful attention both to compliance with prescribed medications as well as potential impact of each medication on all Physical Health (PH) and Behavioral Health (BH) conditions.

The following programs will be initiated for members identified with needs related to Mental Health and SUD as indicated:

- Intensive Care Coordination
- Utilize Community Health Workers to engage members
- Transition of Care from different care settings/levels

The Care Manager will complete an assessment to confirm member needs related to Mental Health and/or SUD, assessing medical, BH, social, and other needs. Within 30 calendar days of identification, or sooner as dictated by member needs, a Care Manager will outreach to members

identified to complete a comprehensive assessment, develop a care plan, and provide other needed assistance. Other outreach processes and initiatives will include:

- Partnering with community care managers, and peer supports to outreach to members with SMI, SUD, and other BH needs.
- Identifying agencies serving the homeless population and coordinate with those agencies on initiatives geared toward identifying and connecting our difficult to reach members with supportive resources and stable housing.
- Building relationships with local hospitals to notify Buckeye when our members visit the ER.
- Education and enrollment of eligible members as applicable

Staff will use comprehensive assessments to identify members who could benefit from a Health Home and educate eligible members on available services, including member's choice to opt in or out of the Health Home program. For members who choose to enroll in a Health Home, the CC will coordinate with the Member's chosen Health Home provider to ensure continuity of care. Once the member is enrolled in the Health Home program, our CC will then work with the Health Home staff and/or other members of the community-based team to promote recovery through a care plan, developed in collaboration with the member, that includes treatment referrals; self-management tools to help the member understand triggers; and use of local support groups and resources. Care plans will also include coordination with the Health Home provider, other involved providers (including OB/GYNs, behavioral health providers, PCPs, and specialists), as well as family and community supports as desired by the member or authorized representative.

COORDINATED SERVICES PROGRAM

What is the Coordinated Services Program (CSP)?

CSP is a health and safety program in which use of abuse potential drugs is monitored, and member claims are reviewed for potential assignment to a designated pharmacy. Please visit **https://medicaid.ohio.gov/stakeholders-and-partners/phm/csp/csp** for additional information.

Section X – Reporting

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. See the Member Rights section of this handbook for policies on member access to medical records.

Required Information

Medical records mean the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations, and notes, accessible at the site of the member's participating PCP or provider, that document all medical services received by the member; this includes inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the provider rendering the services.

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

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance.

- All entries must be legible and maintained in detail.
- 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 and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An appropriate history of immunizations is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Buckeye practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting appeal is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the PCP to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- Appropriate notations concerning use of tobacco, alcohol, and substance use; for members seen three or more times substance abuse history should be queried.
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected.
- Evidence that an Advance Directive has been offered to adults 18 years of age and older.

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

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a member's authorized 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 Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Buckeye members. If the member or member's authorized representative is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, 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.

REPORTING PROVIDER PREVENTABLE CONDITIONS / HOSPITAL ACQUIRED CONDITIONS

Buckeye does not pay for services resulting from a provider-preventable condition, as defined in 42 CFR 447.26. Providers shall report all instances of provider-preventable conditions. Providers shall not restrict access to care or services to a member because of prohibition of payment for provider-preventable conditions.

INCIDENT REPORTING

Providers are required to ensure 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 in accordance with OAC rule 5160-44-05.

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.

FRAUD, WASTE, AND ABUSE

Buckeye takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with state and federal laws.

Fraud means the intentional deception or misrepresentation an individual or entity makes knowing that that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes "reckless disregard" of the facts with the intent to receive an unauthorized payment. This party may also conceal facts in order to receive reimbursement for which they are not entitled.

Waste means the incorrect submission of claims due to factors such as uneducated office staff, coding illiteracy, staff turnover, or keying errors. Wasteful billing can typically be resolved after the provider or subcontractor, andareffice staff is educated on proper billing requirements and/or claim submission.

Abuse: means practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the health plan. It includes billing for services that are not covered or medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes enrollee and provider practices that result in unnecessary cost to the health plan. In the case of abuse, there is no conspiracy or malicious intent to deceive.

Buckeye successfully operates a Special Investigations Unit (SIU), with dedicated staff that reside in Ohio. This unit routinely inspects claims submitted to assure that Buckeye is paying appropriately for covered services. Buckeye performs front and back-end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing Manual located on our website. Buckeye also performs retrospective audits, which in some cases these activities may result in taking actions against providers who, individually or as a practice, commit fraud, waste, and/or abuse. These actions include but are not limited to:

- Remedial education and/or training to prevent billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Referral to the Ohio Program Integrity Unit
- Referral to the Medicaid Fraud Control Unit
- Onsite Investigations
- Corrective Action Plan
- Any other remedies available to rectify

Buckeye instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

Buckeye requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons, or entities providing care or services to all Buckeye members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, healthcare fraud, obstruction of a state and/or federal healthcare fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, Physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are

not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or members' medication fraud.

Training is available on our website under Provider Resources > Report Fraud, Waste and Abuse at: **https://www.buckeyehealthplan.com/providers.html**.

We also include FWA training in our Provider Abuse Line at 1-866-685-8664.

Suspected Inappropriate Billing

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Buckeye takes all reports of potential fraud, waste, and/or abuse very seriously and investigates all reported issues.

NOTE: Due to the evolving nature of fraudulent, wasteful, and abusive billing, Buckeye may enhance the FWA program at any time. These enhancements may include but are not limited to creating, customizing, or modifying claim edits, and upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

Fraud, Waste and Abuse Reporting

Providers may voluntarily disclose any suspected fraud, waste or abuse using the tool on the ODJFS website:
https://jfs.ohio.gov/fraud/index.stm

QUALITY MANAGEMENT

Buckeye culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Management/Quality Improvement (QM/QI) program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs.

This system provides a continuous cycle for assessing and analyzing the quality of care and service among plan initiatives including primary, secondary, and tertiary care, preventive health, acute and/or chronic care, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. The system allows for systemic analysis and re-measurement of barriers to care, the quality of care, and utilization of services over time.

Buckeye recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health status of members.

Where the member's condition is not likely to improve, Buckeye will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions.

Whenever possible, the Buckeye QM/QI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of members.

Program Structure

The Buckeye Board of Directors (BoD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BoD oversees the QM/QI Program and has established various committees and ad-hoc committees to monitor and support the QM/QI Program.

The Quality Improvement Committee (QIC) is a senior management committee with Buckeye network physician representation that is directly accountable to the BoD. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the quality and medical management programs.

The following committees report directly to the Quality Management Committee (QIC):

- Medical Management Committee (MMC)
- Pharmacy & Therapeutics Committee (P&T)
- Credentialing Committee (CC)
- Performance Improvement Team
- Joint Operations Committee
- Cultural Competency Committee
- HEDIS Steering Committee
- Peer Review Committee (Ad Hoc Committee)

In addition to the committees reporting to the QIC, Buckeye has sub-committees and workgroups that report to the above committees including, but not limited to:

- Grievance and Appeals Committee
- Provider Advisory Committee
- Member Advisory Committee
- Hospital Advisory Committee
- Community Advisory Committee

- Ad-hoc committees may also include *regional level* committees for Member Advisory and/or Community Advisory based on distribution of Membership.

Provider Involvement

Buckeye recognizes the integral role provider involvement plays in the success of its QM/QI program. Provider involvement in various levels of the process is highly encouraged through provider representation and participation on the Quality Committees.

Quality Management/Quality Improvement (QM/QI) Program Scope

The scope of the QM/QI program is comprehensive and addresses both the quality of clinical care and the quality of service provided to Buckeye members. Buckeye QM/QI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, ancillary services, and operations.

Goals

Buckeye's primary QM/QI program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

Member Safety and Quality of Care

Member Safety is a key focus of Buckeye's 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 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.

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.

Diamond Designation™ Program

The Diamond Designation™ Program provides ratings on the quality and efficiency of care across 14 different specialty areas; however, specialties vary per market. The specific specialties included for Buckeye Health Plan are listed below. The Program emphasizes quality over efficiency. Provider ratings are determined and reported at a medical practice/group level based on Tax Identification Number.

We aim to update the Diamond Designation™ Program at least every two years with the Program Year 2024 update becoming effective during the first half of 2024.

Specialty Types Included in Program Year 2024 for Buckeye Health Plan

Cardiology	Gastroenterology	Nephrology
Obstetrics/Gynecology	Ophthalmology	Pulmonology
Endocrinology	General Surgery	Neurology
Orthopedic Surgery	Podiatry	

Some primary care providers want to understand more about the quality and efficiency of specialty physicians and other clinicians. Rating results from the Program are made available to our primary care providers to potentially consider as they refer patients to specialty care. Also, a listing of providers who have achieved Diamond Designation™ is made available to potentially help inform specialty care provider selection for Medicaid and MyCare Ohio (Medicare-Medicaid Plan) members in Ohio. Individuals are advised to consider all relevant factors and that Program ratings should not be the sole basis of their decision-making. Buckeye Health Plan members are encouraged to consult with their physicians when selecting a specialty care professional.

The Diamond Designation™ Program methodology for evaluation is based on national standards and incorporates feedback from physicians and other clinicians as well as members. The health plan seeks to produce evaluation results that are as accurate as possible. Ratings from the Diamond Designation™ Program are only a partial evaluation of quality and efficiency and should not solely serve as the basis for specialist provider selection (as such ratings have a risk of error). Other factors may be important in the selection of a specialist. The Program and its results are not utilized to determine payment under pay-for-performance programs. Specialty Provider groups evaluated within the Program have the opportunity to request a change or correction to information used in determining their efficiency or quality scores.

For additional information regarding the Diamond Designation™ Program, please visit **DiamondDesignation.com.** This site includes a description of the most current methodology used in determining Program ratings and specific instructions for Providers to submit requests for reconsideration of their results. The health plan values Provider feedback and welcomes comments and questions. Please send them by email to **ContactUs@DiamondDesignation.com.**

Performance Improvement Process

Buckeye QIC reviews and adopts an annual QM/QI program and Work Plan aligned with Buckeye vision and goals and appropriate industry standards. The QM Department implements quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving member health outcomes, quality of access to care and services.

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 for the provision of that care or service. Each performance improvement initiative is also designed to allow Buckeye to monitor improvement over time. Quality Performance Measures have been identified based on the potential to improve healthcare for Buckeye members. The measures are HEDIS measures, integrated behavioral healthcare, along with identified state metrics. Performance is measured against established benchmarks and progress to performance goals.

Annually, Buckeye develops a QM/QI Work Plan for the upcoming year. The QM/QI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting, and studies from all areas of the organization (clinical and service). It also includes timelines for completion and reporting to the QIC and requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QM/QI Work Plan.

Buckeye communicates activities and outcomes of its QM/QI Program to both members and providers through avenues such as the member newsletter, provider newsletter, and the Buckeye web portal at **https://www.buckeyehealthplan.com/providers.html**.

At any time, Buckeye providers may request additional information on the Health Plan programs, including a description of the QM/QI Program and a report on Buckeye progress in meeting the QAPI program goals, by contacting the QI department.

Feedback on Provider Specific Performance

As part of the quality improvement process, performance data at an individual provider, practice or site level is reviewed and evaluated. This performance data may be used for quality improvement activities, including use by Buckeye quality committees. This review of Provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency, and in-office waiting time.
- Preventive care, including wellness exams, immunizations, prenatal care, lead screening, cervical cancer screening, breast cancer screening, and other age-appropriate screenings for detection of chronic diseases or conditions.
- Member appeal and grievance data.
- Utilization management data including ER visits/1000 and bed days/1000 reports.
- Critical Incident reporting, sentinel events and adverse outcomes.
- Compliance with clinical practice guidelines.
- Pharmacy data including use of generics or specific drugs.

As part of its motivational incentive strategies, Buckeye systematically profiles the quality of care delivered by high-volume PCPs to improve provider compliance with preventive health and clinical practice guidelines and clinical performance indicators. The profiling system is developed with network providers to ensure the process has value to providers, members and Buckeye, and may include a financial component.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Ohio Department of Human Services.

As both Ohio and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. Ohio purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Provider specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for provider incentive programs, such as "Pay for Performance." These programs reward providers based on scoring of such quality indicators used in HEDIS.

How Are HEDIS Rates Calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and submitted to the health plan. Measures calculated using administrative data may include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid rates consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered that were not reported to the Health Plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate procedure and diagnosis codes can reduce the necessity of Medical Record Reviews (MRR); see Buckeye's website and HEDIS booklet for more information on reducing HEDIS medical record reviews and improving your HEDIS scores. Measures typically requiring medical record review include diabetic HbA1c, eye exam and nephropathy, controlling high blood pressure, cervical cancer screening, and prenatal care and postpartum care.

When Will the Medical Record Reviews (MRR) Occur for HEDIS?

MRR audits for HEDIS are usually conducted February through May each year. Buckeye QM representatives, or a national MRR vendor contracted to conduct the HEDIS MRR on Buckeye's behalf, may contact you if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Buckeye which allows them to collect PHI on our behalf.

What Can Be Done to Improve My HEDIS Scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill or report by encounter submission for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as, Body Mass Index (BMI) calculations, eye exam results and blood pressure readings.

If you have any questions, comments, or concerns related to the annual HEDIS project or the MRRs, please contact Buckeye at 1-866-246-4358 and ask to speak with the Quality Improvement Department.

SUPPLEMENTAL DATA ELECTRONIC DATA INTERCHANGE (EDI) FEED OVERVIEW

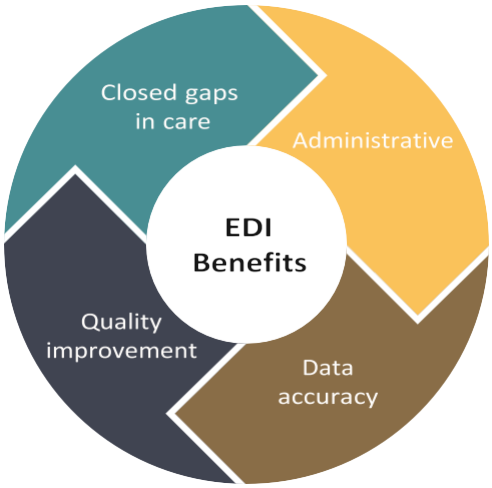
The Future of Healthcare

The Healthcare Industry is moving toward being completely electronic to foster better health outcomes, increase member 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 feedversus 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 someinstances.



Administrative: When measures are reported via EDI, it reduces the potentialburden 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 members 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 member health.

Examples of Standard Supplemental Data Files

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

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Section XI - Next Generation Managed Care Program

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 Medicaid managed care program for children and youth with complex behavioral health and multisystem needs. Children and youth with multisystem needs are often involved in multiple community systems such as juvenile justice, child protection, developmental disabilities, education, mental health and addiction, and others. OhioRISE aims to support these children and youth succeed in their schools, homes, and communities. This support is provided through care coordination and specialized services that are provided in-home or in the young person’s community.

An individual enrolled in OhioRISE has their physical health services covered by their managed care organization or fee-for-service Medicaid. The OhioRISE plan, Aetna Better Health of Ohio, covers their behavioral health services. The MCO is included in the child or youth's care coordination team, whenever their inclusion is requested by the member and family. OhioRISE care coordinators can also help OhioRISE members and families access support from their MCO.

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.
- Not be enrolled in a MyCare Ohio plan.
- Meet a functional needs threshold for behavioral healthcare, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment, or be inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder.

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

Care coordination: Depending on a child or youth's needs, they will receive one of three levels or "tiers" of care coordination. This service is delivered by Aetna or their care management entities (CMEs) in a child or youth's community. OhioRISE members are assigned a care coordinator who has experience working with children, youth, and their families. Care coordinators assist young people and their families with:

- Making a care plan to ensure the young person's behavioral health needs are met.
- Helping young people access services and resources.
- Talking to and providing information to other providers who are involved in the child or youth's care.

Intensive Home-Based Treatment (IHBT): Provides intensive, time-limited behavioral health services for children, youth, and families in their homes. IHBT helps stabilize and improve a young person's behavioral health.

Psychiatric Residential Treatment Facility (PRTF): PRTFs are facilities, other than hospitals, that provide inpatient psychiatric services to individuals 20 years or younger. Ohio's PRTF service aims to keep young people with the most intensive behavioral health needs in-state and closer to their families and support systems.

Behavioral Health Respite: Provides short-term, temporary relief to a child or youth's primary caregivers in a home or community-based environment.

Flex Funds: Provides funding of $1,500 in a 365-day period to purchase services or items that address a need in a child or youth's service plan. These items should otherwise not be provided through Medicaid. Funds must be used to purchase services or items that will:

- Reduce the need for other Medicaid services,
- Keep young people and their families safe in their homes, or
- Help a child or youth be better integrated into the community.

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 billing for behavioral health services provided to youth who are enrolled in the OhioRISE plan and information for providers to determine to which entity to submit claims is located in the OhioRISE Provider Enrollment and Billing Guidance and the OhioRISE Mixed Services Protocol on the OhioRISE website (**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.**

SPBM

The Single Pharmacy Benefit Manager (SPBM) is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that provides 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 conducts Ohio actual acquisition cost surveys, cost of dispensing surveys, and performs oversight and auditing of the SPBM. ODM selected Myers and Stauffer, LC to serve as the PPAC.

The SPBM consolidates the processing of pharmacy benefits and maintains a pharmacy claims system that integrates with the Ohio Medicaid Enterprise System (OMES), new MCOs, pharmacies, and prescribers. The SPBM also works 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. The SPBM also reduces provider 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 are automatically enrolled with the SPBM under a 1915(b) waiver. Additionally, Gainwell Technologies is required to contract with all enrolled pharmacy providers who are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that will ensure access for all members statewide.

SPBM provides coverage for medications dispensed from contracted pharmacy providers. 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 **https://spbm.medicaid.ohio.gov** .