Provider Orientation

2023 Medicaid Orientation

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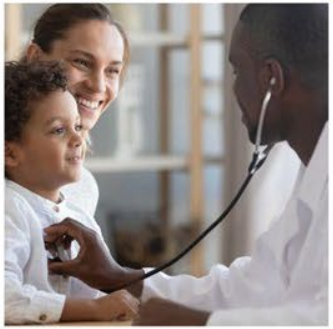
Your Guide to Better Health™
MEDICAID • MEDICARE • MARKETPLACE




Agenda

- Buckeye Health Plan Overview
- Provider Resources
- Provider Responsibilities
- Provider Enrollment
- Utilization Management
- Claims, Adjustments and Appeals
- Care Coordination/Care Management
- Pharmacy/SPBM
- Next Generation Managed Care/OhioRISE
- Contact Us

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Buckeye Health Plan Overview

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Buckeye's Vision

Transforming the health of the community, one person at a time.

Buckeye Health Plan (Buckeye)* is a managed care health plan, providing services throughout Ohio since 2004. As a wholly-owned subsidiary of Centene Corporation, a leading multi-line healthcare enterprise offering both core Medicaid and specialty services, Buckeye coordinates comprehensive care for its members. Through its caring and compassionate associates, Buckeye serves the entire community with programs tailored to meet the unique needs of each individual.

Buckeye is living its vision statement by transforming the health of the community, one person at a time.

More than 900 Buckeye employees serve more than 300,000 members in the Medicaid, Medicare, and Marketplace products in Ohio. Now a $2 billion company, Buckeye is headquartered in Columbus, Ohio.

*Buckeye Health Plan operated as Buckeye Community Health Plan until September 2014.

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Our Products/Plans

Medicaid
Buckeye provides coverage to qualified adults and children; eligible aged, blind and disabled persons and children within the foster care program.

MyCare (Combined Medicare and Medicaid)
MyCare Ohio is a dual-eligible program that contracts with both Medicare and Ohio Medicaid in 12 counties. Qualified enrollees of the Medicare-Medicaid Plan (MMP) receive healthcare benefits of both programs from one single health plan.

Marketplace
Ambetter is a qualified health plan on the Ohio Health Insurance Marketplace. Member plan options vary between costs for monthly premium payments versus out-of-pocket expenses. Subsidies are dependent on member's income level.

Wellcare By Allwell Medicare Advantage (HMO/PPO)
With the Wellcare By Allwell Medicare Advantage HMO/PPO plan, members enjoy the freedom to receive healthcare services from Medicare providers of their choice. As an eligible Medicare provider, Wellcare By Allwell reimburses you at 100% of the Medicare allowable rate for all plan-covered, medically necessary services for our PPO members – whether you are contracted with us or not.

Wellcare By Allwell D-SNP (HMO/PPO)
Wellcare By Allwell D-SNP is a type of Medicare Advantage plan available to people who qualify for both Medicare and Medicaid in 74 counties. This plan allows eligible members to enjoy better coverage by combining Medicare and Medicaid benefits under one plan. These plans also include prescription drug coverage.

Ohio Department of Medicaid
Next Generation of Ohio Medicaid Managed Care

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Medicaid Member ID Cards

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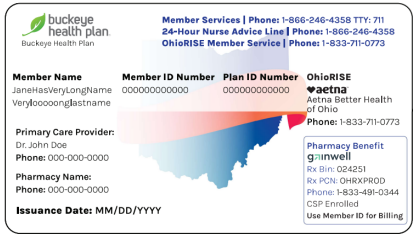

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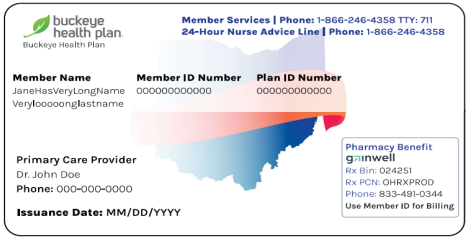

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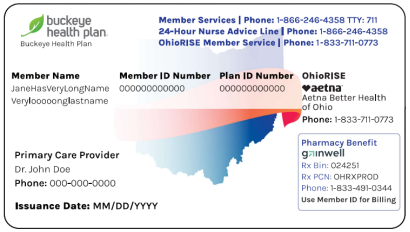

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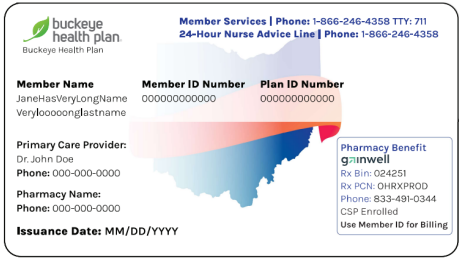

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https://www.buckeyehealthplan.com/providers/welcome-new-providers.html

Provider Resources

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Buckeye Secure Provider Portal

Take care of business on YOUR schedule. The Provider Portal is yours to use 24 hours a day, seven days a week to accomplish several tasks.

- Easily check member eligibility
- View, manage, and download your member list
- View and submit claims
- View and submit service authorizations
- Communicate with us through secure messaging
- Maintain multiple providers on one account
- Control website access for your office
- View historical member health records
- Submit assessments to provide better member care
- And much more

Access the Secure Provider Portal at
https://www.buckeyehealthplan.com/providers.html

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Provider Services

Our Provider Services staff is your first stop in your quest for information. They are available to you and your staff to answer questions, listen to your concerns, assist with patients, respond to your Buckeye Plan inquiries, and connect you to your Buckeye Provider Engagement Administrator.

Provider Services hours of operation: Monday-Friday 7:00 a.m.-8 p.m. (EST)

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

Provider Engagement Administrator

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

- Maintenance of existing Buckeye Provider Manual.
- Network performance engagement.
- Physician and office staff orientation.
- Hospital and ancillary staff orientation.
- Ongoing provider education, updates, and training.

You can find your assigned Provider Engagement Administrator by accessing our Provider Home Page or reach out to Provider Services at 866-296-8731.

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.

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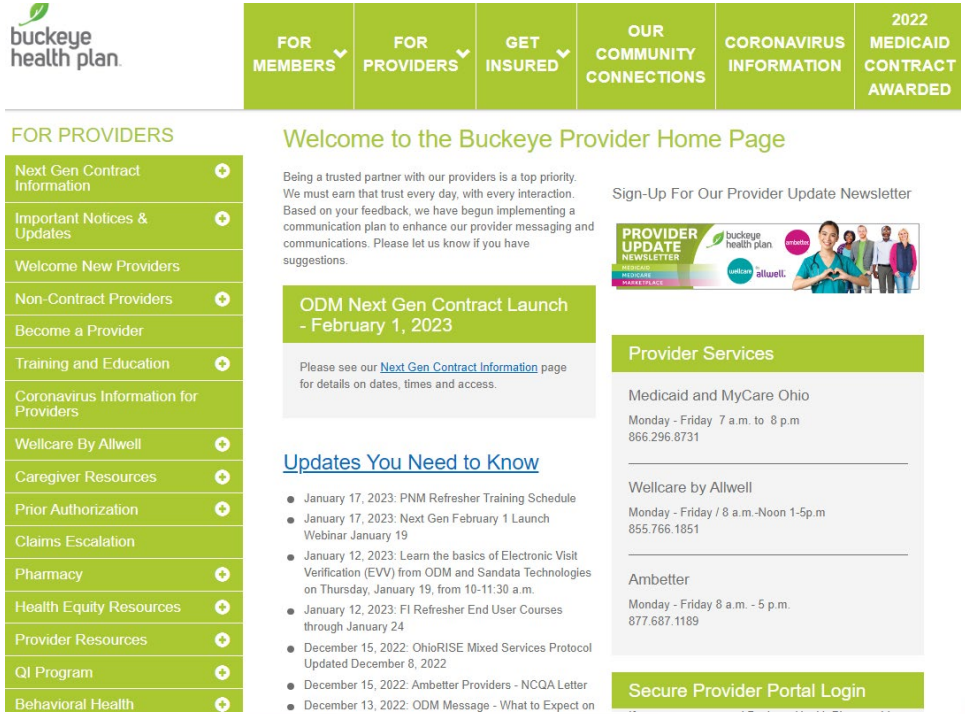
Provider Home Page on Website

Our website Provider Home Page is a one-stop shop to find access to information you need.

- Latest updates on doing business with Buckeye.
- Find-a-Doc provider search with mapping from member's address
- Provider manuals
- Clinical guidelines
- Online tool to verify prior authorization requirements
- Downloadable forms including:
  - Change of PCP
  - Provider Action Request
  - Member Connections



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BuckeyeHealthPlan/provider.com

Website Resources

Join Our Network

Provider Portal

Find A Provider

Provider Manuals

Provider Trainings & Webinars

Forms

Pre-Auth Check

Provider Newsletters

Claims Payment System Error Notifications (CPSE)

Claims Disputes

Clinical & Payment Policies

Preferred Drug List

Pregnancy & Prenatal Information

Report Fraud, Waste and Abuse

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Buckeye Key Information Highlights

- Buckeye's Provider Home Page provides links to key resources, provider updates, communications, and trainings.
- Provider Resources are located via the lefthand side of the Provider home page https://www.buckeyehealthplan.com/providers.html
- Buckeye Provider Manuals: https://www.buckeyehealthplan.com/providers/resources/forms-resources.html
- Buckeye Provider Authorization Code List: https://www.buckeyehealthplan.com/providers/prior-authorization/preauth-check.html
- Dedicated Provider Services support: Medicaid and MyCare Ohio 866.296.8731
- Buckeye Contract Coordination: Ohiocontracting@centene.com
- Contract Negotiators: OHNegotiators@centene.com
- Claims Payment System Error Notifications: https://www.buckeyehealthplan.com/providers/resources/forms-resources.html

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Provider Communications

We believe that communication is vital to a successful partnership and our goal is to communicate essential information, on a consistent basis, to earn your trust and make working with Buckeye easier.

Our newsletter is delivered electronically to all providers each month. This communication covers essential operational and procedural topics to help them do business with Buckeye. In addition, it delivers training and education opportunities and include some of Buckeye's provider-based initiatives. All editions of the newsletter will be available on the website. https://www.buckeyehealthplan.com/providers/provider-communications/provider-update-newsletter.html

Provider Communications Sign-Up

Whether you are an office manager, clinical staff, physician, billing or front desk worker, or serve in another role within our provider locations, Buckeye would like to share relevant, timely information that makes it easier to do business with us. Please sign up for Provider Communications. Even if you have received our email communications in the past, please sign up for future communications.

Provider Responsibilities

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Next Generation Program Key Improvements

The Next Generation of managed care expands Ohio Medicaid managed care member benefits to help address unique individual healthcare needs. The new program includes improvements such as:

Commitment to Individual's Health and Cultural Respect

- We are supporting healthcare staff by providing programs and trainings that include cultural understanding and respect for everyone's experiences.

Single Pharmacy Benefit Manager (SPBM)

- With Gainwell as the Next Generation's single administrator for pharmacy needs and services, you will be able to receive the medications you need regardless of managed care plan.

Enhanced Support for Member Transportation

- Improved trips to appointments and pharmacies will include ambulance, wheelchair van, and other emergency transportation and county non-emergency transportation.

Increased Accessibility

- If English is not your primary language or you are hard of hearing, your plan has a toll-free number and telephone services available to make sure you can easily get the information and services you need.

Additional Support for Children

- Additional behavioral health services will include therapy and substance use disorder treatment services.

Freeing Up Providers to Better Serve You

- Ohio Medicaid has implemented changes to ease the administrative burden on providers, so they have more time to focus on you.

Focus on Preventive Care and Wellness

- Members will have an opportunity to receive rewards for wellness visits, vaccinations, and preventative care screenings for illnesses including diabetes.

Telehealth Services

- To ensure you can receive care even when you can't make it to the doctor's office, telehealth appointments are available for healthcare needs.

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Privacy, Covered Services & Access and Availability

- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Provide all covered physician services, including but not limited to telehealth in accordance with generally accepted clinical, legal, and ethical standards in a manner consistent with physician licensure, qualifications, training, and experience as outlined in the provider manual.
- 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 in accordance with the appointment availability and access standards outlined in the provider manual.
- Providers are required to develop and use telephone protocol standards as outlined in the provider manual and include After-hours availability

Provider Enrollment, Credentialing & Contracting

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PNM & Centralized Credentialing

Centralized Credentialing

ODM has moved to a centralized model in which the agency will manage credentials, and providers need apply only once. Centralized credentialing eliminates the need to understand and comply with seven unique credentialing processes, easing the administrative burden felt by providers serving Ohio's Medicaid members. In addition to standardizing the process and documentation that is collected, centralized credentialing helps eliminate repetitive work, improve revenue cycle, and lower credentialing costs for hospitals, facilities, providers, and practices.

Provider Network Management (PNM)

The PNM module is a part of a larger effort to modernize ODM's management information systems. This modernization roadmap, developed in accordance with CMS guidance, includes a transition to a modular system called the Ohio Medicaid Enterprise System (OMES) that will support ODM in meeting several modernization goals. Ultimately, MITS will be retired.

PNM & Centralized Credentialing Capabilities

One Front Door for Provider Applications and Credentialing

PNM & Centralized Credentialing

PNM & Centralized Credentialing training made available through Ohio Department of Medicaid

- E-learning/On- Demand Trainings
- Classroom Instructor-Led Training
- Virtual Classrooms
- Desk Reference Guides
- Quick Reference Guide
- Post Go-live Training

Additional information on Ohio Medicaid Provider Network Management Module (PNM) and Centralized Credentialing is available at: https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

Credentialing/Contracting

- 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.
- 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.
- 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.

Contracting

Upon initiating your enrollment application through the Ohio Department of Medicaid Provider Network Management (PNM) system, please follow the step-by-step instructions listed in our provider manual to submit your contract request to join our network of participating providers.

- Access our provider pages of the website at https://www.buckeyehealthplan.com/providers.html
- Select the “Become a Provider” in the left menu options.
- On the Become a Provider page, select the blue ‘access forms and information’ link in the Joining our Network section.
- On the Join Our Network page, you will answer a series of questions

Utilization Management

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Prior Authorization

Prior Authorizations are required on some services and will continue to be submitted directly to the health plan until a later date to be determined by the Ohio Department of Medicaid.

To determine if a service needs prior authorization use our **Prior Authorization Prescreen Tool**.

If a service requires prior authorization, please note:

- 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.
- Authorization requests should be submitted via our secure web portal and should include all necessary clinical information.
- Urgent requests for prior authorization should be called in as soon as the need is identified at 866-246-4359.

To submit a Prior Authorization for approval.

- Enter the portal at **https://www.buckeyehealthplan.com/providers.html**
- Access the member's record.
- Select the New Authorization option. The Authorization screen will appear with the member's data pre-populated.
- **Complete the Authorization Form.**

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Care Coordination/Care Management

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Goals

- Provide the best quality care for members by connecting with and tapping into the strengths of all the caregivers/entities working with the member.
- Ensure our populations receive care and assistance to address needs and minimize future increase in risk.
- Keep Members at the center of what we do.

Care Management

- Accountable point of contact (care manager) identified who can help obtain medically necessary care, assist with health-related services and coordinate care needs. Multi-disciplinary team consisting of licensed individuals
- Care management strategies: best-practice and evidence-based clinical guidelines; lower member/care manager ratios
- Guidelines for frequency and intensity of contact with high-risk members
- Face-to-face visits at point of care
- Expected outcomes include optimization of member's health; improved continuity of care coordination; decreased overall medical costs; decreased IP admits and ED visits

Care Management Referral Form:
https://www.buckeyehealthplan.com/providers/resources/forms-resources.html

Care Coordination and Disease Mgmt.

Buckeye provides care coordination and disease coaching services for many conditions, such as asthma, diabetes, COPD, high-risk pregnancy and many more.

Start Smart for Your Baby®

- An incentive for pregnant mothers to encourage them to keep their prenatal appointments.
- Start Smart Education offers education information and education forums to pregnant members and parents.
- Identifies pregnant women that are medically high risk and assigns them a Care Manager to assist them through their pregnancy to a successful delivery.
- Provider Risk Assessment Form incentive program https://www.buckeyehealthplan.com/providers/resources/pregnancy---prenatal-information.html

The provider's role in Buckeye Health Plan's Care Coordination program is extremely important. Practitioners who have identified a member who they think would benefit from disease or case management should contact the Care Coordination Department to speak with a member of our Integrated Care Team at 866-246-4358 or submit a Care Management Referral Form.

A Changing Landscape

Reactive Approach: Intervention

This intervention-based approach focused on members with the most complex needs, requiring enrollment in care management to receive individualized unique services.

Care coordination has largely been separated from or loosely connected to community-based care coordination structures.

This increases the risk for the following:

- Duplication of Care Managers
- Assessment fatigue
- Duplication of Care Plans
- Outreach Fatigue to providers
- Inefficient communication, including multiple touch points

Proactive Approach: Coordinated

All members need access to connected customer service and navigation assistance, even if not "enrolled in care management." This new MCO "Guide" role will provide time-limited help to get people what they need one-time or through short-term services.

The MCO will act as the lead care coordinator (care manager) for certain individuals and specific populations when a designated CCE is not available OR does not meet the individual's needs.

MCOs will support ODM-designated Care Coordination Entities (CCEs) that provide community-based coordination to specific populations of individuals served by our program.

MCO Care Guide+ and Care Manager+

Member Engagement

Identifies healthcare needs & supports engagement with existing and future care relationships

Member Care Monitoring

Ensures care coordination needs are met & reviews data indicators to inform the level and type of care coordination needed by the member

Partnership Development

Develops partnerships with other organizations, entities, and people that are supporting the member in obtaining services and addressing healthcare needs

Partnership Identification

Identifies existing and future care relationships across programs including CCEs, OhioRISE, and CMEs to streamline services

Performs or coordinates care coordination activities with CCEs, OhioRISE, and CMEs

Care Coordination

Care Guide/Care Guide +

- Short term needs 60 days or less
- Event driven coordination i.e., emergency room visit or inpatient admission.
- One IP admission or ER visit in past 30 days.
- Pregnant with no Notification of pregnancy on file.

Care Manager/Care Manager +

- Long term needs greater than 60 days.
- Treatment driven coordination such as a chronic condition.
- Recent admission within 30 days of newly diagnosed chronic condition
- Member with behavioral and physical health needs.

Referrals: Buckeye_Care_Coordination_Escalations@CENTENE.COM

Claims, Adjustments and Appeals

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Fiscal Intermediary

The Fiscal Intermediary is a part of a larger effort to modernize ODM's management information systems. This modernization roadmap, developed in accordance with the Centers for Medicare and Medicaid Services (CMS) guidance, includes a transition to a modular system called the Ohio Medicaid Enterprise System (OMES) that will support ODM in meeting several modernization goals. As a part of this roadmap, updated and new functionality - such as Fiscal Intermediary - is being built into OMES rather than MITS.

Fiscal Intermediary Capabilities

- One Door for Prior Authorization Submissions (whether PNM or EDI) for all lines of business. * FFS Medicaid only at this time
- One Door for Claims Submissions (whether PNM or EDI) for all lines of business and **effective 2/1/2023 will include MCEs**
- One Door for Recipient Eligibility Look-Up (whether PNM, EDI, or IVR) for all lines of business. * FFS Medicaid only at this time
- Additional functionality that exists in MITS today that will continue in PNM in the future: FFS Medicaid only at this time
    - Cost Report Submission
    - Ability to upload attachments for Prior Authorizations and Claims

*Refers to managed care / OhioRISE. MyCare prior authorizations will not be coming in Medicaid's front door. Providers will continue to submit those prior authorizations to the managed care plans until a later date TBD.

Additional information on Ohio Medicaid Fiscal Intermediary is available at: https://managedcare.medicaid.ohio.gov/managed-care/fiscal-intermediary

Claims Submission

Points of submission for claims and prior authorizations

The February 1 launch of EDI and FI will bring a change of submission methods

	Provider Network Management (PNM) via a link to MITS	Managed Care Portals*	Electronic Data Interchange (EDI) Via a trading partner
Managed care claims	✗	✓	✓
Managed care prior authorizations**	✗	✓	✗
Fee-for-service claims	✓	✗	✓
Fee-for-service prior authorizations	✓	✗	✗

**ODM is working with the MCEs to share data for claims and prior authorizations that are submitted directly to the MCOs (not through PNM or EDI).*

***Managed Care prior authorizations are to be submitted via MCE guidance which may include portal entry or other electronic processes.*

Claims Submission

Trading Partner Entry Point

Electronic Data Interchange (EDI) Module

Beginning February 1, all EDI exchanges will have a new entry point. The EDI will be used for:

- Trading partner submission for both fee-for-service and managed care claims.
- Member eligibility inquiries in batch or real time.
- Claim status inquiry.
- Enrollment for 835 electronic remittance advices.

At a later date, the EDI will also be used for managed care prior authorizations.

Billing Methods

- Buckeye accepts claims in a variety of formats, including electronic EDI through FI, Portal Direct Data Entry, and paper claims.

https://managedcare.medicaid.ohio.gov/managed-care/fiscal-intermediary

Claim Submission Time Frame per OAC 5160-1-19.

Coordination of Benefits (COB), First Time Claims (FTC), and Adjustments

Timely Filing Guidelines			
Calendar Days to File:	COB	FTC	Adjustments
	180 days from date on EOB * or * 365 days from DOS to rec'd date	365 days from DOS to rec'd date	180 days from last date of corresp/EOP * or * 365 days from DOS to rec'd date

Claims Submission

- DOS Prior to 2/1/2023 Electronic Claims Submission **Medical** Payor ID **68069**
- DOS Prior to 2/1/2023 Electronic Claims Submission **Behavior Health** Payor ID **68068**
- Visit: www.buckeyehealthplan.com/provider > Click Provider Resources/Electronic Transactions (EDI)

Effective for DOS 2/1/2023 and after

New Buckeye Payer IDs:

- 0004202 BUCKEYE OHIO MEDICAID (837 P & I ONLY)
- V004202 BUCKEYE/ENVOLVE VISION
- D004202 BUCKEYE/ENVOLVE DENTAL (837 Dental)

Electronic Claims Submission

- EDI department: 1-800-225-2573, ext. 25525 or via e-mail at: EDIBA@centene.com

Portal Claims submission can be entered by logging on to the portal
https://www.buckeyehealthplan.com/providers.html

Paper Claims Submission

- Medicaid Medical claims: Buckeye Health Plan PO Box 6200, Farmington, MO 63640
- Medicaid Behavioral Health Claims: Ohio Claims Behavioral Health PO Box 6150, Farmington, MO 63640

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Claims Submission

Top things Providers need to know for EDI claims*

1. Claims with dates of service **on or after February 1** must be submitted through the new EDI vendor, Deloitte. Claims with dates of service prior to February 1 should be submitted via the current processes.
2. Claims must include the internal **managed care payer ID** listed in the ODM Companion guides so the managed care entity (MCE) can route claims appropriately within their own systems.
3. Different rendering providers at the detail level are no longer acceptable for FFS and managed care claims. Claims must only include one **rendering provider at the header level per claim for FFS and managed care members**. The rendering provider must not be included at the detail level.**
4. Upon claim submission **EDI will validate code sets**. Claims with invalid codes will be rejected with the -999 transaction.
5. Separate files must be submitted **using the receiver ID assigned by ODM for each plan**. (e.g., **Buckeye Payer - file can only** contain claims for members covered by **Buckeye)**
6. **Billing providers must be enrolled** with ODM as a provider type who is permitted to be a billing provider and be paid for services.
7. **Non-billing provider types must be affiliated** with the billing provider on the claim. Claims without appropriate affiliation will be rejected on the 824 transaction.
8. Must use **the 12-digit ODM assigned Medicaid member ID** even if an MCE is the destination payer.

Only ODM authorized Trading Partners will be permitted to exchange EDI transactions.

Companion Guides which will be used for both managed care and FFS can be found at: https://Medicaid.ohio.gov/resources-for-providers /billing/trading-partners/companion-guides/companion-guides

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*MyCare claims and prior authorizations will not be coming through the Ohio Medicaid Enterprise System (OMES). Providers will continue to submit those claims and prior authorizations to the MyCare managed care plans.
**Exceptions for FFS Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers are detailed at http://Medicaid.ohio.gov/static/About+Us/PoliciesGuidelines/MAL/MAL622-A.pdf

Claim Dispute Resolution
(Effective February 1, 2023)

- Provider claim disputes are any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial.
- Providers are required to file a written claim dispute no later than 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.
- A dispute is received verbally and/or in writing by the Buckeye Provider Services Call Center (PS), Buckeye Medical Appeals Coordinator or other Buckeye staff, and Corporate Claims Department.

Dispute process

1. Buckeye will provide written notice to the provider of the disposition of all claim disputes once a resolution has been determined. Written notice will not be sent if the claim dispute was resolved with an initial phone call or in-person contact.
2. The dispute will be reviewed by the area responsible for processing to ensure the dispute was received within the appropriate timeframe.
3. Once a resolution has been determined for each claim dispute, Buckeye will reprocess and uphold or pay the associated claim as needed within 30 days from written notice of resolution.

Claim Dispute Resolution
(Effective February 1, 2023)

1. Buckeye will thoroughly investigate each provider claims dispute using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying BHP's written policies and procedures.
2. A letter will be sent to the provider notifying them of the disposition of the dispute review within 15 days of receipt.
    a. If additional time to resolve a dispute is needed past 15 business days, Buckeye will provide the dispute status on the Provider Portal which can be accessed at any time by the provider.
    b. Buckeye will re-process and pay disputed claims, when the resolution determines they were paid/denied incorrectly, within 30 calendar days of the written notice of the resolution unless a system fix is needed then additional time is allotted.
    c. Buckeye will automatically apply the corrective action or claims resolution to correctly adjudicate all other provider claims affected by the same issue.

Pre-Service Appeals

- 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 Health Plan network.
- Standard appeal decisions are issued within 10 days from date of receipt of the appeal request.
- Expedited 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.

- **Who Can File a Pre-Service Appeal:**
- For pre-service member appeals, members or an authorized representative of a member may appeal an adverse determination. This can be the member, doctor, or other service provider like a physical therapist. Written consent is required if provider is appealing on behalf of the member or assisting member in the appeals process. If you are assisting a member to file a pre-service appeal, please go to This is considered a pre-service member appeal.
- If you are assisting a member to file a pre-service appeal, please go to Appointing a Representative (https://www.buckeyehealthplan.com/providers/resources/appeals-process/appointing-a-representative.html). more details.)
- 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 or fax.
- For pre-service provider appeals, requesting providers can appeal on their own behalf without written consent from the member.

Pre-Service Appeals

- **Expedited 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 pre-service appeal is when either Buckeye Health Plan 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 requests the extension, or
  - If Buckeye provides evidence satisfactory to the Department of Health Services (DHS) 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.

Pre-service Appeals

What are the Timeframes?

The timeframe to file a standard appeal is no longer than 60 calendar days from the day following the mailing date of Buckeye's notification of adverse determination of the requested service. An expedited appeal is available for Medicaid members when the service is needed more quickly and for all urgent care requests. These expedited appeal decisions and notification will be no later than 48 hours after the appeal request is received by Buckeye. Therefore, it is important that if this type of request is made all documentation should be in order. Expedited appeals are not available for post-service requests.

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

Helpful Tip

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

How to Submit Pre-Service Appeals

How to Submit Pre-Service Provider Appeals

- Pre-Service Provider appeals can be submitted to Buckeye Health Plan through the following methods:
  - Online: Provider Portal (This is the most efficient method. Please see the next slide for the portal filing instructions for pre-service appeals.)
  - Phone: 1-866-246-4358 (TTY: 711)
  - Fax: 1-866-719-5404
  - Mail:

    Buckeye Health Plan
    4349 Easton Way, Suite 120
    Columbus, OH 43219
- Pre-Service appeals do not include anything that has a claim that has already been submitted to BHP and has been paid or denied accordingly. If a claim has already been submitted, please submit a claim dispute. The provider manual can be referenced for additional claim dispute information.

Provider Portal Filing Instructions for Pre-Service Appeals

- **Login to Provider Portal.**
  - New users can create new account to establish portal access. Go to the Create Account page.
- **Select the appropriate Plan Type (Medicaid) and TIN Number.**
- **Find an eligible member, select authorizations by clicking on the Authorizations tab from the top header of the page or the members overview page.**
  - Authorization page will show a list of authorizations for that member with different status (Example: Approve / Pended / Deny).
  - Authorization Appeal cannot be created for Pending Authorizations.
- **Click on an authorization number to show the Authorization details page which displays:**
  - Details of the authorization
  - List of appeals created for the same authorization number at the bottom of the page along with its status type and other details. Clicking on the 'Request ID' of the appeal will show details of the appeal along with its status.
  - 'Request Appeal' button to create a new appeal.

Cont'd

Provider Portal Filing Instructions for Pre-Service Appeals (Cont'd)

- **Then, click the "Request Appeal" button to display an Appeal Request form.**
- **On the Appeal Request Form, all fields must be completed.**
  - Field 'Appeal type' requires either Medical or Administrative or both to be selected.
  - Rationale is required and has a limit of 2000 characters.
  - Documents must be attached using the "Evidence Materials and Attachment" section.
- **After all required fields are completed, click the "Save & Review Appeal" button at the bottom to review all appeal information are correct before submission.**
- **Select the "Send Request" button at the bottom of the review page. On successful submission, users will be redirected back to the Authorization details page with new appeal being added to the list.**
- **To view the status of your submission, click on the appeal reference number (Request ID) on the Authorization details screen to display Appeal details page.**
- If you have questions, please contact Provider Services at **866-296-8731.**

Pharmacy

buckeye health plan

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 members). ODM has 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, LLC as the PPAC vendor.
- The SPBM will consolidate the processing of retail 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 utilizing a single set of clinical policies and prior authorization procedures, as well as a single pharmacy program point of contact for all members.
- Additional information on Ohio Medicaid Single Pharmacy Benefit Manager (SPBM) is available at: https://managedcare.medicaid.ohio.gov/managed-care/single-pharmacy-benefit-manager

Next Generation Managed Care - OhioRISE

buckeye health plan

OhioRISE

(Resilience through Integrated Systems and Excellence)

A specialized managed care program for youth with complex behavioral health and multi-system needs.

- **Specialized Managed Care Plan**
  Aetna Better Health of Ohio will serve as the single statewide specialized managed care plan.
- **Shared Governance**
  OhioRISE features multi-agency governance to drive toward improving cross-system outcomes – all we all serve many of the same kids and families.
- **Coordinated and Integrated Care & Services**
  OhioRISE brings together local entities, schools, providers, health plans, and families as part of our approach for improving care for enrolled youth.
- **Prevent Custody Relinquishment**
  OhioRISE will utilize a new 1915c waived to target the most in need and vulnerable families and children to prevent custody relinquishment.

Additional information on the OhioRISE services is available at https://managedcare.medicaid.ohio.gov/managed-care/ohiorise.

Aetna Better Health of Ohio can be reached by calling 833-711-0773 or e-mailing OHRISENetwork@aetna.com.

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OhioRISE

Community and Provider Training

Trainings were facilitated jointly by ODM, Aetna Better Health of Ohio, the Child and Adolescent Behavioral Health Center of Excellence (COE) and state agencies and helped community partners and providers prepare for implementing this important program in July 2022. Each session covered a range of topics including OhioRISE implementation, systems, and operations.

OhioRISE community and provider training modules were presented live, and the recordings are available on the OhioRISE Community and Provider Training page. Additionally, office hours were with OhioRISE subject matter experts.

ODM encourages all community partners and providers who will deliver OhioRISE services and supports to OhioRISE-enrolled youth and their families to view each module, as applicable, at the OhioRISE Community and Provider Training link below. Please direct OhioRISE provider training inquiries to OhioRISE@medicaid.ohio.gov.

Additional information on the OhioRISE Community and Provider Training is available at https://managedcare.medicaid.ohio.gov/managed-care/ohiorise/2-OhioRISE-Comunity-And-Provider-Trainings.

OhioRISE
The CANS Assessment

What is a CANS Assessment?

The **Child and Adolescent Needs and Strengths (CANS)** is a functional assessment tool that:

- Assesses both child and family **needs and strengths**.
- Provides **decision support** to identify appropriate approaches.
- Used to make OhioRISE **program eligibility determinations**.
- Used to support OhioRISE **care planning**.

There are two type of CANS Assessments

- **Brief CANS:**
  - Used as an **'initial'** assessment…..
  - Includes core items to determine eligibility, tier of care coordination, qualified residential treatment program (QRTP) level of care (LOC), recommendations for care.
- **Comprehensive CANS:**
  - Used for 'ongoing' assessments – expands items in Brief CANS to improve care planning and coordination

    (Could be used at time of initial assessment if preferred by assessor)
  - Additional modules are triggered by responses on specific items, such as sexually problematic behavior, runaway, adjustment to trauma.

OhioRISE CANS Resources

The new OhioRISE program will use the Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) tool to establish eligibility. The CANS was developed with leadership from Governor DeWine's Children's Initiatives and Ohio's child-serving state agencies and is used by a wide variety of providers to inform care planning and decision-making for children and adolescents with behavioral health needs. Certified Ohio Children's Initiative CANS assessors are expected to use the CANS to gather all information about the child/youth and family story to describe their strengths and needs.

Visit https://managedcare.medicaid.ohio.gov/managed-care/ohiorise/4-cans-resources for more information regarding the CANS tool.

- **How to Obtain Ohio Children's Initiative CANS Certification**
- **Billing for CANS Assessments**
- **CANS IT System Training**
- **Access the CANS IT System**
- **Contacts for Support**

Contact Buckeye

buckeye health plan

Contact Us

Our helpful Provider Services representatives are available to take your call at 866-296-8731 Monday through Friday from 7 a.m. to 8:00 p.m.

Send a secure message on our portal:

1. Log in to the portal.
2. Select “Message” from the top banner.
3. Complete your message. Allow 3 to 5 business days for a reply.

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