AmeriHealth Caritas Ohio

Provider Manual

A Medicaid Managed Care Organization

Published: January 2026
Version: Six

This Provider Manual is subject to change and will be aligned with Model Language/Template provided by ODM. Changes subject to state or federal requirements may be made at any time.

AmeriHealth Caritas Ohio

TABLE OF CONTENTS

I. Welcome and Introduction Information 6

Who We Are 6

About Our Program 6

Sharing Our Mission 6

II. Basic Plan Information 8

Plan and ODM Contact Information 8

AmeriHealth Caritas Ohio Contact Information 8

ODM Contact Information 8

Provider Account Executives 9

III. Provider Resources 11

Provider Portal 11

Subscription Email Services 11

Claims Payment Systemic Error (CPSE) Report 12

Provider Advisory Council 12

Practitioner Involvement 13

Provider Policies 13

Provider Services Call Center Information 13

Provider Trainings 14

New Provider Orientation 14

Orientation Training 14

Provider Education and Ongoing Training 15

Forms 16

Electronic Health Record (EHR) Utilization 16

IV. Provider Responsibilities 19

Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI) 19

Plan Adherence to HIPAA and Related Privacy and Security Regulations 19

Provider Requirements Related to Member Privacy and Protected Health Information (PHI) 19

Provider Obligations for Oral Translation, Interpretation, and Sign Language Services 19

Provider Responsibilities 20

Notification of Practice Changes 21

Procedure to Notify AmeriHealth Caritas Ohio of Changes in Member Circumstances 22

Cultural Competency, Responsiveness and Linguistics Services 22
Principal Standard 22
Governance, Leadership and Workforce 22
Communication of Language Assistance 23
Engagement, Continuous Improvement, and Accountability 23
Advance Directives 25
Member Rights and Responsibilities 26
V. Provider Enrollment, Credentialing, and Contracting 30
Provider Enrollment (ODM functions) 30
Termination, Suspension, or Denial of ODM Provider Enrollment 30
Loss of Licensure 30
Enrollment and Reinstatement After Termination or Denial 30
Provider Maintenance 31
Integrated Help Desk/ODM Provider Call Center 31
Helpful Information 31
Provider Contracting 58 31
Becoming a Plan Provider 31
Initiating the Contracting Process 32
Medicaid Addendum 32
Standards for Participation 32
Termination, Suspension, or Denial of Contract 36
Non-Contracted or Unenrolled Providers 36
Plan Provider Call Center 37
Credentialing and Recredentialing Processes 37
VI. Covered Services 40
Member ID Cards 40
List of Covered Services 41
List of Services not covered 44
Member benefits and Incentives 44
Member Rewards and Incentives 45
Requests for Specialist Referrals 45
Transportation Vendor Contact Info 45
Transportation Policies/Coverage 46

Transportation for OhioRISE Members 46
Emergency Services 46
Out of Network Use of Non-Emergency Services 48
Second Opinions 48
Telehealth Coverage 48
Inpatient at Time of Enrollment 49
Newborn Coverage 50
Sterilizations 50
Preventive Care/Immunizations 50
Immunization Schedules (Childhood, Adolescent, and Adult) 51
Vaccines for Children (VFC) Program 51
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Healthchek 51
Screening Timeframes 52
Pharmacy Services 53
Dental Services 54
Vision Services 54
Laboratory Services 54
Hospice Services 55
Hospice Services in a Nursing Facility 56
Notification and Coverage for Hospice Benefits 56
Non-Covered Services 56
Private Pay for Non-Covered Services 57
Member Grievance, Appeal, and State Hearing Processes and Time Frames 57
Member Grievance Process 57
Member Appeals Process 58
State Hearings 61
Continuation of Benefits 61
VII. Utilization Management 64
Services Requiring Prior Authorization 64
Prior Authorization Submission 68
AmeriHealth Caritas Ohio Standard Prior Authorization Submission Procedures 68
Provider Appeal Process Pre-Service 69
Standard and Expedited Benefit Determinations 72

Provider Medical Appeal Procedures 73
Quality Assessment and Performance Improvement Program 76
VIII. Claims Information 80
Process and Requirements for the Submission of Claims 80
A Clean Claim 80
Initial Claims Verification 81
How to Submit Claims 81
Claim Filing Deadlines 82
TPL, EOBs, and Claims Monitoring 83
Claims Reporting 84
Claims for Telehealth Services 85
Payment in Full / Balance Billing Members 86
Member Co-Payments 87
Provider Claims Dispute Resolution Process 87
IX. Care Coordination 90
Care Coordination Overview 90
Care Coordination Components 91
Program Participation 93
Role of the Provider 93
Care Coordination Delegation Information 95
Integrating Behavioral and Physical HealthCare 95
Person-Centered Plan of Care 96
Coordinating Care through Transitions and Discharge Planning 96
WHAT IS THE COORDINATED SERVICES PROGRAM (CSP)? 97
X. Reporting 100
Medical Record Requirements 100
Medical Record Requests 101
Access to Medical Records 101
Policies and Procedures for MCO Action in Response to Undelivered, Inappropriate, or Substandard Health Care Services 102
Quality of Care Concerns 102
Provider Sanctioning Policy 103
Formal Sanctioning Process 103

Adverse Events Reporting ... 103
Critical Incidents and Provider Preventable Conditions ... 104
HealthCare Acquired Conditions ... 105
Reporting Provider Preventable Conditions or Critical Incidents ... 106
Incident Reporting ... 107
Mandatory Reporting Requirements ... 107
How to Submit an Incident Report ... 107
Compliance Responsibilities ... 108
Program Integrity/Fraud, Waste & Abuse (FWA) ... 108
Americans with Disabilities Act (ADA) and the Rehabilitation Act ... 108
Program Integrity ... 108
Fraud, Waste, and Abuse ... 110
False Claims Act (FCA) ... 113
The Fraud Enforcement and Recovery Act ... 114
XI. Next Generation Managed Care Program ... 118
OhioRISE ... 118
Single Pharmacy Benefit Manager (SPBM) ... 119

AmeriHealth Caritas Ohio

SECTION I
WELCOME AND INTRODUCTION INFORMATION

I. WELCOME AND INTRODUCTION INFORMATION

Welcome to AmeriHealth Caritas Ohio – a mission-driven managed care organization (MCO) located in Ohio and serving beneficiaries of the Ohio Medicaid Managed Care program. By focusing on the individual, creating a personalized care experience, supporting our providers, increasing program transparency and accountability, and leveraging the strength and success of current Ohio Department of Medicaid (ODM) initiatives, we will improve individual and population wellness and health outcomes for Medicaid beneficiaries in Ohio.

This *Provider Manual* was created to assist you and your office staff with providing services to our members, your patients. As a provider, you agree to use this *Provider Manual* as a reference pertaining to the provision of healthcare services for members of AmeriHealth Caritas Ohio.

This *Provider Manual* may be changed or updated periodically. AmeriHealth Caritas Ohio will provide you with notice of updates; providers are also responsible to check the Plan's website, www.amerihealthcaritasoh.com regularly for updates. Thank you for your participation in the AmeriHealth Caritas Ohio provider network. We look forward to working with you!

WHO WE ARE

AmeriHealth Caritas Ohio, Inc. ("AmeriHealth Caritas Ohio" or the "Plan" or "ACOH") is a managed care organization (MCO) and a member of the AmeriHealth Caritas Family of Companies – an industry leader in the delivery of quality healthcare to populations covered by publicly funded programs, including Medicaid, Medicare, and State Children's Health Insurance programs.

ABOUT OUR PROGRAM

AmeriHealth Caritas Ohio administers a Medicaid managed care plan on behalf of the Ohio Department of Medicaid (ODM). AmeriHealth Caritas Ohio has been contracted by ODM to administer the provision of covered services for enrollees of the Medicaid program, which includes eligibility in the following categories, as determined by ODM:

- Aged, Blind, or Disabled;
- Covered Families and Children (including Healthy Start and Healthy Families);
- Children in Custody and Adopted Children;
- Breast and Cervical Cancer Project (BCCP) individuals;
- Medicaid eligible individuals enrolled in the Bureau of Children with Medical handicaps (BCMH) program; or
- Adult extension.

Medicaid eligibility in Ohio is determined by the Ohio Department of Medicaid. For those interested in additional eligibility information, the Ohio Medicaid Consumer Hotline is available at **1-800-324-8680** or visit: https://www.ohiomh.com/.

SHARING OUR MISSION

Through our collaboration with you – our dedicated providers – we intend to help our members achieve healthy lives and build healthy communities.

SECTION II
BASIC PLAN INFORMATION

II. BASIC PLAN INFORMATION

PLAN AND ODM CONTACT INFORMATION

AMERIHEALTH CARITAS OHIO CONTACT INFORMATION

Address:
AmeriHealth Caritas Ohio
5525 Parkcenter Circle, Suite 100
Dublin, OH 43017

PROVIDER SERVICES

Phone: **1-833-644-6001**
Provider Services is available **Monday through Friday, 7 a.m. to 8 p.m., ET,** except for the following holidays: New Year's Day, Martin Luther King Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day, day after Thanksgiving, and Christmas Day. Emergency closures will be listed online at https://www.amerihealthcaritasoh.com/provider/newsletters-and-updates/index.aspx.

MEMBER SERVICES (24X7)

Phone: **1-833-764-7700 (TTY: 1-833-889-6446)**
Fax: **1-833-641-3290**

RAPID RESPONSE AND OUTREACH TEAM (RROT)

Phone: **1-833-464-7768**
Fax: **1-833-564-3290**

UTILIZATION MANAGEMENT / PEER-TO-PEER (8:30 A.M. TO 5 P.M. ET)

Phone: **1-833-735-7700**
Fax: **1-833-329-6411**

BRIGHTSTART MATERNITY

Phone: **1-833-606-2727**
Fax: **1-833-732-9640**

24/7 NURSE CALL LINE

Phone: **1-833-625-6446**

QUALITY MANAGEMENT

Phone: **1-833-959-7676**
Fax: **1-833-533-2964**
For a listing of important contact information, refer to the *Provider Reference Guide* in the provider section of our website at https://www.amerihealthcaritasoh.com/provider/resources/index.aspx.

ODM CONTACT INFORMATION

Provider Hotline: **1-800-686-1516**

Ohio Medicaid Consumer Hotline webpage: https://www.ohiomh.com/

PROVIDER ACCOUNT EXECUTIVES

AmeriHealth Caritas Ohio's Provider Network Account Executives (AEs) function as a provider relations team to advise and educate AmeriHealth Caritas Ohio providers.

When you join AmeriHealth Caritas Ohio, a local and knowledgeable Provider Network Account Executive (AE) is assigned to your area. Your AE is your single point of contact and is available to assist you in resolving issues and answering any questions you may have. AmeriHealth Caritas Ohio Account Executives live in Ohio and have specific training and experience working with the local provider communities.

Your dedicated AE is available to routinely meet with you to provide orientations, ongoing education, and assistance. Network AEs assist providers in adopting new business policies, processes, and initiatives.

From time to time, providers will be contacted by Plan representatives to conduct meetings that address topics including, but not limited to:

- Contract Terms
- Health Management Programs
- Orientation, Education, and Training
- Program Updates and Changes
- Provider Appeals
- Provider Responsibilities
- Quality Enhancements
- Self-Service Tools

If you have questions, please contact your Provider Account Executive or contact Provider Services at ohioproviderservices@amerihealthcaritasoh.com or 1-833-644-6001.

SECTION III
PROVIDER RESOURCES

AmeriHealth Caritas Ohio

III. PROVIDER RESOURCES

PROVIDER PORTAL

Providers can access helpful information at their convenience through AmeriHealth Caritas web-based provider portal, NaviNet. The portal links providers to AmeriHealth Caritas Ohio and enables the secure sharing of administrative, financial, and clinical data.

Through the portal, you can access:

- Member eligibility verification.
- Prior Authorization.
- Claims investigation.
- Claims submission
- Care gap reports to identify needed services.
- Member Clinical Summaries.
- Medical claims data.
- Member panel rosters for PCPs included under your contract.

If you are not a NaviNet user, visit https://register.navinet.net/ to sign up. You will need your practice name, NPI number, and services location. Make sure to complete all information requested. You will be able to access the AmeriHealth Caritas Ohio information and any specific data for your practice.

If you need more information or assistance, call NaviNet at **1-888-482-8057** or AmeriHealth Caritas Ohio Provider Services at **1-833-644-6001**.

SUBSCRIPTION EMAIL SERVICES

SUBSCRIBE TO PROVIDER PARTNERSHIPS

Providers are encouraged to subscribe to *Provider Partnerships*— the no-cost email alert service for AmeriHealth Caritas Ohio providers. Joining *Provider Partnerships* allows you to receive timely and important updates regarding tools and resources, education opportunities, process changes, plan updates, and more. You may unsubscribe at any time.

To subscribe, please visit www.amerihealthcaritasoh.com/provider/newsletters-and-updates.

SUBSCRIBE TO RECEIVE MEDICAID UPDATES

Providers are also encouraged to sign-up to receive news and information from the Ohio Department of Medicaid (ODM) by visiting: https://medicaid.ohio.gov/wps/portal/gov/medicaid/home/govdelivery-subscribe.

PLAN-TO-PROVIDER COMMUNICATIONS

In addition to our email service, providers receive or have access to regular communications from AmeriHealth Caritas Ohio in many other formats, including, but not limited to:

- Provider manual
- Provider newsletters
- Website updates and information
- Provider notices and announcements
- Surveys
- Faxes
- Miscellaneous other materials

CLAIMS PAYMENT SYSTEMIC ERROR (CPSE) REPORT

In accordance with the expectations of the Ohio Department of Medicaid (ODM), and as outlined in the Medicaid Managed Care Provider Agreement between ODM and AmeriHealth Caritas Ohio, the Plan must report to ODM when claims adjustments are processed for incorrectly underpaying, overpaying, denying, or suspending claims that impact, or have the potential to impact, five or more providers. Cases that meet these criteria are defined as Claims Payment Systemic Errors (CPSEs).

On a monthly basis, at a minimum, AmeriHealth Caritas Ohio releases a Claims Payment Systemic Error (CPSE) report. A CPSE is defined as the MCO's claims adjudication incorrectly underpaying, overpaying, or denying claims that impact five or more providers. A report containing all active CPSEs is updated monthly and can be found here: https://www.amerihealthcaritasoh.com/provider/claims-billing/cpse-reports.aspx.

PROVIDER ADVISORY COUNCIL

The AmeriHealth Caritas Ohio Quality Program is designed to measure, manage, and improve quality of care and services delivered to Plan members. As part of the Quality Program, the Provider Advisory Council returns accurate and timely feedback on the Managed Care program, as reflective of member needs. The purpose of the Provider Advisory Council is to gather input, discuss and learn about issues affecting providers, identify challenges and barriers, problem-solve, share information, and collectively find ways to improve and strengthen the healthcare service delivery system.

The Provider Advisory Council includes representation from a broad spectrum of local providers, including Dental and Behavioral Health providers, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Community Mental Health Centers (CMHCs), and Integrated Delivery Networks (IDNs).

PRACTITIONER INVOLVEMENT

We encourage provider participation in our quality-related programs. Providers who are interested in participating in the Provider Advisory Council may contact Provider Services at 1-833-644-6001 or their Provider Network Account Executive.

PROVIDER POLICIES

AmeriHealth Caritas Ohio values communication with providers, including the accessibility of health plan policies and procedures, such as clinical and coverage policies, claims submission and editing information, prior authorization procedures, and other critical process descriptions. Important health plan processes and requirements, as well as clinical and coverage policies, are made available online at https://www.amerihealthcaritasoh.com/provider/resources/policies.aspx.

Online information is routinely updated, and providers are also notified by subscription email service at least 30 calendar days in advance of health plan process or requirement changes (though shorter times may be dictated by regulatory or state contract requirements).

PROVIDER SERVICES CALL CENTER INFORMATION

The AmeriHealth Caritas Ohio Provider Services Call Center is available to assist you with:

- Eligibility checking.
- Claims status inquiry.
- Electronic data exchange (EDI) technical support.
- Reporting demographic data changes.
- Filing an informal complaint.

Provider Services Phone: **1-833-644-6001**
Provider Services Fax: **1-833-643-2901**
TTY: **1-833-889-6446**

Monday through Friday, 7 a.m. to 8 p.m., Eastern Time, except for the following holidays: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Juneteenth, Labor Day, Thanksgiving Day, the day after Thanksgiving, and Christmas Day. Other emergency closures will be listed online at www.amerihealthcaritasoh.com and https://www.amerihealthcaritasoh.com/provider/newsletters-and-updates.

For a complete listing of important contact information, refer to the *Provider Reference Guide* in the provider section of our website at https://www.amerihealthcaritasoh.com/assets/pdf/provider/resources/provider-reference-guide.pdf .

PROVIDER TRAININGS

NEW PROVIDER ORIENTATION

Upon completion of AmeriHealth Caritas Ohio's enrollment process, each provider will receive a welcome letter within 30 business days of the contract being executed. The welcome letter will include the contract effective date, AmeriHealth Caritas Ohio provider ID, and the Provider Network Account Executive's contact information. Please note, providers are not considered participating (and therefore are not eligible to provide services to members) until **both** credentialing and contracting have been completed.

The welcome letter will refer all Plan providers to online resources, including AmeriHealth Caritas Ohio provider orientation and training information and this *Provider Manual*. The *Provider Manual* serves as a source of information regarding the Plan's covered services, policies and procedures, selected statutes and regulations, telephone access and special requirements intended to support provider compliance with all provider contract requirements. The welcome letter explains how to request a hard copy of this *Provider Manual* by contacting the Provider Services department at **1-833-644-6001**.

ORIENTATION TRAINING

AmeriHealth Caritas Ohio will conduct initial training within 30 days of entering into a contract with a provider, or provider group. Orientation training topics will include:

- Medicaid program overview
- Member access standards
- Provider enrollment and credentialing processes
- Provider responsibilities (including Advance Directives; Fraud, Waste, & Abuse; Medical Record Retention; IDEA; HIPAA; and Privacy)
- Cultural competency/CLAS
- Plan policies and procedures
- Utilization management, quality improvement, and population health programs
- Medical necessity criteria, clinical practice guidelines, and screening tools
- Medicaid compliance
- Covered services, benefit limitations, and value-added services
- Copays, if applicable
- Provider inquiry and appeal process
- Member grievance and appeals and State fair hearing processes
- Billing, claims filing, and encounter data reporting
- Electronic Funds Transfer and Electronic Remittance Advice
- Quality enhancement programs
- Community resources
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)/ Healthchek requirements
- Other topics as indicated by the Plan or by ODM

We have a dedicated Cultural Responsiveness webpage with multiple resources and training opportunities that address subjects such as: Cultural Humility, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Cultural Responsiveness Training, Servicing Members With Limited English Proficiency (LEP) and best practices when using language services.

PROVIDER EDUCATION AND ONGOING TRAINING

AmeriHealth Caritas Ohio's provider training and development are fundamental components of continuous quality and superior service. The Plan offers on-going educational opportunities for providers and their staff. The Plan is committed to offering appropriate training and education to help providers achieve compliance with Plan standards, and federal and state regulations. Provider training and educational programs are based on routine assessments of provider training and educational needs. This training may occur in the form of an on-site visit or in an electronic format, such as online or virtual, interactive training sessions. Detailed information is shared in advance of training opportunities and is available on the AmeriHealth Caritas Ohio website at https://www.amerihealthcaritasoh.com/provider/training-and-education/index.aspx.

At a minimum, AmeriHealth Caritas Ohio also offers training on the following topics:

- Claims, billing, and required documentation, including submitting claims through the centralized submission portal
- Requesting prior authorization through the centralized submission process
- Verifying eligibility and benefits
- Provider website, provider manual, provider orientations and training
- Supporting and assisting members in grievances and appeals.
- Opportunities for quality improvement
- When and how to refer members for behavioral health services (for physical health providers)
- When and how to refer members for physical health services (for behavioral health providers)

Additionally, the Plan offers training to providers on the topics below. Providers can contact Provider Services at **1-833-644-6001** or their Account Executive for more information.

- Integration of physical and behavioral health, person-centered care management, social determinants of health, trauma informed care, and quality
- Clinical components necessary to meet the needs of children with special healthcare needs
- Mental health first aid, recovery and resiliency principles, and trauma-informed care
- Training for primary care clinics on best practices for behavioral health screening and integrated care for depression, anxiety, and substance use disorders (SUD)
- Cross training for mental health providers received on SUD and for SUD providers on mental health
- New models for behavioral health interventions that can be implemented in primary care settings
- Clinical care integration models
- Community-based resources to address social determinants of health
- Best practices for providers serving infants with Neonatal Abstinence Syndrome (NAS)

FORMS

AmeriHealth Caritas Ohio strives to reduce the administrative burden on providers. All required provider forms are available online at https://www.amerihealthcaritasoh.com/provider/forms/index.aspx. Available forms include but are not limited to:

- Link to ODM Forms Page: https://medicaid.ohio.gov/stakeholders-and-partners/legal-and-contracts/forms/forms
- Consent for Sterilization (English): https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-english-2025.pdf
- Consent for Sterilization (Spanish): https://opa.hhs.gov/sites/default/files/2022-07/consent-for-sterilization-spanish-2025.pdf
- Acknolwegement of Hysterectomy Information: https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM03199fillx.pdf
- Abortion Certification: https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM03197fillx.pdf
- Grievances (Secure contact form): https://apps.amerihealthcaritasoh.com/securecontact/index.aspx
- Appeal (Request requirements) https://www.amerihealthcaritasoh.com/assets/pdf/member/eng/grievance-and-appeal-form.pdf
- Provider Specific Appeal Forms
- SUD Residential Admission Form: https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10294Fillx.pdf
- Medicaid Contract Addendum(s) – Medicaid addenda for use in subcontracting by managed care entities: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda
- Out-of-Network Provider Application: https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10282Fillx.pdf
- Ohio Medicaid Provider Agreement Form: https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10283Fillx.pdf
- Prior Authorization: https://navinet.my.salesforce-sites.com/

ELECTRONIC HEALTH RECORD (EHR) UTILIZATION

AmeriHealth Caritas Ohio encourages, supports, and facilitates network providers' adoption and effective use of electronic health records (EHRs), including for population health and quality improvement purposes. AmeriHealth Caritas Ohio identifies which network providers have or have not adopted EHRs and how effectively they use EHRs with a specific focus on population health and quality improvement activities.

AmeriHealth Caritas Ohio supports providers in the effective use of EHRs through the identification and promotion of connectivity to one of the state Health Information Exchanges (HIEs) to allow for data exchange within the clinical data ecosystem.

AmeriHealth Caritas Ohio intends to participate with both of Ohio's health HIEs and will be capable of

exchanging protected health information, connecting to inpatient and ambulatory electronic health records, connecting to care coordination information technology system records, and supporting secure messaging or electronic querying between providers, patients, and the Plan. This includes but is not limited to the use of HIEs for admission, discharge, and transfer (ADT) data and closing referral loops for social determinants of health (SDoH).

SECTION IV
PROVIDER RESPONSIBILITIES

IV. PROVIDER RESPONSIBILITIES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND PROTECTED HEALTH INFORMATION (PHI)

PLAN ADHERENCE TO HIPAA AND RELATED PRIVACY AND SECURITY REGULATIONS

AmeriHealth Caritas Ohio is committed to strict adherence with all federal and Ohio laws and regulations ("Regulations") regarding member privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) and their implementing regulations, as well as all federal statutes and regulations governing the privacy of Substance Use Disorder patient records (42 CFR, Part 2). All member health and enrollment information is used, disseminated, and stored according to Plan policies and guidelines to ensure its security, confidentiality, and proper use.

PROVIDER REQUIREMENTS RELATED TO MEMBER PRIVACY AND PROTECTED HEALTH INFORMATION (PHI)

As an AmeriHealth Caritas Ohio provider, you are expected to be familiar with your responsibilities under the aforementioned Federal and Ohio Privacy and Security Regulations, and to take all necessary actions to fully comply. Any member record containing clinical, social, financial, or any other identifying information must be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure. AmeriHealth Caritas Ohio providers are required to assist with privacy and security investigations, as necessary; including providing attestations of destruction for misdirected documentation containing protected health information (PHI), personally identifiable information (PII), or other sensitive or confidential information, to ensure that contractual as well as federal obligations are met in a timely manner.

PROVIDER OBLIGATIONS FOR ORAL TRANSLATION, INTERPRETATION, AND SIGN LANGUAGE SERVICES

In summary, Section 601 of Title VI of the Civil Rights Act of 1964 requires that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

In summary, Title III of the Americans with Disabilities Act (ADA) provides that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

Section 4302 of the Affordable Care Act supports the self-reported collection of race, ethnicity, sex, primary language and disability status according to the Office of Management and Budget (OMB) categories. This provision allows the Plan to comply with federal and national provisions established to reduce health disparities and deliver culturally competent care.

PROVIDER RESPONSIBILITIES

As a provider of healthcare services who receives federal financial payment through the Medicaid program, you are responsible for making arrangements for language services for members, upon request, who are either Limited English Proficient (LEP) – that is, they do not speak English as their primary language and have a limited ability to read, write, speak or understand English - or are sensory-impaired or experience other interpretation needs, and facilitate the provision of healthcare services to such members.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/healthcare provider relationship. The key to equal access to benefits and services for LEP, sensory impaired, or members who experience other interpretation needs is to help ensure that you, our network provider, can effectively communicate with these members. Plan providers are required to offer translation services to LEP member's needs upon request and to accommodate members with other sensory impairments.

To request interpreter services for AmeriHealth Caritas Ohio members:

1. Call Provider Services at 1-833-644-6001 to arrange interpreter services for ACOH members
2. Provider the member's information
3. Provider Services associates are able to arrange interpreter services for the provider/member.

Providers are required to:

- Offer written and verbal language access at no cost to Plan members with limited- English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of qualified interpreters, as necessary.
- Offer members verbal or written notice (in their preferred language or format) about their right to receive free language services assistance.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.
- Discourage members from using family or friends as oral translators.*
- Advise members that language services are available through AmeriHealth Caritas Ohio, if the provider is not able to obtain necessary language services for a member.

***Note**: The assistance of friends, family, and bilingual staff is not considered qualified, quality interpretation. These persons should not be used for interpretation services except where a member has been made aware of his/her right to receive free interpretation services and specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances. These persons may also provide such services in an emergency involving an imminent threat to the safety or welfare of the member or the public where there is no qualified interpreter immediately available.

AmeriHealth Caritas Ohio contracts with a competent telephonic interpreter service provider. We have an arrangement to make our corporate rate available to participating Plan providers. If you need more information on using this telephonic interpreter service, please contact Provider Services at **1-833-644-6001**.

Healthcare providers who are unable to arrange for interpretation services for an LEP, LLP, or sensory-impaired member should contact Member Services at **1-833-764-7700**, TTY: **1-833-889-6446**, and a representative will help locate a professional interpreter to communicate in the member's primary language.

When a member uses the Plan's interpretation services, the provider must sign, date and complete documentation in the medical record in a timely manner to reflect the use of services.

In addition to the requirements listed above, under The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) as set forth by the U.S. Department of Health and Human Services, Plan providers are strongly encouraged to:

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Additional tips to support members with LEP and other interpretation needs include:

- Establishing written policies to provide interpretive services for Plan members upon request.
- Routinely documenting preferred language or format, such as Braille, audio, or large type, in all member medical records.

NOTIFICATION OF PRACTICE CHANGES

As an AmeriHealth Caritas Ohio provider, you are required to notify the Plan of changes to your practice including at a minimum:

- Address and telephone numbers.
- Practitioners working at each location.
- Acceptance of new patients.
- Standard office hours.

Changes must be reported in a timely way by contacting your Account Executive or Provider Services at **1-833-644-6001**.

Changes must also be reported to ODM via the Provider Network Management (PNM) module, which serves as the source of truth for provider data. As a result, data in the PNM is used in both the Plan's provider directory and ODM provider directory. To ensure provider information remains current it is

important for providers to keep their information up to date in the PNM module, as well. For more information, please see “Provider Maintenance” in Section V. of this *Provider Manual*.

PROCEDURE TO NOTIFY AMERIHEALTH CARITAS OHIO OF CHANGES IN MEMBER CIRCUMSTANCES

You can contact your Account Executive or Provider Services at 1-833-644-6001 to notify AmeriHealth Caritas Ohio of changes in enrollee circumstances that may affect the member’s eligibility including changes in the member’s residence and death of the member.

CULTURAL COMPETENCY, RESPONSIVENESS AND LINGUISTICS SERVICES

Embedded in all AmeriHealth Caritas Ohio efforts is an equitable, culturally and linguistically appropriate approach to the delivery of healthcare services. We foster cultural and health equity awareness both in our staff and in our provider community. We leverage demographic data, including but not limited to: race, ethnicity, language data (REL), sexual orientation, and gender identity (SOGI) data, to help ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network.

AmeriHealth Caritas Ohio routinely examines the access to care standards for both the general population and the population who speaks a threshold language. A threshold language is a language spoken by at least five percent or 1,000 members of AmeriHealth Caritas Ohio’s member population, whichever is less.

In addition, the provider newsletter includes pertinent articles on addressing equity, cultural or language information.

Our Health Equity Program, led by the Market Director for Health Equity, is composed of a cross-departmental workgroup and follows the 15 National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) as set forth by the U.S. Department of Health and Human Services:

PRINCIPAL STANDARD

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

GOVERNANCE, LEADERSHIP AND WORKFORCE

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

COMMUNICATION OF LANGUAGE ASSISTANCE

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all healthcare and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

ENGAGEMENT, CONTINUOUS IMPROVEMENT, AND ACCOUNTABILITY

9. Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance-resolution process that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

Providers may request more information on the Cultural Competency and Responsiveness Program by contacting Provider Services **1-833-644-6001** or inquiring with their dedicated Provider Account Executive.

ENHANCING CULTURAL COMPETENCY IN HEALTHCARE SETTINGS

AmeriHealth Caritas Ohio encourages providers and their staff to report their race and ethnicity, the languages they speak, the language services and specialties that are available through the practice, and their training in equity.

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.

Provider and member information is analyzed to identify opportunities for improvement so the Plan can provide the best possible service to its providers and members. The languages reported by providers are published in the provider directory so members can easily find providers who speak their language. We also encourage providers to report the diversity of their staff and practices, to ensure that we are serving the cultural needs of our members.

ADDITIONAL RESOURCES

The following additional resources are available upon request:

- Health Resources and Services Administration: Culture, Language Health Literacy
- National Institutes of Health: Clear Communication / Cultural Competency
- The Health Literacy & Plain Language Resource Guide

CULTURAL RESPONSIVENESS TRAINING

In an effort to deliver culturally and linguistically appropriate care to members who have limited English proficiency, who represent diverse multicultural and ethnic backgrounds, who have special health needs, who are impacted by social determinants of health (SDoH), or who are from a population group that disproportionally faces systemic discrimination, AmeriHealth Caritas Ohio offers providers an annual cultural responsiveness training aimed at:

- Delivering services and care that honors members' beliefs and cultural practices.
- Understanding and providing services in a manner that is sensitive to cultural diversity.
- Fostering attitudes and interpersonal communication styles that respect diverse cultural backgrounds.
- Addressing health disparities, bias of the social determinants of health, and health literacy.

Providers are also encouraged to complete the free eLearning cultural competency training offered by HHS Office of Minority Health titled "A Physician's Practical Guide to Culturally Competent Care." This training offers up to six CEUs and can be accessed at: https://cccm.thinkculturalhealth.hhs.gov/.

CULTURAL COMPETENCY TERMS AND DEFINITIONS

Providers should be aware of the following terms and their definitions:

Cultural Competence: The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations.

Culture as defined by the CDC refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Competence as defined by the U.S. Department of Health and Human Services implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by members and their communities.

Cultural affiliations may include, but are not limited to race, preferred language, gender identity, sexual orientation, ethnicity, disability, age, religion, deaf and hearing impaired, citizenship status, homelessness, and geographic location.

Individuals with Limited English Proficiency (LEP): Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

Low Literacy Proficiency: In Public Law 102-73, the National Literacy Act of 1991, Congress defined literacy as an individual's ability to read, write, and speak English and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve his or her goals and develop his or her knowledge and potential. Individuals lacking these levels of proficiency would be considered to have low literacy proficiency.

Sensory Impaired: A person who is deaf or visually impaired.

ADVANCE DIRECTIVES

All participating Plan providers are required to facilitate advance directives for individuals as defined in 42 C.F.R 489.100 and to comply with all federal and state laws and regulations related to advance directives. "Advance Directive" means written instructions such as a living will or durable power of attorney for healthcare relating to the provision of healthcare when an adult is incapacitated.

Providers are required to document in the member's medical record and plan of care whether, or not, the member has executed an Advance Directive. The member has the right to choose a person to act on his or her behalf to make healthcare decisions for him/her if the member cannot make the decision for him or herself.

AmeriHealth Caritas Ohio requires its contracted providers to maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advance directives must be furnished to members by providers and/or organizations as required by federal regulations:

- Hospital - at the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - at the time of the individual's admission as a resident.
- Home Health Agency - in advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient at the time of the first home visit, if the information is furnished before care is provided.
- Hospice Program - at the time of initial receipt of hospice care by the individual from the program.

Additionally, providers and/or organizations are not required to:

- Provide care that conflicts with an advance directive.
- Implement an advance directive if doing so would violate an attending physician's conscience or the conscience-based policy of the facility at which a patient is being treated. However, the physician must without delay make the necessary arrangements to affect the transfer of the patient and medical records to a facility or physician chosen by the patient, the patient's agent, or the patient's family.
- Implement an advance directive if, after reasonable inquiry, there are reasonable grounds to question the genuineness or validity of a declaration.

MEMBER RIGHTS AND RESPONSIBILITIES

AmeriHealth Caritas Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or Veteran's status, sexual orientation, and gender identity or expression or any other status protected by federal or state law.

AmeriHealth Caritas Ohio is committed to complying with all applicable requirements under federal and state law and regulations pertaining to member privacy and confidentiality rights.

AmeriHealth Caritas Ohio has provided its members with this information on their rights. We look forward to providers support in further protecting these rights. These can also be found in the member handbook https://www.amerihealthcaritasoh.com/assets/pdf/member/eng/member-handbook.pdf.

YOUR MEMBERSHIP RIGHTS

As a member of AmeriHealth Caritas Ohio, you have the following rights:

- To make recommendations about the rights and responsibilities of AmeriHealth Caritas Ohio members.
- To receive all services that AmeriHealth Caritas Ohio must provide
- To receive all information about AmeriHealth Caritas Ohio's services, practitioners, and providers.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss medically necessary treatment options for your condition(s), no matter the cost or benefit coverage.
- To participate with providers in making decisions relating to your health care.

- To be able to take part in decisions about your health care as long as the decisions are in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To say “yes” or “no” to having any information about you given out unless AmeriHealth Caritas Ohio must by law.
- To say no to treatment or therapy. If you say no, the provider or AmeriHealth Caritas Ohio must talk to you about what could happen, and they must put a note in your medical record about it.
- To file an appeal, a grievance (complaint) or state hearing. See pages 27-29 of this handbook to learn more.
- To get help free of charge from AmeriHealth Caritas Ohio and its providers if you do not speak English or need help in understanding information.
- To get all written member information from the AmeriHealth Caritas Ohio:
    - at no cost to you.
    - in the prevalent non-English languages of members in the AmeriHealth Caritas Ohio service area.
    - in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse their care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See page 22 to learn more about advance directives.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP in the AmeriHealth Caritas Ohio’s network at least monthly. AmeriHealth Caritas Ohio must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that the AmeriHealth Caritas Ohio, the AmeriHealth Caritas Ohio providers or the Ohio Department of Medicaid will not hold this against you.
- To know that the AmeriHealth Caritas Ohio must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman’s health provider in the AmeriHealth Caritas Ohio network for covered woman’s health services.
- To get a second opinion from a qualified provider in the AmeriHealth Caritas Ohio‘s network. If a qualified provider is not able to see you, AmeriHealth Caritas Ohio must set up a visit with a provider not in our network.
- To get information about AmeriHealth Caritas Ohio from us.
- To contact the Ohio Department of Medicaid and/or the United States Department of Health and Human Services Office of Civil Rights at the addresses below with any complaint of discrimination based on race, ethnicity, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

AmeriHealth Caritas Ohio

The Ohio Department of Medicaid
Office of Human Resources, Employee Relations
P.O. Box 182709
Columbus, Ohio 43218-2709

E-mail: ODM_EmployeeRelations@medicaid.ohio.gov
Fax: 1-614-644-1434

Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave. – Suite 240
Chicago, Illinois 60601
Ph: 1-312-886-2359 TTY 1-312-353-5693

YOUR MEMBERSHIP RESPONSIBILITES

Give AmeriHealth Caritas Ohio and your providers all the information they need to provide care.

- Show your member ID card when using health care services and inform AmeriHealth Caritas Ohio if you lose your ID card.
- Provide your PCPs and other providers with accurate and complete medical information.
- Let AmeriHealth Caritas Ohio and your providers know if you have changes in your health or contact information.

Follow your doctor's care instructions and treat your health care providers with kindness and respect.

- Keep your appointments. If you must cancel, call as soon as you can.
- Ask questions.
- Let your providers know if there are any reasons why you cannot follow their treatment plan.
- Treat healthcare staff with respect. Contact Member Services if you have any problems with healthcare staff. Call Member Services at 1-833-764-7700 (TTY 1-833-889-6446), 24 hours a day, seven days a week.

Learn as much as you can about your health so you can play an active role in your care.

- Be aware of the benefits and services available through AmeriHealth Caritas Ohio and how to use them.
- If you have questions or require additional information, contact AmeriHealth Caritas Ohio Member Services or speak to your PCP.
- Ask for more explanation if you do not understand your doctor's instructions.
- To the extent you can understand your health conditions and develop mutually agreed upon treatment goals.

SECTION V
PROVIDER ENROLLMENT, CREDENTIALING, AND CONTRACTING

V. PROVIDER ENROLLMENT, CREDENTIALING, AND CONTRACTING

PROVIDER ENROLLMENT (ODM FUNCTIONS)

GENERAL PROVIDER INFORMATION/ENROLLMENT INFORMATION

Pursuant to 42 Code of Federal Regulations (CFR) 438.602, the Ohio Department of Medicaid (ODM) is required to screen, enroll, and revalidate all managed care organization (MCO) network providers. This provision does not require MCO network providers to render services to fee-for-service (FFS) beneficiaries.

There are many resources available on the Ohio Department of Medicaid website about the requirements to become a participating provider. Please visit https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support for several useful documents that answer relevant questions.

Organizational provider types will be required to pay a fee. The fee does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 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.

INTEGRATED HELP DESK/ODM PROVIDER CALL CENTER

If you have questions or need assistance with your Ohio Medicaid provider enrollment, call the ODM Integrated Helpdesk at **1-800-686-1516** 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 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

PROVIDER CONTRACTING

BECOMING A PLAN PROVIDER

AmeriHealth Caritas Ohio maintains and adheres to all applicable state and federal laws and regulations, Ohio Department of Medicaid (ODM) requirements including any additional provider selection requirements, and accreditation standards governing credentialing and re-credentialing functions as defined by the National Committee on Quality Assurance (NCQA). Unless otherwise indicated, all providers participating with AmeriHealth Caritas Ohio must also be enrolled with Ohio Medicaid and have an Ohio Medicaid identification number and unique National Provider Identifier (NPI) for every provider

type. For additional requirements for participation in the ACOH provider network, please refer to the Standards for Participation section of this manual.

INITIATING THE CONTRACTING PROCESS

To request a Provider Agreement, please complete a *Provider Contract Inquiry Form* available online at https://www.amerihealthcaritas.com/assets/pdf/become-a-provider/ohio/provider-contract-inquiry.pdf or contact AmeriHealth Caritas Ohio Provider Recruitment by emailing providerrecruitmentoh@amerihealthcaritas.com or by calling **1-833-296-2259**.

For examples of our provider contracts, please visit: https://www.amerihealthcaritasoh.com/provider/credentialing/index.aspx.

MEDICAID ADDENDUM

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organization and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachments are only needed when providers are offering different services or practitioners through this plan contract than are identified in the PNM system. Attachment A is needed for all PCPs to identify the providers' capacity and service location. Attachment A is also required when a provider has specific practitioner affiliates identified in the PNM who are agreeing to provide services under this plan contract. Attachment C is only required when the contract between the managed care entity and the provider includes particular specialties rather than all specialties the provider identified in the PNM system. The most current Medicaid Addendum is posted on the ODM website here: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda. The addendum must be completed along with the MCO provider contract.

TERMINATION, SUSPENSION, OR DENIAL OF CONTRACT

PROVIDER CONTRACT TERMINATIONS

AmeriHealth Caritas Ohio uses provider agreements that have been approved by all the appropriate local authorities.

AmeriHealth Caritas Ohio Provider Agreements specify termination provisions that comply with AmeriHealth Caritas Ohio and ODM requirements.

CONTINUITY OF CARE

Upon notification from a member or provider of a need to continue services, ACOH will allow a new member to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services.

DENIED PARTICIPATION

AmeriHealth Caritas Ohio makes every effort to contract with all willing providers for all specialties that enhance access and improve the quality of care for our members. However, there may be instances where our provider network may have reached capacity with regard to a specific provider specialty or service. In those instances, AmeriHealth Caritas Ohio will notify the provider of the decision to decline participation of the provider via letter or electronic notification.

If the provider is denied participation due to findings during the credentialing process, the provider will have the ability to file an appeal based on policies and procedures related to the AmeriHealth Caritas Ohio credentialing process. Until credentialing-related participation issues are resolved or overturned, a provider will not be considered “in network” or have the ability to treat AmeriHealth Caritas Ohio members.

NON-CONTRACTED OR UNERNROLLED 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)

PLAN PROVIDER CALL CENTER

The AmeriHealth Caritas Ohio Provider Services Call Center is available to assist you with:

- Eligibility checking.
- Claims status inquiry.
- Electronic data exchange (EDI) technical support.
- Reporting demographic data changes.
- Filing an informal complaint.

Provider Services Phone: **1-833-644-6001**
Provider Services Fax: **1-833-643-2901**

Monday through Friday, 7 a.m. to 8 p.m., Eastern Time, except for the following holidays: New Year’s Day, Martin Luther King Day, Memorial Day, Independence Day, Juneteenth, Labor Day, Thanksgiving Day, day after Thanksgiving, and Christmas Day. Emergency closures will be listed online at www.amerihealthcaritasoh.com.https://www.amerihealthcaritasoh.com/provider/newsletters-and-updates/index.aspx.

By agreeing to provide services to AmeriHealth Caritas Ohio members, providers must:

- Be eligible to participate in any federal healthcare benefit program and participate in the Ohio Medicaid program.
- Comply with all pertinent Ohio Medicaid regulations.
- Treat AmeriHealth Caritas Ohio members in the same manner as other patients.
- Provide covered services to all AmeriHealth Caritas Ohio members who select or are referred to you as a provider.
- Provide covered services and not discriminate against, or use any policy or practice that has the effect of discriminating against, an individual on the basis of health or behavioral health history or status, need for healthcare services, amount payable to the Plan on the basis of the eligible person's actuarial class, pre-existing medical/health conditions, or race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, or physical or mental handicap. All providers must comply with the requirements of the Americans with Disabilities Act (ADA) and Section 504 of Rehabilitation Act of 1974.
- Not segregate members from other patients (applies to services, supplies and equipment).
- Not refuse to provide services to members due to a delay in eligibility updates.

In addition, pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, AmeriHealth Caritas Ohio may not make payment to any person or an affiliate of a person who is debarred, suspended, or otherwise excluded from participating in the Medicare, Medicaid, or other federal healthcare programs.

A sanctioned person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other federal healthcare program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Upon request of AmeriHealth Caritas Ohio, a provider will be required to furnish a written certification to the Plan that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a sanctioned person.

A provider is required to immediately notify AmeriHealth Caritas Ohio upon knowledge that any of its employees, directors, officers, or owners has become a sanctioned person, or is under any type of investigation which may result in their becoming a sanctioned person. In the event that a provider cannot provide reasonably satisfactory assurance to AmeriHealth Caritas Ohio that a sanctioned person will not receive payment from the Plan under the provider agreement, AmeriHealth Caritas Ohio may immediately terminate the provider agreement. The Plan reserves the right to recover all amounts paid by AmeriHealth Caritas Ohio for items or services furnished by a sanctioned person.

ACCESS TO CARE

AmeriHealth Caritas Ohio providers must meet access standard guidelines as outlined in this publication to help ensure that Plan members have timely access to care.

AmeriHealth Caritas Ohio endorses and promotes comprehensive and consistent access standards for

members to assure member accessibility to healthcare services. The Plan establishes mechanisms for measuring compliance with existing standards and identifies opportunities for the implementation of interventions for improving accessibility to healthcare services for members.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance or comparable to the hours of operation offered to Medicaid Fee for Service patients. Appointment scheduling and wait times for members should comply with the access standards defined below. The standards below apply to healthcare services and medical and behavioral health providers.

AmeriHealth Caritas Ohio monitors the following access standards on an annual basis per AmeriHealth Caritas Ohio guidelines. If a provider becomes unable to meet these standards, he/she must immediately advise his/her Provider Network Account Executive or the Provider Services department at **1-833-644-6001**.

The following appointment and availability standards do not replace access requirements established by ODM for Comprehensive Primary Care (CPC) practices as part of a value-based agreement.

Member Appointment & Availability Standards		
Visit Type	Description	Standard
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 Appointment	Care provided for a non-urgent illness or injury with current symptoms.	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
Prenatal Care – First or Second Trimester	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 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

Member Appointment & Availability Standards		
Visit Type	Description	Standard
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
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency medical condition.	24 hours, 7 days/week
Behavioral Health		
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
Child and Adolescent Needs and Strengths (CANS) Initial Assessment	Assessment for the purpose 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
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

MISSED APPOINTMENT TRACKING

If a member misses an appointment with a provider, the provider should document the missed appointment in the member's medical record. Providers should make at least three documented attempts to contact the member and determine the reason for the missed appointment. The medical record should reflect any reasons for delays in providing healthcare, as a result of missed appointments, and should also include any refusals of care by the member. Providers are encouraged to advise AmeriHealth Caritas Ohio's Rapid Response and Outreach Team at **1-833-464-7768** if outreach assistance is needed when a member does not keep appointment and/or when a member cannot be reached during an outreach effort.

AFTER-HOURS ACCESSIBILITY

AmeriHealth Caritas Ohio members have access to quality, comprehensive healthcare services **24 hours a day, seven days a week**. PCPs must have either an answering machine or an answering service for members during after-hours for non-emergent issues. The answering service must forward calls to the PCP or on-call provider or instruct the member that the provider will contact the member within 30 minutes. When an answering machine is used after hours, the answering machine must provide the member with a process for reaching a provider after hours. The after-hours coverage must be accessible using the medical office's daytime telephone number.

For emergent issues, both the answering service and answering machine must direct the member to call 911 or go to the nearest emergency room. AmeriHealth Caritas Ohio will monitor access to after-hours care on an annual basis by conducting a survey of PCP offices after normal business hours.

MONITORING APPOINTMENT ACCESS AND AFTER-HOURS ACCESS

AmeriHealth Caritas Ohio will monitor appointment waiting times and after-hours access using various mechanisms, including:

- Reviewing provider records during site reviews.
- Monitoring administrative complaints and grievances; and,
- Conducting an annual Access to Care survey to assess member access to daytime appointments and after-hours care.
- Non-compliant providers will be subject to corrective action and/or termination from the network.
- A non-compliance letter will be sent to the provider.
- The non-compliant provider will be re-surveyed within three to six months after the infraction.

CREDENTIALING AND RECREDENTIALING PROCESSES

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 AmeriHealth Caritas Ohio.

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 AmeriHealth Caritas Ohio so they can start contracting with you.

SECTION VI
COVERED SERVICES

VI. COVERED SERVICES

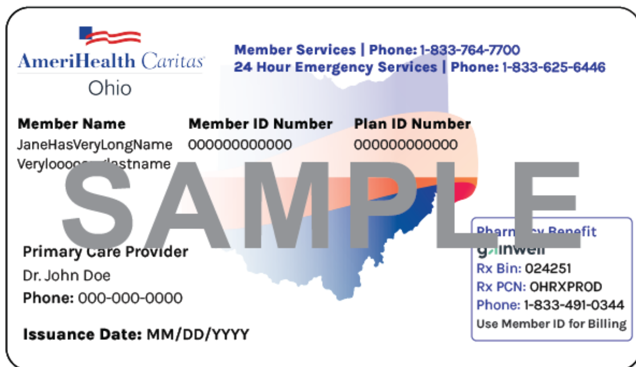
This section provides a summary of the covered services offered to AmeriHealth Caritas Ohio members under the Medicaid managed care program.

No content found in this publication or in the Plan's participating Provider Agreement is intended to prohibit or otherwise restrict a provider from acting within the lawful scope of his or her practice, or to encourage providers to restrict medically necessary covered services or to limit clinical dialogue with patients. Providers are not prohibited from advising or advocating on behalf of a member who is his or her patient and may discuss the member's health status, healthcare, treatment options (including any alternative treatment that may be self-administered), information the member needs to make a decision between relevant treatment options, the risks, benefits and consequences of treatment or non-treatment and the member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions. Regardless of benefit coverage limitations, providers are encouraged to openly discuss all available treatment options with Plan members.

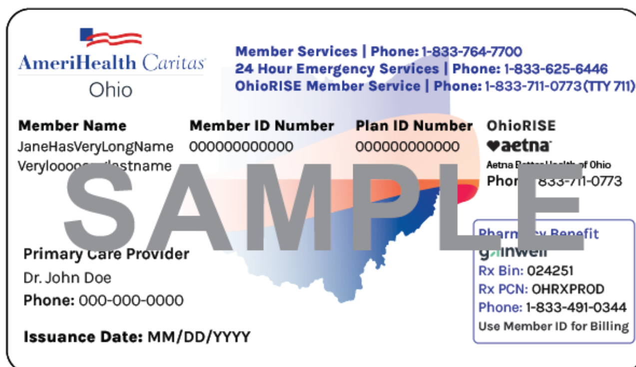
MEMBER ID CARDS

AmeriHealth Caritas Ohio will issue an ID card to each member. Each card is valid for as long as the person is a member of AmeriHealth Caritas Ohio. Providers may call the Provider Services Call Center to check member eligibility at **1-833-644-6001**.

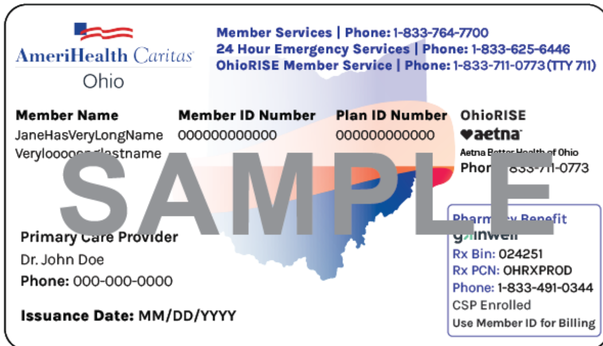
AmeriHealth Caritas Ohio Medicaid Standard Member ID card – front and back



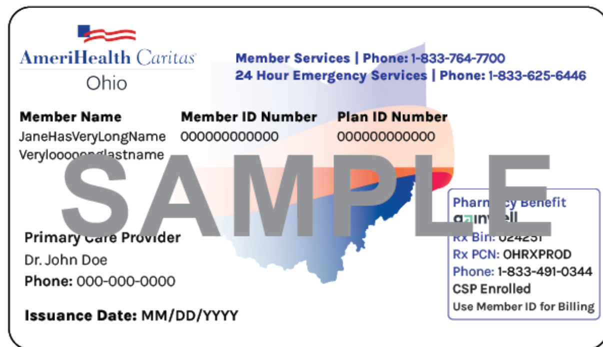
AmeriHealth Caritas Ohio Medicaid Ohio Rise Member ID card – front and back



AmeriHealth Caritas Ohio Medicaid Ohio Rise with Coordinated Services Program (CSP) Member ID card – front and back



AmeriHealth Caritas Ohio Medicaid Coordinated Services Program (CSP) Member ID card – front and back



LIST OF COVERED SERVICES

Basic covered services include inpatient; outpatient and ambulatory medical and surgical services; gynecological, obstetric, and family planning services; transportation; behavioral health services (except for certain behavioral health services for members enrolled in OhioRISE); and a variety of other services. Plan members may also be eligible to receive Value Added services not covered by Ohio's fee-for-service Medicaid program.

All services must be medically necessary, and some services may have limitations or require authorization. For information on Prior Authorization requirements, see the "Utilization Management" section of this *Provider Manual*.

For the most complete and up-to-date benefit information please contact AmeriHealth Caritas Ohio Provider Services at **1-833-644-6001**.

For additional information regarding the Ohio Medicaid program policies and benefits, please consult the ODM Resources for Providers webpage.

Covered Services
Acupuncture – to treat certain conditions
Allergy Services
Ambulance and Wheelchair Van Transportation
Behavioral Health Services (including mental health and substance use disorder treatment)
Certified Nurse Midwife Services
Certified Nurse Practitioner Services
Chemotherapy Services
Chiropractic (Back) Services
Dental Services
Developmental Therapy Services for Children Aged Birth to Six Years
Diagnostic Services (X-ray, Lab)
Durable Medical Equipment over $750
Emergency Services
Family Planning Services and Supplies
Free-Standing Birth Center Services at a Free-Standing Birth Center
Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) Services
Gynecological Services (OBGYN)
Home Health Services
Hospice Care
Inpatient Hospital Services
Medical Nutrition Therapy (MNT) Services
Nursing Facility Services (except where ODM determines the member will return to fee-for-service Medicaid)
Maternity Care – prenatal and postpartum including at risk pregnancy services

Outpatient Hospital Services
Pharmacist Services (under the medical benefit)
Physician 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 Cancer and Cervical Cancer Screenings
Primary Care Provider Services
Renal Dialysis (Kidney Disease) Services
Respite Services – for members under 21 years of age and who have LTC (Long Term Care) or behavioral health needs
Screening and Counseling for Obesity
Services for Children with Medical Handicaps (Title V)
Shots (Immunizations)
Specialist Services
Speech and Hearing Services – including hearing aids.
Telehealth Services
Tobacco Cessation Services – including tobacco cessation counseling and FDA approved medications for tobacco cessation
Vision (Optical) Services – including eyeglasses
Well-Child (Healthchek) Exams for Children Under the Age of 21
Yearly Well-Adult Exams

LIST OF SERVICES NOT COVERED

AmeriHealth Caritas Ohio 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.

AmeriHealth Caritas Ohio is not required to cover pharmacy services other than the limited pharmacy services as described in this manual. All other pharmacy benefits are covered by ODM's single pharmacy benefit manager (SPBM). AmeriHealth Caritas Ohio will coordinate and collaborate with the SPBM as necessary to ensure that members receive medically necessary pharmacy services.

MEMBER BENEFITS AND INCENTIVES

AmeriHealth Caritas Ohio offers members some extra benefits in addition to the covered services required by Ohio Medicaid. Additional details are available on our website or by calling Member Services at **1-833-764-7700** (TTY: **1-833-889-6446**).

Extra benefits include:

- Care coordination: A dedicated Care Coordinator can help members manage health conditions and other important areas affecting their health. This can include finding emergency food or helping fill out an application for affordable housing.
- Dental: Children and adults can receive a dental cleaning and exam twice per year (every six months). Coverage for dentures, fillings, crowns, etc. may be covered when medically necessary.
- Eye care: One exam and eyeglasses every 12 months (individuals younger than age 21 and older than age 60). One exam and eyeglasses every 24 months (individuals between the ages of 21 and 59). Additional eye care is available for members living with diabetes.
- Contact lenses: Members will be eligible for an allowance up to $150 for contact lenses per calendar year. To qualify for the $150 allowance, members must get an exam, lens fitting and receive a prescription for contact lenses.
- Transportation: AmeriHealth Caritas Ohio provides a supplemental transportation benefit that covers up to 60 non-emergency one-way trips per member per year for provider visits less than 30 miles. If a member must travel 30 miles or more from home to receive covered healthcare services, AmeriHealth Caritas Ohio will provide transportation to and from the provider's office. The member can call 1-833-664-6368 to schedule a ride.
- Games on mobile phone: Motivv mobile gaming supports health education and links to member benefits by asking health trivia questions. By playing ad-free, no-cost games members can earn rewards on their CARE Card.
- Food as Medicine: Qualifying members recently discharged from a hospital or enrolled in our diabetes program, and pregnant and post-delivery members and families can receive home-delivered meals at no cost.
- Housing help: Access to a housing coordinator to identify local resources for safe and stable housing for pregnant members.
- School essentials: Up to $75 per child for school uniforms and school supplies.
- Diabetes care
    - Home delivered meals and nutrition counseling
    - Continuous glucose monitoring for members with diabetes: AmeriHealth Caritas Ohio provides members living with diabetes with mobile smartphones. Apps and tools on the phone will support continuous glucose monitoring (CGM) so members with diabetes can have easier control of their blood sugar levels.

    - For our members (age 21 to 64) who have a diagnosis of diabetes, we offer a special vision program.
        - One comprehensive eye exam every year.
        - One new pair of glasses (frame and lenses) every 2 years. Adjustments to lenses, as needed, every year.
- Pregnancy and postpartum care
    - Bright Start maternity management program. Members get access to our pregnancy care program to help schedule appointments and connect to community resources and additional programs.
    - Bright Start Beginnings Bundle: a bundle to provide essential items for a new baby, including items to support a safe sleep environment and postpartum support such as a sleep sack, pacifiers, nursing pads, and a wearable baby carrier.
    - Home delivered meals for new moms and their families.
    - Access to a housing coordinator to identify local resources for safe and stable housing and up to $750 toward housing-related expenses in emergency situations for pregnant members.
- Mission GED: This program can help members further their education and earn their GED certificate. It includes motivational coaching and vouchers to help with testing expenses.
- Weight Watchers (WW) online membership: Members ages 18 – 64 can get WW membership at no cost for six months (up to a $250 value).
- Living Beyond Pain: This chronic pain management program can help a member improve pain management with non-opioid alternatives. This includes 15 additional chiropractic and 30 acupuncture visits per year.
- Mobile phone: AmeriHealth Caritas Ohio members may qualify for the Lifeline Wireless program. It includes a no-cost smartphone, unlimited talk, unlimited text, and 4.5 GB data.
- Home health aide training: Offers interested members Ohio Council for Home Care & Hospice's Home Health Aide Training Program at no cost to train and certify new home health aides.
- Asthma bundle: a bundle for members under 18 with a diagnosis of asthma to support a healthy home environment with an air purifier, set of two hypoallergenic pillowcases, and gift card for cleaning supplies.

MEMBER REWARDS AND INCENTIVES

CARE Card — With our CARE Card program, members can receive rewards for completing health-related activities. Members can earn up to $250 in cash and non-cash goods and services each state fiscal year ending June 30. Visit our website to learn more about how members can earn rewards.

REQUESTS FOR SPECIALIST REFERRALS

AmeriHealth Caritas Ohio does not require referrals to in-network specialists. Prior authorization is required for out-of-network providers.

TRANSPORTATION VENDOR CONTACT INFO

AmeriHealth Caritas Ohio contracts with MTM for Non-Emergency Medical Transportation (NEMT).
MTM Telephone: **1-833-664-6368.**

FOR TRANSPORTATION CLAIM SUBMISSION

For transportation providers currently contracted with MTM, you may contact MTM at 1-888-597-1180. Or contact your MTM vendor account manager directly. For transportation providers that are not contracted with MTM, please contact MTM for more information on how to join the NEMT network at https://www.mtm-inc.net/service-providers/.

TRANSPORTATION POLICIES/COVERAGE

AmeriHealth Caritas Ohio contracts with MTM for NEMT. Members who must travel 30 or more miles from home to receive covered health services, can access NEMT services for travel to and from the provider's office by contacting MTM at **1-833-664-6368**. MTM will arrange NEMT for members via the most cost-effective and least expensive mode of transportation available.

AmeriHealth Caritas Ohio also provides **additional transportation** benefits as outlined below:

- 30 additional one-way or 15 additional round trips per member per year (for a total of 60 one-way and 30 round trips).
- Additional trips for chemotherapy, radiation, or dialysis appointments, as needed.
- Transportation provided for members to access out-of-network providers for service if we are unable to provide in-network is not counted toward the transportation benefit.
- Include medical and non-medical trips to places that are less than 30 miles from the member's home when members cannot access transportation through the county departments of Job and Family Services, including pharmacy stops and non-medical trips.

In addition to the transportation assistance offered by AmeriHealth Caritas Ohio, health plan members have access to transportation for certain services through the local county Department of Job and Family Services Non-Emergency Transportation (NET) program. Members should call their county Department of Job and Family Services for questions or assistance with NET services.

Additional details are available on our website.

TRANSPORTATION FOR OHIORISE MEMBERS

AmeriHealth Caritas Ohio 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. AmeriHealth Caritas Ohio 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, even when the member is not being transported.

EMERGENCY SERVICES

In the event of a member emergency, please contact 911.
AmeriHealth Caritas Ohio ensures the availability of emergency services and care **24 hours a day, 7 days a week**, and is responsible for coverage and payment of emergency and post-stabilization care services in accordance with federal law, regardless of whether the provider who furnishes the services has a contract with AmeriHealth Caritas Ohio.

Post-stabilization services are medically necessary services and treatment provided to the member after the Emergency Services.

ACOH covers post-stabilization services that are not pre-approved but are administered to maintain, improve, or resolve the member's stabilized condition in the following instances:

- ACOH was not available at the time of initial request;
- ACOH did not respond within one (1) hour from initial request; or,
- ACOHs representative and the treating physician cannot reach an agreement concerning the member's care and an ACOH physician is not available for consultation. In this case, ACOH will give the treating physician the opportunity to consult with an ACOH physician and the treating physician may continue with the care of the member until the ACOH physician is reached or one of the other post-stabilization services criteria is met.

ACOHs financial responsibility for post-stabilization services that it has not pre-approved ends when:

- A network physician with privileges at the treating hospital assumes responsibility for the member's care;
- A network physician assumes responsibility for the member's care through transfer;
- A representative of ACOH and the treating physician reach an agreement concerning the member's care; or,
- The member is discharged.

AmeriHealth Caritas Ohio will not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulted in serious impairment to bodily functions, or resulted in serious dysfunction of any bodily organ or part.

ACOH will not refuse to cover emergency services, including ambulance services, based on the provider of such services, the hospital, or the fiscal agent not notifying the Member's AMH/PCP or PHP of the Member's screening and treatment within ten (10) calendar days of presentation for emergency services.

Under no circumstances is the member financially responsible for emergency room care provided by a facility within the United States, regardless of whether that facility participates in ACOHs network.

In accordance with 42 CFR 438.114 and OAC rule 5160-26-03, the ACOH will reimburse out-of-network providers of emergency services the lesser of billed charges or 100% of the current Medicaid FFS rate.

Definitions and requirements regarding urgent/emergent care are as follows:

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency Services: Covered inpatient and outpatient services, or medical transportation, that are furnished by a provider that is qualified to furnish the services needed to evaluate, treat, or stabilize an Emergency Medical Condition. Providers of emergency services also include physicians or other healthcare professionals or healthcare facilities not under employment or under contractual arrangement with the health plan.

Urgent Care: 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. The minimum standard for the provision of urgent care is within 48 hours of request.

OUT OF NETWORK USE OF NON-EMERGENCY SERVICES

For providers who are not contracted with AmeriHealth Caritas Ohio, reimbursement for covered services will be made at seventy-five percent (75%) of the applicable fee schedule amount. This reimbursement level applies to non-emergent services and or services without limitations around reimbursement defined under the Ohio Administrative Code. For more information on reimbursement please visit our provider homepage.

For members who require services from an out of network provider, AmeriHealth Caritas Ohio will provide timely approval or denial of requests for authorization of out-of- network service(s) through the assignment of a prior authorization number, which refers to and documents the determination.

Providers are required to inform Medicaid members about the costs associated with services that are not covered by AmeriHealth Caritas Ohio, prior to rendering such services. Should the patient and provider agree the services will be rendered as a private pay arrangement; the provider must obtain a signed document from the member to validate the private payment arrangement.

SECOND OPINIONS

AmeriHealth Caritas Ohio members have the right to request a second opinion from a qualified, participating healthcare professional. If a participating healthcare professional is not available within time and travel requirements, AmeriHealth Caritas Ohio will arrange for the member to obtain a second opinion outside the network, at no cost to the member.

TELEHEALTH COVERAGE

AmeriHealth Caritas Ohio members have access to telehealth services defined as the direct delivery of healthcare services to a patient related to diagnosis, treatment, and management of a condition. Telehealth is the interaction with a patient via synchronous, interactive, real-time electronic communication comprising both audio and video elements. Telehealth may also include the following activities that are asynchronous or do not have both audio and video elements:

- Telephone calls;
- Remote patient monitoring; and,
- Communication with a patient through secure electronic mail or a secure patient portal.

Conversations or electronic communication between practitioners regarding a patient without the patient present is not considered telehealth unless the service would allow billing for practitioner-to-practitioner communication in a non-telehealth setting.

Practitioners are responsible to deliver telehealth services in accordance with all state and federal laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any HIPAA related directives from the office for civil rights (OCR) at the department of health and human services (HHS) issued during COVID-19 national emergency and 42 C.F.R. part 2 (January 1, 2020).

Practitioners are also responsible to deliver telehealth services in accordance with rules set forth by their respective licensing board and accepted standards of clinical practice.

The practitioner site, or the physical location of the treating practitioner at the time a healthcare service is provided using telehealth, is responsible for maintaining documentation for the healthcare service delivered with telehealth and to document the specific telehealth modality used.
For practitioners who render services to an individual through telehealth for a period longer than twelve consecutive months, the telehealth practice or practitioner is expected to conduct at least one in-person annual visit or refer the individual to a practitioner or their usual source of clinical care that is not an emergency department for an in-person annual visit.

Services listed as requiring prior authorization in Section VII require prior authorization whether they are delivered in-person or via telehealth.

Practitioners eligible to render services using telehealth, per Ohio Administrative Code 5160-1-18, include:

- Physician
- Psychologist
- Physician assistant
- Clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner
- Licensed independent social worker, licensed independent marriage and family therapist, or licensed professional clinical
- Licensed independent chemical dependency counselor
- Supervised practitioners, trainees, residents, and interns
- Audiologist, speech-language pathologist, speech-language pathology aides, audiology aides, and individuals holding a conditional license
- Occupational and physical therapist and occupational and physical therapist assistants.
- Home health and hospice aides
- Private duty registered nurse or licensed practical nurse in a home health or hospice setting
- Dentists
- Dietitians
- Behavioral health practitioners
- Optometrists
- Other practitioners if specifically authorized by ODM

INPATIENT AT TIME OF ENROLLMENT

The managed care organization responsible for a member's inpatient care depends upon the timing of the member's Medicaid enrollment. If a member, transferring from another Medicaid plan to AmeriHealth Caritas Ohio, is hospitalized at the time of enrollment, the member's originating health plan is responsible for inpatient coverage until discharge, including for ancillary and health professional services rendered

during the inpatient stay. The member's new Medicaid health plan is responsible for all benefits rendered after discharge.

Likewise, if a member transfers from AmeriHealth Caritas Ohio to another Medicaid plan during an inpatient stay, AmeriHealth Caritas Ohio is responsible for inpatient facility coverage until discharge, including for ancillary and health professional services rendered during the inpatient stay.

For new members transitioning to AmeriHealth Caritas Ohio with no immediately prior period of Medicaid managed care enrollment or fee-for-service enrollment with inpatient coverage, AmeriHealth Caritas Ohio will be responsible for any diagnosis-related group based inpatient facility claims if the member's first day of health plan enrollment is during the hospital stay.

NEWBORN COVERAGE

Newborns born to mothers who are covered by AmeriHealth Caritas Ohio at the time of birth will be auto enrolled for coverage with AmeriHealth Caritas Ohio. The Plan will provide covered services to eligible newborns retroactive to the date of birth.

AmeriHealth Caritas Ohio will not limit benefits for postpartum hospital stays to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn child before that time. A participating provider is not required to obtain prior authorization for stays up to the 48- or 96-hour periods.

STERILIZATIONS

Providers must submit the appropriate required forms (*ODM 03197, ODM 03199, HHS-687, and HHS-687-1 [SPANISH VERSION]*) with the prior authorization requests and with the claim's submission for these services. Sterilizations are not covered for members less than 21 years of age. Appropriate consent forms can be found online at www.amerihealthcaritasoh.com or on the ODM website at https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/forms/forms.

A member seeking sterilization must voluntarily give informed consent on the consent form, which must accompany each claim.

The member must give informed consent not less than 30 full calendar days (or not less than 72 hours in the case of emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. In the case of premature delivery, informed consent must have been given at least 30 days before the expected date of delivery. A new consent form is required if 180 days have passed before the sterilization procedure is provided.

The Sterilization Consent Form must accompany all prior authorization requests for sterilization services and all claims for reimbursement for sterilization services. The form must be completed correctly in accordance with the instructions. The claim and consent forms will be retained by the Plan.

PREVENTIVE CARE/IMMUNIZATIONS

Preventive care includes a broad range of services (including screening tests, counseling, and immunizations/vaccines).

- Providers are required to administer immunizations in accordance with the recommended childhood immunization schedule for the United States, or when medically necessary for the member's health.
- Providers are required to prepare for the simultaneous administration of all vaccines for which a member under the age of 21 is eligible at the time of each visit.
- Providers are required to participate in the Ohio Department of Health (ODH) Immunization Program.

AmeriHealth Caritas Ohio has adopted the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services [childhood and adolescent immunization schedule approved by: the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP)/Bright Future, and the American Academy of Family Physicians (AAFP)], and the adult immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP).

IMMUNIZATION SCHEDULES (CHILDHOOD, ADOLESCENT, AND ADULT)

- Visit the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/vaccines/hcp/imz-schedules/?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/hcp/index.html for recommended vaccines and immunizations.
- Visit the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/tools-and-resources-for-better-preventive-care for recommendations made by the USPSTF for clinical preventive services.
- For more information on the ODM Immunization Program, including recommended schedules, please visit: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Immunization.

VACCINES FOR CHILDREN (VFC) PROGRAM

AmeriHealth Caritas Ohio PCPs are required to enroll with the Ohio Department of Health (ODH) Immunization Program to receive vaccines for members under age 19 years through the Vaccines for Children (VFC) Program. Vaccinations covered by the VFC program will not be reimbursed by AmeriHealth Caritas Ohio; however, the Plan reimburses providers for appropriate vaccine administration to members aged 18 years and younger. Providers are expected to plan for a sufficient supply of vaccines and are required to report the use of VFC vaccines immunizations by:

- Billing the Plan with the appropriate procedure code(s) and modifier.
- Complying with all reporting requirements of the ODH Immunization Program and the VFC Program.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)/HEALTHCHEK

Our Pediatric Preventive Healthcare Program is designed to improve the health of members from birth to under age 21 who are enrolled in Medicaid by increasing adherence to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines through identification of growth and development needs and coordination of appropriate healthcare services.

All Plan, Ohio-licensed practitioners (including registered nurses, physicians, or physician's assistants; or a person with a master's degree in health services, public health, or healthcare administration or another related field, and/or who is a Certified Professional in Healthcare Quality or CHCQM) are responsible to provide EPSDT/Healthchek services to AmeriHealth Caritas Ohio members from birth to under age 21 according to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule or upon request to evaluate the general physical and mental health, growth, development, and nutritional status of a member. The most current periodicity schedules are available online https://brightfutures.aap.org/Pages/default.aspx.

EPSDT services include all mandatory and optional medically necessary services (including treatment) and items listed in 42 USC 1396d(a) to correct or ameliorate defects, and physical and mental illness and conditions discovered by a Healthchek screening. Such services and items, if approved through prior authorization, include those services and items listed at 42 USC 1396d(a), including services provided to members with a primary diagnosis of autism spectrum disorder, in excess of state Medicaid plan limits applicable to adults.

For the initial examination and assessment of a child, practitioners are required to perform the relevant EPSDT/Healthchek screenings and services, as well as any additional assessment, using the Ohio Department of Medicaid (ODM) developed, standardized, developmental screening tools to determine whether or not a child has special healthcare needs.

Periodic assessments must consist of the following components:

- Routine physical examinations as recommended by the AAP and "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents"
- Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders
- Screening for developmental delay at each visit through the fifth year using a validated screening tool
- Screening for Autism Spectrum Disorders per AAP guidelines
- Comprehensive, unclothed physical examination
- All appropriate immunizations in accordance with the schedule established by the Advisory Committee on Immunization Practices
- Vision and hearing screening
- Dental screening and education
- Nutrition assessment and education
- Laboratory tests including blood lead screening
- Health education and anticipatory guidance for both the child and caregiver
- Referral for further diagnostic and treatment services, if needed

EPSDT/Healthchek providers (PCPs) are expected to provide written and verbal explanation of EPSDT

services to AmeriHealth Caritas Ohio members including pregnant women, parent(s) and/or guardian(s), child custodians and sui juris (of one's own right) teenagers. This explanation of EPSDT/Healthchek services should occur on the member's first visit and quarterly thereafter and must include distribution of appropriate EPSDT/Healthchek educational tools and materials. Specification of Healthchek components to be provided to eligible members as specified in OAC 5160-1-14.

For additional information on EPSDT, including billing guidance and annual provider training requirements, please visit https://www.amerihealthcaritasoh.com/provider/resources/healthchek.

SCREENING TIMEFRAMES

Healthchek screening services are covered at the following frequency:

- For immunizations, in accordance with the schedule regarding the appropriate periodicity, dosage, and contraindications applicable to pediatric vaccines established by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, found at https://www.cdc.gov/acip-recs/hcp/vaccine-specific/?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
- For other screening services, at ages and intervals in accordance with the bright futures guidelines; and,
- For all screening services, at such other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions.

Plan practitioners are expected to assist members and parents/caregivers with accessing substance use disorder and mental health services, as needed. The Plan's EPSDT Manager on the Rapid Response and Outreach Team is also available to members and providers to support the care coordination of EPSDT services. Members and providers may request the EPSDT Manager's support by calling **1-833-464-7768**.

PHARMACY SERVICES

AmeriHealth provides coverage and reimbursement for covered outpatient provider-administered drugs, as indicated by benefits, and approved per applicable criteria, except for those supplied by a pharmacy (Provider Type 70 that are payable through the SPBM) and those that are reimbursed by OhioRISE.

Calls related to physician-administered medications (medical billing) should be directed to PerformRx at 1-855-662-0279.

- Standard Fax: 1-855-839-3882
- Urgent Fax: 1-833-498-1208

Prior authorization requests for medications covered under outpatient Medical Benefit should be submitted to:

- PerformRx: 1-855-662-0279
- AmeriHealth Provider Portal: https://navinet.my.salesforce-sites.com/.

Ohio's 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 has selected Gainwell Technologies to serve as the SPBM. Information on Ohio's SBPM, Gainwell, is available in the following locations:

- Single Pharmacy Benefit Manager (SPBM) section of this Provider Manual
- The Ohio Department of Medicaid pharmacy website: https://medicaid.ohio.gov/stakeholders-and-partners/phm.

Gainwell utilizes the Ohio Medicaid Unified Preferred Drug List (UPDL). The drug benefit has been developed to cover medically necessary prescription products. The pharmacy benefit design provides for outpatient prescription services that are appropriate, medically necessary, and are not likely to result in adverse medical outcomes. The formulary and UPDL are available on Gainwell's website at https://spbm.medicaid.ohio.gov/.

DENTAL SERVICES

AmeriHealth Caritas Ohio's dental benefits are administered through DentaQuest. Inquiries regarding these benefits should be directed to the DentaQuest provider line at 1-855-398-8411 or you may visit their website at https://www.dentaquest.com/en/providers.

VISION SERVICES

AmeriHealth Caritas Ohio has contracted with two optical laboratories to provide glasses: Classic Optical Laboratories and Robertson Optical Laboratories. Member glasses must be ordered through one of these labs. A prior authorization (PA) is not required; however, eligibility must be confirmed.
For questions for Classic Optical, call 1-888-522-2020. For questions for Robertson Optical Laboratories, call 1-800-922-5525.

We offer the following benefits at no cost to our members:

- One exam and one pair of glasses (frames and lenses) every 12 months (individuals ages 0 – 20 or age 60 and older).
  One exam and one pair of glasses (frames and lenses) every 24 months (individuals ages 21 – 59).
  Additional eye care is available for members living with diabetes.

Beginning in 2026, AmeriHealth Caritas Ohio offers a value-added benefit for vision services that includes a contact lens allowance of up to $150 per benefit period. No prior authorization is required for services received up to $150. If a member's cost exceeds the $150 benefit limit, the member may choose to pay the difference out of pocket, or request prior authorization if additional contact lenses are deemed medically necessary.

LABORATORY SERVICES

In an effort to provide high quality laboratory services in a managed care environment for our members, AmeriHealth Caritas Ohio members may receive laboratory services from laboratories at our contracted hospital facilities and hospital-affiliated physician groups. The Centers for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) regulations apply to laboratory testing in all settings including commercial, hospital and physician office laboratories. Claims submitted for laboratory services without the appropriate CLIA identification number will be denied.

Also, AmeriHealth Caritas Ohio has made an agreement with the following commercial laboratory:

Laboratory	Type	Phone	Website
Quest Diagnostics	General lab services	See website for locations and contact information	www.questdiagnostics.com

To quickly establish an account with the lab, please visit the website listed above. For more information about the lab, please visit their website.

- Network Physicians are encouraged to perform venipuncture in their office whenever possible.
- Providers should contact the laboratory provider in question to arrange a pick-up service.
- AmeriHealth Caritas Ohio highly recommends that pre-admission laboratory testing be completed by the PCP. However, testing can be completed at the hospital where the procedure will take place and does not require a referral from AmeriHealth Caritas Ohio.
- **STAT labs must only be utilized for urgent problems**. The ordering physician may give the member a prescription form or AmeriHealth Caritas Ohio procedure confirmation form to present to the participating facility.

HOSPICE SERVICES

A hospice provides palliative and supportive services to meet the physical, psychological, social, and spiritual needs of a terminally ill member, including the family or other persons caring for the member regardless of where the member resides.

Members must meet the criteria below to be eligible for hospice:

- Be eligible for Medicaid;
- Be certified as being terminally ill by a qualifying medical professional;
- Elect hospice care in a written statement; and
- Meet all applicable criteria as set forth in Chapter rule 5160-56-02 of the Ohio Administrative Code.

An individual may choose to discontinue hospice services, and may re-elect hospice services after cancellation, at any time.

Below are some covered core hospice services when furnished or arranged by the designated hospice based on the member's needs, appropriate level of care, and plan of care:

- Nursing Care;
- Medical Social Services, provided by a social worker under the direction of a physician or attending provider;
- Physician Services, including attending physician services, and services rendered by advance nurse practitioners or physician assistants acting as attending physicians; and,
- Counseling Services.

Non-core hospice services may be provided through a combination of contracting services and telehealth services as necessary and appropriate:

- Physical therapy, occupational therapy, and speech-language pathology provided for symptom control or to enable the member to maintain activities of daily living and basic functional skills;
- Hospice aide, home health aide and homemaker services that enable the member to carry out the

plan of care;

- Volunteers;
- Medical appliances and supplies, including drugs and biologicals;
- Short-term inpatient care provided in hospital, hospice inpatient unit, or a participating SNF or NF on an intermittent, non-routine basis for relief of the member's caregivers, and/or general inpatient care for the purpose of respite, pain control and acute or chronic symptom management that cannot feasibly be provided in other settings; and,
- Any other item or service provided in relation to the terminal condition, when medically indicated, included in the plan of care and for which payment may otherwise be made under Medicaid.

HOSPICE SERVICES IN A NURSING FACILITY

Hospice services can occur in the home or in a nursing facility. When services occur in a nursing facility, the facility can be considered the residence of the member. In accordance with Sections 1902(a)(13)(B) and 1905(o)(3)(C) of the Social Security Act, the Plan will pay room and board payments to the hospice provider instead of the nursing facility if the member resides in a nursing facility and is receiving hospice services.

When the member resides in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

- The member is terminally ill.
- The member has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.
- The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

NOTIFICATION AND COVERAGE FOR HOSPICE BENEFITS

AmeriHealth Caritas Ohio covers hospice services provided to members who are certified as terminally ill.

When a member needs hospice services – including home hospice, inpatient hospice, continuous care, and respite – the primary care practitioner, attending physician, or hospice agency must notify the AmeriHealth Caritas Ohio Utilization Management department at **1-833-735-7700**. The Plan will coordinate the necessary arrangements between the primary care practitioner and the hospice provider in order to assure continuity and coordination of care.

It is the responsibility of hospice to obtain certification from the physician that the member is terminally ill.

NON-COVERED SERVICES

AmeriHealth Caritas Ohio will refer members to local resources for services that are not covered by the Plan, as appropriate. Providers may contact the Rapid Response and Outreach Team at **1-833-464-7768** for assistance with coordination of non-covered services.

AmeriHealth Caritas Ohio will not pay for services or supplies received that are not covered by Medicaid,

including the following:

- 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

PRIVATE PAY FOR NON-COVERED SERVICES

Providers are required to inform Medicaid members about the costs associated with services that are not covered under AmeriHealth Caritas Ohio, prior to rendering such services. Should the patient and provider agree the services will be rendered as a private pay arrangement, the provider must obtain a signed document from the member to validate the private payment arrangement.

MEMBER GRIEVANCE, APPEAL, AND STATE HEARING PROCESSES AND TIME FRAMES

MEMBER GRIEVANCE PROCESS

If a member has a concern or question regarding the healthcare services, he/she has received under AmeriHealth Caritas Ohio, he/she should contact Member Services at the toll-free number on the back of the member ID card. A Member Services representative will answer questions or concerns. The representative will try to resolve the problem. If the Member Service representative does not resolve the problem to the member's satisfaction, the member has the right to file a grievance.

A *grievance* expresses dissatisfaction about any matter other than an *action* by AmeriHealth Caritas Ohio. (See examples of *actions* in the Appeals Process section below.) A grievance is usually submitted by a member and is not generally related to a claim's payment. The member may file a grievance in writing or by telephone using the information below. It may be filed at any time either orally or in writing. It may be filed by the treating provider or primary care provider (or another authorized representative) on behalf of the member with the member's written consent.

A grievance may be filed about issues such as the quality of the care the member receives from AmeriHealth Caritas Ohio or a provider, rudeness from a Plan employee or a provider's employee, a lack of respect for their rights by AmeriHealth Caritas Ohio, dispute of an extension of time AmeriHealth Caritas proposed to make an authorization decision, violation of member rights as afforded by Ohio law, the belief that mental health or SUD benefits are not being provided by AmeriHealth Caritas Ohio, or any service or item that did not meet accepted standards for healthcare during a course of treatment.

To file a grievance:
Call Member Services (24/7): **1-833-764-7700**; TTY: **1-833-889-6446.**

Use the Secure Contact form: https://apps.amerihealthcaritasoh.com/securecontact/index.aspx
Or send written grievance to:

AmeriHealth Caritas Ohio
Attn: Member Grievances
PO Box 7133
London, KY 40742

If the member needs assistance in filing his/her grievance or needs the help of an interpreter, the member may call Member Services and, if needed, interpretation services will be made available to the member free of charge. AmeriHealth Caritas Ohio will send the member a letter acknowledging receipt of the grievance unless the member or authorized provider requests expedited resolution.

The Plan will receive and resolve grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, will meet the following time frames:

- Within two business days of receipt if the grievance is regarding access to services.
- Within 30 calendar days of receipt for non-claims-related grievances except when the grievance is regarding access to services.
- Within 60 calendar days of receipt for claims-related grievances.

If the member requests an extension, or if the Plan shows that information is necessary and a delay would be in the member's interest, AmeriHealth Caritas Ohio may seek an extension of up to 14 calendar days by request to Ohio Department of Medicaid (ODM) prior to the expiration of the standard or expedited grievance resolution time frame. If the timeframe is extended, as approved by ODM, the member will be given prompt oral notice of the delay and written notice within two calendar days.

MEMBER APPEALS PROCESS

ADVERSE BENEFIT DETERMINATION

If AmeriHealth Caritas Ohio decides to deny, reduce, limit, suspend, or terminate a service the member is receiving, or if the Plan fails to act in a timely manner, the member will receive a written "Adverse Benefit Determination." In most cases, the Adverse Benefit Determination will be sent within 10 calendar days of receipt of the request.

If the member does not agree with AmeriHealth Caritas Ohio's determination as outlined in the Adverse Benefit Determination, he/she may file an appeal. The member may ask an "authorized representative" (e.g., his/her physician (with the written consent of the member), a family member or friend) to file the appeal for them. The provider may also file the appeal, with the member's written consent. If the member is deceased, the legal representative of the deceased member's estate shall be a party to the appeal.

A member may appeal any **action** taken by the Plan. Actions include but are not limited to the following examples:

- 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 in part, of payment for a service.
- Failure to provide services in a timely manner.
- Untimely service authorizations.
- Failure of the Plan to act within the timeframes set forth in its Agreement with Ohio Department

of Medicaid (ODM) or as required under 42 CFR 438 Subpart F and Ohio Administrative Code (OAC) 5160-26-08.4.

The member, or an authorized representative with the written consent of the member, may ask for a State Hearing after the appeals process has been exhausted. Additional information on requesting a State Hearing is available in this section of the *Provider Manual*.

STANDARD APPEAL

A standard appeal asks AmeriHealth Caritas Ohio to review a decision about the member's care. The member must file an appeal within 60 calendar days from the Notice of Adverse Benefit Determination.

An Appeal Request Form will be sent to the member with the Adverse Benefit Determination, or the member may call Member Services to ask for a printed form.

To file an appeal:

The member or authorized representative may send a written appeal by completing the *Appeal Request Form* and returning to:

AmeriHealth Caritas Ohio
Attn: Member Appeals Coordinator
Member Appeals Department
PO Box 7346
London, KY 40742

Over the telephone by calling AmeriHealth Caritas Ohio Member Services (24x7): **1- 833-764-7700** (TTY: **1-833-889-6446**).

Using the Secure Contact form: https://apps.amerihealthcaritasoh.com/securecontact/index.aspx
Provider appeals (on behalf of a member and with written consent): Call **1-833-764-7700** and follow the prompts.

Or send in writing to:

AmeriHealth Caritas Ohio
Attn: Member Appeals Coordinator
Provider Appeals (on behalf of Member) Department
PO Box 7400
London, KY 40742

If an appeal is received by telephone from a member, the Plan will immediately convert an oral appeal filing to a written appeal on behalf of the member and consider the date of the oral appeal filing as the filing date. An appeal requested by a provider on behalf of the member will require written consent to be sent to the Plan within 60 calendar days of the denial of services. The date which the written consent is received is considered the filing date of the appeal. The review begins the day the Plan receives the oral or written request, whichever occurs first. The Plan will send a written acknowledgement to the member within three business days of receipt of the appeal. The Plan will provide a written notice of resolution of the appeal as expeditiously as the member's health condition requires and no later than 15 calendar days after receiving the appeal, whether oral or written, to make a decision regarding the matter. If the Plan fails to adhere to notice and timing requirements (noted above), then the member is deemed to have exhausted the Plan's appeals process and the member may initiate a State Hearing (see below).

Before the Plan makes a decision, the member and/or the person helping the member with the appeal may give information in writing or in person to AmeriHealth Caritas Ohio.

In some cases, the Plan, or the member may need additional time to obtain more information. The member may request up to 14 more days, or the Plan may have an additional 14 days if additional information is needed and the delay is in the member's best interest. If the Plan needs more time, the Plan will:

- Make reasonable efforts to give the member prompt oral notice of the delay.
- Within two calendar days give the member written notice of the reason for the decision to extend the timeframe.
- Inform the member of the right to file a grievance if he or she disagrees with the decision to extend the timeframe.
- Resolve the appeal as expeditiously as required by the member's health condition and no later than the date the extension expires.

The member may receive his/her file any time while AmeriHealth Caritas Ohio is reviewing the appeal. The member and his/her authorized representative may look at the case file. The member's estate representative may review the file after the member's death. The file may have medical records and/or other papers.

AmeriHealth Caritas Ohio will send the member or his/her authorized representative a letter with the decision, explaining how AmeriHealth Caritas Ohio made its decision and the date the decision was made.

EXPEDITED APPEAL

If the time for a standard resolution could jeopardize the member's life, health, or ability to attain, maintain or regain function, a member, or his/her authorized representative may request an expedited appeal orally or in writing. **Note**: Expedited appeals are for adverse benefit determinations pertaining to healthcare services only – not related to payment of claims.

To request an expedited appeal, the member, his/her authorized representative, or provider may call Member Services within 60 calendar days of the date on the notice of adverse benefit determination. The Plan will not take punitive action against a provider who either requests an expedited resolution or supports a member's appeal. AmeriHealth Caritas Ohio will acknowledge in writing the receipt of an expedited appeal request within 24 hours of receipt. If the request to expedite the appeal process is denied, the appeal will immediately be moved into the standard appeal timeframe of no longer than 15 calendar days and the member will be notified in writing within two business days of the denial for an expedited appeal request.

The Plan will also attempt to provide prompt oral notice of the denial. The member may file a grievance if he or she does not agree with the decision to change the appeal timeframe to a standard appeal. For expedited resolution of appeals, the Plan shall make a determination as expeditiously as the member's health condition requires but shall provide written notice, and make reasonable effort to provide oral notice, of resolution no later than 72 hours of receipt of the expedited appeal request unless the Plan determines an extension is necessary. The Plan may extend the timeframes for expedited resolution of an appeal request by up to 14 calendar days if the member requests the extension, or the Plan determines that there is a need for additional information and the delay is in the member's interest. If the Plan needs more time, the member will be informed of the reason for the extension in writing. The Plan will also make reasonable efforts to provide oral notice.

For appeals not resolved wholly in favor of the member, the written notice shall include information about the right to request a State Hearing, including how to do so and the right to request to receive benefits while the hearing is pending and how to make the request for benefits to continue while the hearing is pending. The written notice shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Plan's action.

STATE HEARINGS

The member or his/her authorized representative may seek a State Hearing after the appeals process has been exhausted. Exhaustion of the Plan's appeals process includes circumstances in which the Plan fails to adhere to notice and timing requirements for appeals. The State Hearing must be requested within 90 calendar days from the date of AmeriHealth Caritas Ohio's Appeal decision letter upholding the adverse benefit determination, also called the *Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Plan* letter. A provider may also request a State Heating on behalf of a member with the member's consent by written notice.

Members have the right to self-representation or to be represented by a family caregiver, legal counsel, or other representative during a State Hearing. Parties to the State Hearing are the Plan and the member or his/her authorized representative, or the representative of a deceased member's estate.

Members can request a State Hearing by:

- Signing and returning the State Hearing Form to the address or fax number listed on the form;
- Calling the Ohio Department of Job and Family Service Bureau (ODJFSB) Consumer Access Line at1-866-635-3748; or,
- Submitting a request via e-mail at bsh@jfs.ohio.gov.

CONTINUATION OF BENEFITS

A member may continue to receive services while waiting for the AmeriHealth Caritas Ohio appeal or the State Hearing decision if all of the following apply:

- The appeal is filed timely as described above.
- ACOH automatically will continue ongoing services that are the subject of an Appeal if:
  - The Appeal or State Hearing is filed timely: within fifteen (15) calendar days of the mailing of the Notice of Action sent by ACOH, or the intended effective date of the proposed action.
  - The Appeal involves termination, suspension, or reduction of previously authorized course of treatment.
  - The service was ordered by an authorized Provider; and
  - The authorization period has not expired.
    - Please note that services will cease to continue if the member requests that benefits no longer be in place.
- The appeal is related to reduction, suspension, or termination of previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not ended.
- The member has requested the services to continue, orally or in writing.

The member's services continue to be covered until one of the following occurs:

- The member withdraws the appeal in writing.
- The member does not request a State Hearing within 90 calendar days of the Plan mailing an

adverse decision regarding the member's appeal.

- The authorization expires or the authorization service limits are met.
- The fair hearing office issues a hearing decision adverse to the member.

The member may have to pay for the continued services if the final decision from the State Hearing is adverse to them. If the State Hearing officer agrees with the member, AmeriHealth Caritas Ohio will pay for the covered services that were rendered to the member while waiting for the decision. If the State Hearing officer agrees with the member and the member did not continue to receive covered services while waiting for the decision, AmeriHealth Caritas Ohio will issue an authorization for the covered services to restart as soon as possible and the Plan will pay for the covered services.

SECTION VII
UTILIZATION MANAGEMENT

VII. UTILIZATION MANAGEMENT

The AmeriHealth Caritas Ohio Utilization Management (UM) program establishes processes for an effective, efficient utilization management system. Utilization Management decision-making is based only on appropriateness of care and services and existence of coverage. AmeriHealth Caritas Ohio will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the diagnosis, type of illness, or condition of the member. AmeriHealth Caritas Ohio does not reward healthcare professionals/providers or other individuals conducting utilization review for issuing denials of coverage or services. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas Ohio reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued, and the service was provided.

Per the provider agreement with AmeriHealth Caritas Ohio, providers are required to comply fully with the Plan's medical management programs.

This includes:

- Obtaining authorizations and/or providing notifications, depending upon the requested service.
- Providing clinical information to support medical necessity when requested.
- Permitting access to the member's medical information.
- Involving the Plan's medical management nurse and/or licensed clinician in discharge planning discussions and meetings.
- Providing the Plan with copies of plan of treatment, progress notes, and other clinical documentation, as required.

The most up-to-date list of services requiring prior authorization will be maintained in the provider section of our website at https://www.amerihealthcaritasoh.com/provider/resources/prior-auth. The Plan's UM department hours of operation are 8:30 a.m. to 5:00 p.m. ET, Monday through Friday except for holidays. The UM departments can be reached at:

- UM Telephone: **1-833-735-7700**
- UM Prior Authorization Fax: **1-833-329-6411**

For prior authorizations after hours, weekends and holidays, call Member Services at **1-833-764-7700**.

SERVICES REQUIRING PRIOR AUTHORIZATION

For the most up-to-date and detailed listing of services that require authorization, please visit the provider pages of our website at https://www.amerihealthcaritasoh.com/provider/resources/prior-auth.

Physical Health Services Requiring Prior Authorization

- Elective Air ambulance
- All out-of-network services, excluding emergency services
- All services that may be considered experimental and/or investigational

- All services not listed on the Ohio Department of Medicaid Fee Schedule
- All unlisted miscellaneous and manually priced codes (including, but not limited to, codes ending in "99")
- All inpatient hospital admissions, including medical, surgical, skilled nursing, long-term acute, and rehabilitation services
- Obstetrical admissions, newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section
- Elective transfers for inpatient and/or outpatient services between acute care facilities
- Medical detoxification
- Long-term care initial placement (while enrolled with the plan- up to 90 days)
- Chiropractic care (prior authorization required for members under age 18)
- Cochlear implantation
- Durable medical equipment (DME) rentals, leases, and custom equipment.
- Durable medical equipment (DME), prosthetics, and orthotics with billed charges over $750.
- Diapers/pull-ups (ages 4-20) for amounts over 300 units
- Negative pressure wound therapy
- Elective procedures, including, but not limited to: joint replacements, laminectomies, spinal fusions, discectomies, vein stripping, laparoscopic/exploratory surgeries
- Gastric restrictive procedure and surgeries
- Elective termination of pregnancy
- Speech, occupational, and physical therapy require prior authorization after the 30th visit. This applies to private and outpatient facility-based services.
- Surgical services that may be considered cosmetic, including:
  - Blepharoplasty
  - Mastectomy for gynecomastia
  - Mastopexy
  - Panniculectomy
  - Penile prosthesis
  - Plastic surgery or cosmetic dermatology
  - Reduction mammoplasty
  - Septoplasty
- Gender reassignment services
- Genetic testing
- Hyperbaric oxygen
- Home-based services:
  - Home healthcare (physical, occupational and speech therapy) and skilled nursing (after 18 combined visits, regardless of modality)
  - Home infusion services and injections (see pharmacy list of HCPCS codes that require prior authorization)
  - Home health aide services
  - Private duty nursing (extended nursing services)
  - Hospice inpatient services
- Hysterectomy (Hysterectomy Consent Form required)
- Cardiac and pulmonary rehabilitation
- Pain management-external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation, and nerve blocks

- Transplants (prior authorization for transplants must be requested directly from the appropriate consortium:

Ohio Solid Organ Transplantation Consortium	**Ohio Hematopoietic Stem Cell Transplant Consortium**
9200 Memorial Dr. Plain City, Ohio 43064 Telephone: 614-504-5705 FAX: 1-614-504-5707	9500 Euclid Avenue, Desk R32 Cleveland, Ohio 44195 Telephone: 440-585-0759 FAX: 1-440-943-6877

- The following radiology services when performed as an outpatient service require prior authorization by AmeriHealth Caritas Ohio's radiology benefits vendor, **National Imaging Associates Inc. (NIA)**
  - Computed tomography angiography (CTA)
  - Coronary computed tomography angiography (CCTA)
  - Computed tomography (CT)
  - Magnetic resonance angiography (MRA)
  - Magnetic resonance imaging (MRI)
  - Myocardial perfusion imaging (MPI)
  - Positron emission tomography (PET)
  - Multiple-gated acquisition scan (MUGA)

Physical Health Services That Do Not Require Prior Authorization

- Emergency room services (in-network and out-of-network)
- 48-hour observations (except for Maternity-notification required)
- Low-level plain films- X-rays, EKGS's
- Family planning services (in or out of network)
- Post stabilization services (in-network and out-of-network
- EPSDT screening services
- Women's healthcare (OB-GYN Services)
- Routine vision services
- Dialysis
- Post-operative pain management (must have a surgical procedure on the same date of service).
- Services rendered at school-based clinics
- Primary care provider (PCP)
- Local health department

Physical Health Services that Require Notification

- All newborn deliveries
- Maternity obstetrical services (after first visit) and outpatient care (includes observation).

Behavioral Health Services Requiring Prior Authorization

- Inpatient Hospitalizations (mental health and/or substance use disorder)
  - Inpatient psychiatric prior authorization requests for members under the age of 21 should be submitted to the OhioRISE plan. AmeriHealth Caritas Ohio will deny these authorization requests because the service is covered by another payer.
- Psychological and neuropsychological testing (over 20 hours per patient per calendar year).
- Electroconvulsive therapy
- Therapeutic Group Services (Day Treatment Per Diem, if more than one per day)
- Assertive Community Treatment

- Behavioral Analysis Therapy for Autism Spectrum Disorder
- Substance Use Disorder Partial Hospitalization Program (ASAM 2.5)
- Substance Use Disorder Residential Treatment (ASAM 3.1, 3.5, 3.7)
    - 1st & 2nd admissions in a calendar year are not subject to a medical necessity review but notification is recommended
        - 31+ days during either admission requires a prior authorization and medical necessity review
    - 3rd and subsequent admissions in a calendar year require a prior authorization and medical necessity review
- Unlisted Psychiatric Services

Services Covered by OhioRISE ONLY

- Inpatient Psychiatric Hospital stays for youth under 21 that are enrolled on OhioRISE Behavioral Health Respite
- Primary Flex Funds
- Intensive Home-Based Treatment (IHBT)
- Psychiatric Residential Treatment Facility
- OhioRISE 1915(c) Waiver services (Out-of-Home Respite, Transitional Services and Supports, Secondary Flex Funds)

Services Requiring Notification

- Substance Use Disorder Residential Treatment (ASAM 3.1, 3.5, 3.7)
    - 1st & 2nd admissions in a calendar year requires a notification and are not subject to a medical necessity review
        - 31+ days during either admission requires a prior authorization and medical necessity review
    - 3rd and subsequent admissions in a calendar year require a prior authorization and medical necessity review
- Mobile Response and Stabilization Services (MRSS) notification within 72 hours of initiation, prior authorization required if services last longer than 6 weeks

Behavioral Health Services That Do Not Require Authorization

- Psychotherapy for Mental Health and Substance Use Disorder: Individual, Family, Multiple-family, Group
- Psychotherapy for Crisis for Mental Health and Substance Use Disorder
- Behavioral Health Counseling
- Psychosocial Rehabilitation Services
- Community Psychiatric Supportive Treatment (Individual and Group)
- Substance Use Disorder Assessment
- Substance Use Disorder Individual and Group Counseling
- Substance Use Disorder Case Management
- Medically Monitored Inpatient Withdrawal Management ASAM 3.7-WM
- Clinically Managed Residential Withdrawal Management ASAM 3.2-WM
- Substance Use Disorder Intensive Outpatient Program (ASAM 2.1)
- Substance Use Disorder Urine Drug Screen Withdrawal Management ASAM 2-WM
- Substance Use Disorder Peer Support Services (up to 4 hours per day)

- Evaluation and Management Visits for Mental Health and Substance Use Disorder including home and prolonged visits
- Psychiatric Diagnostic Evaluation
- Smoking and Tobacco Cessation Counseling
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- A Child and Adolescent Needs and Strengths (CANS) assessment
- Depression Screening and Cognitive Behavioral Health Therapies provided in coordination with the Help me Grow program including services performed in the home. ACOH Population Health team will assist with the Member with arranging for depression screening and cognitive behavioral health therapies for Members enrolled in the Help Me Grow program who are either pregnant or the birth mother of an infant or toddler under three years of age.

PRIOR AUTHORIZATION SUBMISSION PROCESS

Providers may submit authorization requests via the AmeriHealth Caritas NaviNet Provider portal: https://www.amerihealthcaritasoh.com/provider/resources/navinet.aspx. Provider's may also fax completed authorization forms to 1-833-329-6411. Authorization forms for faxing can be found by visiting the provider page at: https://www.amerihealthcaritasoh.com/assets/pdf/provider/resources/forms/prior-auth-request-form.pdf.

AMERIHEALTH CARITAS OHIO STANDARD PRIOR AUTHORIZATION SUBMISSION PROCEDURES

1. Applies to all services and providers.

2. Prior authorizations with AmeriHealth Caritas Ohio are required for certain services for participating providers. Please refer to the list of services that require prior authorization in this manual. For out of network providers, prior authorization is required for all services except emergency services.

3. AmeriHealth Caritas Ohio has a Prior Authorization call center available for prior authorization requests and education. Our Prior Authorization call center is open Monday – Friday, 8:30 am to 5:00 pm ET. Please call **1-833-735-7700** to reach our Utilization Management department.

4. After hours and on weekends and holidays, please call the AmeriHealth Caritas Ohio Member Services department at **1-833-764-7700** to be connected with the on-call prior authorization nurse or licensed clinician. Our staff will be able to answer questions and help assist you with your prior authorization request, including requests for inpatient hospitalizations.

5. For members new to AmeriHealth Caritas Ohio, we will cover a member's medical or behavioral health condition that is currently being treated or where a prior authorization has been issued, through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with AmeriHealth Caritas Ohio. AmeriHealth Caritas Ohio may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. If the member is pregnant and in her second or third trimester, prenatal services will be covered through her pregnancy and up to 60 calendar days after delivery.

6. For members new to the Plan, AmeriHealth Caritas Ohio will receive a list of existing prior authorizations for its members and will have a record of those on file.

7. AmeriHealth Caritas Ohio will pay claims according to the prompt pay requirements for both in-network and out-of-network providers.

8. AmeriHealth Caritas Ohio may conduct retrospective reviews of claims for services that did not receive prior authorization to ensure medical necessity.

9. AmeriHealth Caritas Ohio may recover payments from providers for reimbursed services determined not to be medically necessary.

10. AmeriHealth Caritas Ohio offers information on its prior authorization policies to reduce the risk of recovery for claims paid when the service is determined to not be medically necessary. Prior Authorization requirements are listed in detail in this section of the *Provider Manual*, in the new provider orientation program, and are available in a searchable tool online at https://www.amerihealthcaritasoh.com/provider/resources/prior-auth-lookup-tool.aspx.

11. Determination of lack of medical necessity is considered an adverse action and may be appealed through the provider appeals process.

12. AmeriHealth Caritas Ohio will provide comprehensive, ongoing provider training and outreach to contracted providers. Training will include prior authorization and billing processes to help providers treating our members to avoid delays in payment or member service delivery.

13. AmeriHealth Caritas Ohio offers additional training materials on its website and these materials are accessible for both in-network and out-of-network providers.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas Ohio reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between the time authorization was issued and the time the service was provided.

PROVIDER APPEAL PROCESS PRE-SERVICE

Providers may file an appeal on a denied pre-service within 30 days of the notice of Adverse Benefit Determination (ABD).
Timeframes for responding to Requests for Information:

- **Standard Provider Appeals, which includes requests regarding policy research queries, coding, rate change inquiries, and any other request:** 10 days
- **Inquiries regarding member access to services, including Urgent Care:** 48 hours
  1. Member consent is not required
  2. Appeal request are to be sent to:
     Mail: PO Box 7400
     London, KY 40742
     Fax: 1-833-564-1329
  3. Per Ohio code: https://codes.ohio.gov/ohio-revised-code/section-5160.34

(a) For urgent care services, the appeal shall be considered within forty-eight hours after the department or its designee receives the appeal.
(b) For all other matters, the appeal shall be considered within ten calendar days after the department or its designee receives the appeal.
(c) The appeal shall be between the health care provider requesting the service in question and a clinical peer appointed by or contracted by the department or ACOH.
(d) If the appeal does not resolve the disagreement, the appeal procedures shall permit the recipient to further appeal in accordance with section 5160.31 Ohio Revised Code.

4. Provider Pre-Service appeal process must be exhausted prior to submitting a request for an External Medical Review

MEDICAL NECESSITY OF SERVICES

For members 21 years of age and older "Medically Necessary" or "Medical Necessity" is defined as services that a licensed provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, or disease, or its symptoms, and that are:

- Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the member's illness, injury, disease, or symptoms.
- Not primarily for the convenience of the member or the member's family, caregiver, or healthcare provider.
- No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the member's illness, injury, disease, or its symptoms.
- Not experimental, investigative, cosmetic, or duplicative in nature.

Per EPSDT/Healthchek for members under twenty-one (21) years of age, "Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid state plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions. The need for the item or service must be clearly documented in the member's medical record.

AmeriHealth Caritas Ohio uses the following medical necessity criteria as guidelines for determinations related to medical necessity:

- ODM Ohio Medicaid Provider Agreement for MCO
- Ohio Administrative Code (OAC) & Rules
- Change HealthCare InterQual® Level of Care Criterion
    - InterQual Acute Adult Criteria (Condition Specific- Responder, Partial Responder, Non-responder)
    - InterQual Acute Pediatric Criteria (Condition Specific- Responder, Partial Responder, Non-responder)
    - InterQual Outpatient Rehabilitation and Chiropractic Criteria
    - InterQual Home Care Criteria
    - InterQual Procedures Criteria
    - InterQual DME Criteria
    - InterQual Long-Term Acute Care (LTAC) Criteria
    - InterQual Rehabilitation (Acute Rehab) Criteria
    - InterQual Subacute/SNF Criteria

  - InterQual Criteria for Behavioral Health Adult and Geriatric Psychiatry Criteria
  - InterQual Criteria for Behavioral Health Child and Adolescent Psychiatry Criteria
  - InterQual Criteria for Behavioral Health Residential and Community Based Treatment
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines)
- American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines
- Corporate Clinical Policies
- NIA Radiology Guidelines
- Avesis Dental Guidelines

When applying these criteria, Plan staff also consider the individual member factors and the characteristics of the local health delivery system, including:

MEMBER CONSIDERATIONS

- Age, comorbidities, complications, progress of treatment, psychosocial situation, social determinants of health, home environment, and compliance with parity in mental health and substance use disorder treatment.

LOCAL DELIVERY SYSTEM

- Availability of sub-acute care facilities or home care.
- AmeriHealth Caritas Ohio service area for post-discharge support.
- AmeriHealth Caritas Ohio benefits for sub-acute care facilities or home care where needed.
- Ability of local hospitals to provide all recommended services within the estimated length of stay.
- Availability of the medically necessary behavioral health level of care.

Any request that is not addressed by or determined to not meet medical necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure, or extension of stay, based on medical necessity, or to approve a service in an amount, duration or scope that is less than requested, is made by the Plan's Medical Director or other designated practitioner under the clinical direction of the Vice President of Population Health Medical Services.

Medical Necessity decisions made by the Plan's Medical Director or designee are based on the above definition of medical necessity, in conjunction with the member's benefits, medical expertise, AmeriHealth Caritas Ohio medical necessity guidelines (as listed above), and/or published peer-review literature. At the discretion of the Plan's Medical Director or designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting practitioner/provider may provide input to the decision. The Plan's Medical Director or designee makes the final decision.

Upon request by a member or practitioner/provider, the criteria used for medical necessity decision-making in general, or for a particular decision, is provided in writing by the Plan's Medical Director or designee.

The Utilization Management staff involved in medical necessity decisions is assessed quarterly, and physicians involved in medical necessity decisions are assessed semi-annually for consistent application of review criteria. An action plan is created and implemented for any variances among staff outside of the

specified range. Both clinical and non-clinical staff members are audited for adherence to policies and procedures.

SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION

The following services will not require prior authorization from AmeriHealth Caritas Ohio:

- Emergency room services (in network and out of network).
- 48-hour observations (except for maternity — notification required).
- Low-level plain films — X-rays, electrocardiograms (EKGs).
- Family planning services.
- Post-stabilization services (in network and out of network).
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.
- Women's healthcare by in-network providers (OB/GYN services).
- Routine vision services.
- Post-operative pain management (must have a surgical procedure on the same date of service).
- Medication-assisted treatment (MAT).
- Licensed opioid treatment programs.
- Mental Health outpatient and medication management services.
- Substance Use Disorder services including Peer Support Services.

SERVICES THAT REQUIRE NOTIFICATION

Providers will be asked to notify AmeriHealth Caritas Ohio within one business day of when the following services are delivered:

- Maternity obstetrical services (after the first visit) and outpatient care (includes 48-hour observations).
- All newborn deliveries.
- Continuation of covered services for a new member transitioning to the Plan the first 90 calendar days of enrollment.

Providers can notify us by:

Calling UM: **1-833-735-7700.**
Faxing UM: **1-833-329- 6411.**
Submitting notification via the provider portal.

For certain behavioral health services, notification is required:

- Crisis Intervention: Notification required within 2 business days post service.

STANDARD AND EXPEDITED BENEFIT DETERMINATIONS

STANDARD DETERMINATION DECISION TURNAROUND TIME

AmeriHealth Caritas Ohio must notify the member of its determination as expeditiously as the member's health condition requires, or no later than 10 calendar days after AmeriHealth Caritas Ohio receives the request.

The timeframe may be extended up to 14 additional calendar days if:

- The provider or the member requests an extension; and,
- The Plan justifies the need for additional information and the extension is in the member's best interest.

A benefit determination is any medical necessity review and determination (i.e., approval or denial) by AmeriHealth Caritas Ohio regarding the covered services a member is entitled to receive from the Plan. Detailed information on benefit determination requirements can be found in Ohio Administrative Code (OAC) 5160-26-03, 5160-26-03.1 and Ohio Revised Code (ORC) 5160.34.

URGENT DETERMINATION AND CONTINUED/EXTENDED SERVICES DECISION TURNAROUND TIME

The member's physician may request an expedited determination, including authorizations, from AmeriHealth Caritas Ohio when the member or physician believes waiting for a decision under the standard timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function.

In situations where a provider indicates or AmeriHealth Caritas Ohio determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, AmeriHealth Caritas Ohio will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 48 hours after receipt of the request for service.

If the member or member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, AmeriHealth Caritas Ohio will, within 24 hours of the receipt of the request, advise the member or member's representative of the specific information necessary to make the determination.

AmeriHealth Caritas Ohio will allow the member or member's representative at least 48 hours to provide the specified information and will provide notification of the determination as soon as possible but not later than 48 hours after the receipt of the specified additional information or the end of the period afforded the member or member's representative to furnish the additional information, whichever is earlier.

For untimely prior authorization, appeal, or grievance resolution, the MCP shall give notice simultaneously with the MCP becoming aware of the untimely resolution. Service authorization decisions not reached within the time frames specified in rule 5160-26-03.1 of the Administrative Code constitutes a denial and is thus considered to be an adverse benefit determination. Notice shall be given on the date the authorization decision time frame expires as specified in OAC rule 5160-26-08.4.

PROVIDER MEDICAL APPEAL PROCEDURES

If a provider does not agree with a coverage decision, the following steps should be followed to review and appeal that decision.

1. Provider peer-to-peer review
2. Provider appeal with AmeriHealth Caritas Ohio

The member appeal process is outlined earlier in this document.

PEER-TO-PEER CONSULTATIONS

The provider has the right to complete a peer-to-peer review with the Utilization Management Department. Providers may request a peer-to-peer consultation when AmeriHealth Caritas Ohio denies a prior authorization request. The peer-to-peer consultations will be conducted amongst healthcare 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.

Peer-to-Peer Review Telephone Line
To discuss a medical determination with a physician in the AmeriHealth Caritas Ohio Medical Management department before filing an appeal, providers may reach the Peer-to-Peer telephone line by following the prompts at **1-833-735-7700**. Providers must call to request a peer-to-peer review within five business days of notification of the determination for a prior authorization (non-urgent request) or within five business days of discharge for an inpatient request. AmeriHealth Caritas Ohio will provide peer-to-peer review in a timely manner before the provider seeks recourse through the appeal process.

Note: The purpose of the Peer-to-Peer Review process is to address ***medical determinations*** regarding healthcare services. This process is not intended to address denied claims or other issues. For information on disputing a claim, please see Section VIII of this Provider Manual.

As a reminder, a provider may also file a member appeal on a member's behalf, with the member's written consent. To file an appeal as an authorized representative on behalf of a member, a provider may call **1-833-764-7700** and follow the prompts.

PROVIDER APPEALS

Providers may request a provider appeal if AmeriHealth Caritas Ohio 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.

EXTERNAL MEDICAL REVIEW

The review process conducted by an independent, external medical review entity that is initiated by a provider who disagrees with AmeriHealth Caritas Ohio'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 External Medical Review will be conducted by Permedion. This vendor has a contract with ODM to perform the External Medical Review.

To request an External Medical Review, providers must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using AmeriHealth Caritas Ohio's internal provider appeal or claim dispute resolution process. Failure to exhaust AmeriHealth Caritas Ohio's

internal appeals or claim dispute resolution process will result in the provider's inability to request an External Medical Review.

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

An External Medical Review can be requested by a provider as a result of:

- AmeriHealth Caritas Ohio's service authorization denial, limitation, reduction, suspension, or termination (includes pre-service, concurrent, or retrospective authorization requests) based on medical necessity; or
- AmeriHealth Caritas Ohio'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 pre-service, 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 AmeriHealth Caritas Ohio's clinical coverage or utilization management policy or policies) is not met.

MCOs are required to notify providers of their option to request an External Medical Review.

How to Request External Medical Review

The request for an External Medical Review 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 http://www.hmspermedion.com https://www.gainwelltechnologies.com/permedion/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 healthcare 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 External Medical Review, providers may submit new or other relevant documentation as part of the External Medical Review request.

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

The External Medical Review 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 External Medical Review request, they do not need to take further action.

THE EXTERNAL MEDICAL REVIEW

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

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

For reversed service authorization decisions, AmeriHealth Caritas Ohio must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when AmeriHealth Caritas Ohio receives the External Medical Review decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), AmeriHealth Caritas Ohio 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 External Medical Review, please contact Permedion at 1-800-473-0802, and select Option 2.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

Quality Assessment and Performance Improvement (QAPI) is an integrative process that links together the knowledge, structure, and processes throughout a Managed Care Organization to assess and improve quality. This process also assesses and improves the level of performance of key processes and outcomes

within an organization. Opportunities to improve care and service are found primarily by examining the systems and processes by which care and services are provided.

Purpose and Scope

The purpose of the QAPI Program is to provide the infrastructure for the systematic monitoring, evaluation and improvement in care and service. The QAPI Program is broad in scope and encompasses the range of clinical and service issues relevant to Members. The scope includes quality of clinical care, quality of service, and preventive health services. The QAPI Program continually monitors and reports analysis of aggregate data intervention studies and measurement activities, programs for populations with Special Needs and surveys to fulfill the activities under its scope. The QAPI Program centralizes and uses performance monitoring information from all areas of the organization and coordinates quality improvement activities with other departments.

Objectives

The objectives of the QAPI Program are to systematically develop, monitor and assess the following activities:

- Maximize utilization of collected information about the quality of clinical care and service and to identify clinical and service improvement initiatives for targeted interventions
- Ensure adequate practitioner and Provider availability and accessibility to effectively serve the membership
- Maintain credentialing/recredentialing processes to assure that the Managed Care Organization's network is comprised only of qualified practitioners/Providers
- Oversee the functions of delegated activities
- Continue to enhance physician profiling processes and optimize enhanced systems to communicate performance to participating practitioners
- Coordinate services between various levels of care, Network Providers, and community resources to assure continuity of care
- Optimize Utilization Management to assure that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- To ensure that Member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize Member and Network Provider satisfaction study results when implementing quality activities
- Implement and evaluate Disease Management programs to effectively address chronic illnesses affecting the membership
- Maintain compliance with evolving National Committee for Quality Assessment (NCQA) accreditation standards
- Communicate results of our clinical and service measures to Network Providers, and Members
- Identify, enhance and develop activities that promote Member safety
- Document and report all monitoring activities to appropriate committees

An annual QAPI work plan is derived from the QAPI Program goals and objectives. The work plan provides a roadmap for achievement of program goals and objectives and is also used by the Quality Management Department as well as the various quality committees as a method of tracking progress toward achievement of goals and objectives.

QAPI Program effectiveness is evaluated on an annual basis. This assessment allows AmeriHealth Caritas Ohio to determine how well it has deployed its resources in the recent past to improve the quality of care

and service provided to AmeriHealth Caritas Ohio membership. When the program has not met its goals, barriers to improvement are identified and appropriate changes are incorporated into the subsequent annual QI work plan. Feedback and recommendations from various committees are incorporated into the evaluation.

Every provider in the AmeriHealth Caritas Ohio provider network is required by contract to cooperate with and participate in AmeriHealth Caritas Ohio's QAPI program. We rely on your cooperation and participation to meet our own state and federal obligations as a Medicaid MCO.

Quality Assessment and Performance Improvement Program Authority and Structure
AmeriHealth Caritas Ohio's Quality Assessment and Performance Improvement Committee (QAPIC) provides leadership in AmeriHealth Caritas Ohio's efforts to measure, manage and improve quality of care and services delivered to Members and to evaluate the effectiveness of AmeriHealth Caritas Ohio's QAPI Program through measurable indicators. All other quality-related committees report to the QAPIC.

SECTION VIII
CLAIMS INFORMATION

VIII. CLAIMS INFORMATION

PROCESS AND REQUIREMENTS FOR THE SUBMISSION OF CLAIMS

All claims for services rendered by in-network providers must be submitted to AmeriHealth Caritas Ohio within 365 days from the actual date of service (or the date of discharge for inpatient admissions). Claims submitted by practitioners must be billed via the electronic equivalent (EDI) of the CMS-1500 or UB-04 forms.

The following mandatory information is required on all claims:

- Member's (patient's) name.
- Member's Plan ID number.
- Member's date of birth and address.
- Other insurance information: company name, address, policy and/or group number.
- Amounts paid by other insurance (with copies of matching EOBs).
- Information advising if member's condition is related to employment, auto accident or liability suit.
- Date(s) of service, admission, discharge.
- Primary, secondary, tertiary and fourth ICD-10-CM/PCS diagnosis codes, coded to the full specificity available, which may be 3, 4, 5, 6, or 7 digits.
- Name of referring physician, if appropriate.
- HCPCS procedures, services or supplies codes.
- CPT procedure codes with appropriate modifiers.
- CMS place of service code.
- Charges (per line and total).
- Days and units.
- Physician/supplier Federal Tax Identification Number or Social Security Number.
- National Provider Identifier (NPI) of ordering, rendering, and prescribing physician.
- NPI and Taxonomy.
- Physician/supplier billing name, address, zip code, and telephone number.
- Name and address of the facility where services were rendered.
- NDCs required for physician-administered injectables that are eligible for rebate.
- Invoice date.
- Provider signature.

AmeriHealth Caritas Ohio is required by state and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to help ensure timely processing of claims. When required data elements are missing or invalid, claims will be **rejected** by the Plan for correction and re-submission.

A CLEAN CLAIM

A Clean Claim is a claim for payment for a healthcare service, which has been received by AmeriHealth Caritas Ohio and has no defect or impropriety. A clean claim can be processed without obtaining additional information from the provider of a service or from a third party. Clean claims do not include payments made to a provider of service or a third party where the timing of the payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also does not

include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

A defect or impropriety includes a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with 42 CFR §447.45(b), the term does not include a claim from a healthcare provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.

INITIAL CLAIMS VERIFICATION

Claims filed with AmeriHealth Caritas Ohio are subject to the following procedures:

- Verification that all required fields are completed and all required information was provided.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that an out-of-network provider has received authorization to provide services to the eligible member.
- Verification that an authorization has been given for services that require prior authorization by AmeriHealth Caritas Ohio.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that the Plan is the "payer of last resort" on all claims submitted to AmeriHealth Caritas Ohio.

For more detailed billing information, please refer to the provider area of our website at https://www.amerihealthcaritasoh.com/provider/claims-billing.

HOW TO SUBMIT CLAIMS

Ohio Department of Medicaid Provider Network Management System Direct Data Entry

Providers may submit eligibility inquiries through the Provider Network Management (PNM) system. For more information and guidance visit: 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. For a full list https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners.

Providers may also submit claims via the AmeriHealth Caritas NaviNet Provider Portal. Claims may also be keyed into the ConnectCenter within the AmeriHealth Caritas NaviNet provider portal using the 1500 and UB-04 online claim forms or submitted into the system by using the claim upload functionality.

Following registration, providers can either create or attach either a Professional (1500 Claim Form) or Institutional (UB-04 Claim form) claim form using the claim submission functionality of the AmeriHealth Caritas Ohio NaviNet provider portal. Detailed guidance and instructions can be found by accessing the provider section of our website at https://www.amerihealthcaritasoh.com/provider/resources/navinet.

ODM's expectation is that for each Medicaid provider AmeriHealth Caritas Ohio's system and data are current and consistent with information held by 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. AmeriHealth Caritas Ohio 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.

AMERIHEALTH CARITAS OHIO'S PAYER ID

AmeriHealth Caritas Ohio's Payer ID: **35374**

All claims sent to AmeriHealth Caritas Ohio, through the central PNM portal, should include the AmeriHealth Caritas Ohio Payer ID in **1000B Receiver Loop** and **2010BB Payer Name Loop**.

Emergency Transportation Claims – 837P (AmeriHealth Caritas Ohio) – Send to ODM

CLAIM FILING DEADLINES

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. This applies to capitated and fee-for-service claims.

Claim Type	Timely Filing
Original claim submissions (Excluding inpatient hospital claims.)	Must be received within 365 days of the actual date the service was provided.
Inpatient hospital claims	Must be received within 365 days of the date of discharge.
Resubmitted claims	Denied claims may be resubmitted and must be received by the later of the following: 365 days from the actual date of service or 180 days from the date the claim was denied. *Resubmitted claims beyond 730 days from the actual date of service or discharge will be denied.*

Claims with prior payment by another insurance plan (Including Medicare.)	Claims with prior payment by Medicare or another insurance plan must be received within 180 days from the date the other insurer paid on the claim.
Exceptions	Claims received beyond 365 days from the actual date of service or hospital discharge date will be denied except when exceptions apply. See OAC 5160-1-19(E) for a list of exceptions.
Adjustments to claims	Underpaid claims must be adjusted and submitted via EDI format within 180 days from the paid claim date. Overpaid claims must be submitted, and overpayments refunded, within 60 days of discovery.

Good cause exceptions may be made to accommodate events such as a member providing the wrong Medicaid identification number, a natural disaster, or a failure of information technology systems. Good cause exceptions will be considered on a case-by-case basis. To initiate a good cause exception, please contact your Provider Account Executive.

Please allow for normal processing time (which may be approximately 30 days) before re-submitting a claim through the EDI process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

TPL, EOBS, AND CLAIMS MONITORING

THIRD PARTY LIABILITY (TPL)

Third Party Liability (TPL) is when the financial responsibility for all or part of a member's healthcare expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than AmeriHealth Caritas Ohio. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as AmeriHealth Caritas Ohio, are always the payer of last resort. This means that all other insurance carriers (the “Primary Insurers”) must consider the healthcare provider's charges before a claim is submitted to AmeriHealth Caritas Ohio.

Therefore, before billing AmeriHealth Caritas Ohio when there is a Primary Insurer, healthcare providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Providers may then bill AmeriHealth Caritas Ohio for the remaining balance on a claim by submitting the claim along with a copy of the Primary Insurer's EOB.

CLAIMS WITH EOBS

Claims with Explanation of Benefits (EOBs) from primary insurers (prior payment by Medicare or another insurance plan) must be submitted within 180 days of the date the other insurer paid on the claim.

In the event of an accidental injury (personal or automobile) where a third-party payer is deemed to have liability and makes payment for services that have been considered and paid under the AmeriHealth Caritas Ohio contract, the Plan will be entitled to recover any funds up to the amount owed by the third-party payer.

While this is a requirement in most cases, there is an exception when providers are not required to bill the third party prior to AmeriHealth Caritas Ohio. This exception is when the claim is for preventive pediatric services (including EPSDT/Healthchek) that are covered by the Medicaid program.

Following reimbursement to the provider in these cost avoidance exception cases, AmeriHealth Caritas Ohio shall actively seek reimbursement from responsible third parties and will adjust claims accordingly.

IMPORTANT DEFINITIONS REGARDING CLAIMS

Rejected claims are those returned to provider or EDI source without being processed or adjudicated, due to a billing issue and defined as claims with missing or invalid data elements, such as the provider tax identification number or member ID number. Rejected claims are not registered in the claim processing system and can be resubmitted as a new claim. Claims originally rejected for missing or invalid data elements must be resubmitted with all necessary and valid data within 365 days from the date services were rendered (or the date of discharge for inpatient admissions). Rejected claims are considered original claims and the timely filing limits should be followed.

Denied claims are those that were processed in the claims system. They may have a payment attached or may have been denied. A corrected claim (see below) may be submitted to have the claim reprocessed.

Corrected claims are defined as claims that AmeriHealth Caritas Ohio processed based on the information submitted but the provider submits a claim correcting the original data. A corrected claim must be submitted within 180 days of the paid claim date. The original claim number must be submitted as indicated below as well as the correct frequency code.

- You can find the original claim number from the 835 ERA or from the claim status search in NaviNet®.
- If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet® to get the claim number.
- Corrected/replacement and voided claims must be sent electronically.
    - If sent electronically, the claim frequency code (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values ‘7’ for the Replacement (correction) of a prior claim and ‘8’ for the void of a prior claim. The Value “6” should not be sent.
    - In addition, the submitter must also provide the original claim number in **Payer Claim Control Number** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).

CLAIMS REPORTING

VISIT REPORTING

CMS defines an encounter as "an interaction between an individual and the healthcare system." Encounters occur whenever an AmeriHealth Caritas Ohio member is seen in a provider's office or facility, whether the visit is for preventive healthcare services or for treatment due to illness or injury. An encounter is any healthcare service provided to a Plan member. Encounters must result in the creation and submission of an

encounter record or claim to AmeriHealth Caritas Ohio. The information provided on these claims represents the encounter data the Plan reports to the state, according to mandatory reporting requirements.

COMPLETION OF ENCOUNTER (CLAIMS) DATA

PCPs must complete and submit an electronic claim every time an AmeriHealth Caritas Ohio member receives services from the provider. Submission of the electronic claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services.
- It allows the Plan to gather statistical information regarding the medical services provided to members, which better support our statutory reporting requirements.
- It allows the Plan to identify the severity of illnesses of our members.

AmeriHealth Caritas Ohio accepts claim submissions electronically (via EDI) through Ohio's PNM portal centralized claims submission process. For more information on electronic claim submission and how to become an electronic biller, please contact your Account Executive or refer to the billing information available on our Plan website at https://www.amerihealthcaritasoh.com/provider/claims-billing.

In order to support timely statutory reporting requirements, PCPs must submit encounters (claims) within 120 days of the visit.

HEALTH PLAN CLAIMS MONITORING

AmeriHealth Caritas Ohio monitors claim data submissions for accuracy, timeliness and completeness through claims processing edits and through network provider profiling activities. Claims can be rejected or denied for inaccurate, untimely, and/or incomplete information. Network providers will be notified of the rejection via a remittance advice and are expected to resubmit corrected information to the Plan. Network providers may also be subject to sanctioning by the Plan for failure to submit accurate claim data in a timely manner.

CLAIMS PAYMENT SYSTEMIC ERROR (CPSE) REPORT

In accordance with the expectations of the Ohio Department of Medicaid (ODM), and as outlined in the Medicaid Managed Care Provider Agreement between ODM and AmeriHealth Caritas Ohio, the Plan communicates to providers when claims adjustments are processed for incorrectly underpaying, overpaying, denying, or suspending claims that impact, or have the potential to impact, five or more providers. Cases that meet these criteria are defined as Claims Payment Systemic Errors (CPSEs).

On a monthly basis, at a minimum, AmeriHealth Caritas Ohio releases a Claims Payment Systemic Error (CPSE) report and posts it online at: https://www.amerihealthcaritasoh.com/provider/claims-billing/cpse-reports.

CLAIMS FOR TELEHEALTH SERVICES

Please note, services listed as requiring prior authorization in Section VII require prior authorization whether they are delivered in-person or via telehealth.
Provider types eligible to bill for services rendered using telehealth include:

- Any practitioner identified in Section VI as "eligible to render services" except for the following

dependent practitioners:
  - Supervised practitioners, trainees, residents, and interns
  - Occupational therapist assistant
  - Physical therapist assistant
  - Speech-language pathology aides, audiology aides, and individuals holding a conditional license
- A professional medical group
- A professional dental group
- A federally qualified health center (FQHC) or rural health clinic (RHC)
- Ambulatory healthcare clinics (AHCC)
- Outpatient hospitals on behalf of licensed psychologists and independent practitioners not eligible to separately bill when practicing in an outpatient hospital setting
- Private duty nurses
- Home health and hospice agencies
- Behavioral health providers
- Hospitals operating an outpatient hospital behavioral health program

Professional claims submitted for healthcare services utilizing telehealth should include:
- A "GT" modifier;
- A place of service code that reflects the physical location of the treating practitioner at the time a healthcare service is provided using telehealth; and,
- An appropriate modifier to indicate the physical location of the patient.

Hospital providers are eligible to bill for telehealth services provided by licensed psychologists and independent practitioners not eligible to separately bill a professional claim. To bill outpatient hospital telehealth services, please append modifier “GT” to the procedure code.

If telehealth services are performed as a result of the COVID-19 pandemic, please also append Modifier “CR” – Catastrophe/Disaster to the applicable procedure codes and include Condition Code “DR” – Disaster Related at the header level of the institutional claim.

PAYMENT IN FULL / BALANCE BILLING MEMBERS

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 a prior authorization; or
3) A retroactive finding by a peer review organization (PRO) that a rendered service was not medically necessary.

A provider may bill a Medicaid recipient for a Medicaid covered service in lieu of submitting a claim to the Ohio department of Medicaid (ODM) only if all of the following conditions are met:
1) The provider explains to the Medicaid recipient that the service is a covered Medicaid service and other Medicaid providers may render the service at no cost to the individual;
2) Prior to each date of service for the specific service rendered, the provider notifies the Medicaid recipient in writing that the provider will not submit a claim to ODM for the service;
3) The Medicaid recipient agrees to be liable for payment of the service and signs a written statement

to that effect before the service is rendered; and

4) The Medicaid covered service is not a prescription for a controlled substance as defined in section 3719.01 of the Revised Code.

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

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) in accordance with section 5168.14 of the Revised Code.

Under the requirements of the Social Security Act, all payments from AmeriHealth Caritas Ohio to participating Plan providers must be accepted as payment in full for services rendered. **Members may not be balance billed for medically necessary covered services under any circumstances.** Providers may use the appeal process to resolve any outstanding claims payment issues.

MEMBER CO-PAYMENTS

AmeriHealth Caritas Ohio does not impose a member cost share as part of its program as an Ohio Medicaid Managed Care Entity. Although AmeriHealth does not require members to share the cost of traditional medical services, additional out-of-pocket costs may apply for value added services where benefit maximums have been exceeded (i.e. value-added services for contact lenses).

AmeriHealth may review and make changes to the program in the future. If AmeriHealth Caritas Ohio decides to implement a member cost sharing program, we will do so only after approvals from the Ohio Department of Medicaid.

PROVIDER CLAIMS DISPUTE RESOLUTION PROCESS

- Provider claims 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 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.
- Disputes are related to claim payment reconsideration and medical necessity review can be submitted only if a claim has been billed and denied. If a claim has not been billed a medical necessity appeal should be submitted as described in Section VI of this Provider Manual.

These disputes can come in through multiple avenues:

1. **Phone**: 1-833-644-6001 (Select the prompts for the correct department and then select the prompt for claim issues).
2. **NaviNet/Web**: https://navinet.my.salesforce-sites.com/ with the claims adjustment inquiry function.
3. **Mail**: (The request must include a copy of the dispute resolution letter)
   AmeriHealth Caritas Ohio
   Attn: Provider Claim Inquiry Team

PO Box 7126
London, KY 40742

4. **Fax**: 1- 833-216-2272

Disputes must be filed 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 provider is entitled to one level of dispute with the exception of denials related to "No authorization", or "Authorization exhausted/limited."

External Medical Review

- After exhausting AmeriHealth Caritas Ohio'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.

Refunds for improper payment or overpayment of claims

- Self-identified refunds or overpayment should be submitted as described in the process SECTION X REPORTING of this provider manual under CLAIMS COST CONTAINMENT UNIT.
- Disputes concerning Program Integrity related to recoveries should be submitted according to the process outlined within the letter received by the provider. The outlined steps should be followed to ensure accurate processing of the overpayment dispute/refund.

SECTION IX
CARE COORDINATION

IX. CARE COORDINATION

The following information is regarding AmeriHealth Caritas Ohio's Care Coordination program that encompasses the full spectrum of care coordination activities, ranging from short-term assistance to meet care gaps to longer-term, intensive, and holistic care management for Members with the most intense needs. Care Coordination assists members with health and wellness activities, pregnancy related services (Bright Start), transitions of care between settings, complex and chronic condition management.

CARE COORDINATION OVERVIEW

The Plan's Population Healthcare Coordination program is a holistic, person-centered approach that addresses physical and behavioral health, special healthcare needs, pharmacy needs, and Social Determinants of Health (SDoH) that supports the population health. This fully integrated model allows members to move seamlessly from one component to another, depending on their unique needs. From this integrated solution, the Plan delivers and coordinates care across all programs.

The Care Coordination program includes assessments, education, care planning, linking to community-based resources and collaborating with providers, Care Coordination Entities (CCEs), and the OhioRISE Plan/Care Management Entity (CME). The Care Coordination program also incorporates health and wellness self-management education. Members in the Care Coordination program are screened for social determinants of health and offered community-based resources to address their needs. The program is structured around a member-based decision support system that drives both communication and person-centered care plan development through a multidisciplinary approach to management. The Care Coordination process also includes reassessing and adjusting the person-centered care plan and its goals as needed. The Care Coordination program uses evidence-based practice guidelines.

The AmeriHealth Caritas Ohio Care Coordination program is supported by an internal team of Ohio based, integrated clinical and non-clinical staff whose skills and professional experience complement and support one another including physical and behavioral health medical officers, registered nurses, licensed behavioral health clinicians (e.g., social worker), Care Guide/Care Guide Plus, community designated staff, clinical pharmacist. AmeriHealth Caritas Ohio's Care Coordination team collaborates with primary care physicians (PCPs), specialists, other care coordination entities, and community service agencies, specialists, members, parents/caregivers to support the members' person-centered care plan goals.

Local care management is an integral part of our Care Coordination program. ACOH will coordinate and collaborate with other care management entities for Members who are engaged with them. Members who have frequent hospital admissions, readmissions, and complex needs, including both physical and behavioral, or are difficult to contact via telephone may be engaged in high-touch, face-to-face care coordination services through a community-based team of registered nurses, licensed social workers, and community health navigators to help them navigate and increase their access to needed medical, behavioral health, and social services. The care coordination team also supports the development of member self-management skills through encouragement and coaching for chronic disease management.

In addition to improving the care and health outcomes of members, this community-based team provides valuable information for, and coordination with, other health plan staff and services, as well as advancing integrated care through a person-centered approach and close collaboration with other providers, agencies, and caregivers in the community.

CARE COORDINATION COMPONENTS

There are core components of our Care Coordination program:

- Pediatric Preventive Healthcare
- Bright Start® (Maternity Management)
- Rapid Response and Outreach Team (RROT) and Wellness Coordination
- Transitional Care Management
- Complex Care Management (CCM)

PEDIATRIC PREVENTIVE HEALTHCARE – EPSDT/HEALTHCHEK

This program is designed to improve the health of members under the age of 21 years who are enrolled in Medicaid by increasing adherence to Early and Periodic Screening, Diagnosis and Treatment (EPSDT), also known as "Healthchek" in Ohio, guidelines. This is accomplished by identifying and coordinating preventive services with these members and parents/caregivers. Program approach combines scheduled member outreach and point-of-contact notification for Plan staff and providers when a member is due or overdue for an EPSDT/Healthchek service. The EPSDT Manager will help coordinate EPSDT services with members and parents/caregivers as indicated

BRIGHT START® (MATERNITY MANAGEMENT)

Bright Start is a multifaceted program designed to improve the health and experience of our mothers and infants by early identification and stratification of our members, care management based off prenatal care guidelines from the American College of Obstetrician and Gynecologist, member and provider incentives, and community partnerships. This program emphasizes the importance of prenatal and postpartum care while supporting the entire family and their educational and SDoH needs. Our nurse care managers serve as a member's single point of contact assisting with education and support on complex healthcare needs, care coordination and connection to obstetrical providers. As pregnant members are identified by new member assessments, claims data, routine member outreach, and provider reporting, Plan staff work to ensure that each pregnant member is aware of the services and support offered through the Bright Start program.

Under this program and state guidelines, prenatal care providers are expected to complete the AmeriHealth Caritas Ohio Pregnancy Needs Assessment Form (PRAF) for each expectant mother and submit it to the Plan as part of the authorization for obstetric services.

It is the provider's responsibility to address identified risk factors upon contact with the member and to develop appropriate action items in collaboration with the member to resolve the identified risks.

RAPID RESPONSE AND OUTREACH TEAM (RROT) AND WELLNESS COORDINATION

This team is designed to address the needs of members in accessing needed healthcare by identifying and decreasing barriers to such care. The RROT also gives support to providers and their staff, aiding in assistance and follow-through for members experiencing barriers to their healthcare. This team performs the following functions for Plan members and providers:

- Receiving inbound calls from members and providers.
- Conducting outreach activities which include a special focus on EPSDT and care gaps.
- Conducting Health Risk Assessments (HRAs) and Social Determinant of Health screenings.
- Providing care coordination support to address barriers to care.
- Coordinating value added services.

Members and providers may request RROT and wellness support by calling **1-833-464-7768**.

TRANSITIONAL CARE MANAGEMENT

This program coordinates services for adult and pediatric members with transitions of care needs. Program staff includes Care Managers who are licensed registered nurses (RN) or licensed behavioral health professionals (e.g., social worker). Program staff supports members by providing resolution for issues relating to access, care coordination, and follow up-care with the provider after hospital discharge. Program staff will monitor a member's condition(s) for a short-term period of time; if program staff feels the member's condition requires long term/complex care, a referral is made to program staff in Care Coordination.

COMPLEX CARE MANAGEMENT

This program serves members identified as needing comprehensive and disease-specific assessments, and re-assessments, along with the development of person-centered prioritized goals that are incorporated into the person-centered plan of care, developed in collaboration with the member, the member's caregiver(s) and/or other participant of the member's choice, and the member's primary care provider (PCP) and supporting service providers when applicable and with appropriate consents. Program staff includes Care Managers who are licensed registered nurses (RN) or licensed behavioral health professionals (e.g., social workers).

Members are identified for the Complex Care Management program through multiple sources, including provider referrals and referrals from internal and external sources. For more information and/or to refer Members to the Rapid Response Outreach Team at 1-833-646-7768.

Members in the Care Management program are screened for the following as part of standard protocol:

- All AmeriHealth Caritas Ohio members engaged in complex care management receive a comprehensive initial assessment that meets NCQA requirements.
- Adolescents ages 11 through 17 and adult members ages 18 years and older receive a depression screening to assess for symptoms of depression. Based on the depression score, the member is offered education and referred to the appropriate behavioral health services.

- Subsequent detailed reassessments are performed for any item that screens positive in the initial assessment.

PROGRAM PARTICIPATION

Participation in the Care Coordination program is offered to all Plan members, with the ability for members to opt out upon request. Members may also self-refer into a program by contacting the Plan.

Members are initially identified for specific Care Coordination needs upon joining the Plan through systematic risk stratification. The Plan will systematically re-stratify members on a monthly basis. Members are also identified through material and telephonic outreach by the Plan. Members are encouraged to let the Plan know if they have a chronic health condition, special health need, or if they are receiving on-going care. A new member assessment is included in the members' welcome packet to identify current health conditions and healthcare services. Based upon their responses to the initial health risk assessment, members are identified for participation in the appropriate care coordination program.

ROLE OF THE PROVIDER

CARE COORDINATION WITH THE PCP

AmeriHealth Caritas Ohio recognizes that the PCP is the cornerstone of the member's care coordination and delivery system. Our care coordination staff contacts each PCP during a member's initial enrollment into the complex care management program, as part of the comprehensive assessment and person-centered plan of care development process.

Program staff works with the member to develop the person-centered plan of care. Program staff complements the PCP's recommendations in the development of an enhanced and holistic plan of care specific to the member's needs. The Care Manager remains in close communication with the PCP, particularly during the implementation of the plan of care, should issues or new concerns arise.

CARE COORDINATION WITH OTHER PROVIDERS

Program staff also contact the member's key and/or current providers of care, such as the member's behavioral healthcare providers, CCEs, OhioRISE Plan/CME, to determine the best process to support the member. This process eliminates redundancies and supports efficiencies for both programs. Program staff may also engage key providers to be part of the development of the person-centered plan of care if the member agrees. As the member is reassessed, a copy of the care plan goals is supplied to both the provider and member.

HEALTH & LIFESTYLE EDUCATION

AmeriHealth Caritas Ohio PCPs are expected to provide Plan members with education and information about lifestyle choices and behaviors that promote and protect good health. AmeriHealth Caritas Ohio will

support Plan providers in this effort by developing and distributing State-approved health education materials for Plan members, from time to time and as needed to address specific health education needs.

Additionally, AmeriHealth Caritas Ohio PCPs are expected to help educate Plan members regarding:

- Appropriate use of Urgent Care and Emergency Services, including how to access such care when necessary.
- How to access services such as vision care, mental healthcare and substance use disorder services, and dental care.

Recommendations for self-management of health conditions and self-care strategies (e.g., care gaps) relevant to the member's age, culture, and conditions.

LET US KNOW PROGRAM

Providers are encouraged to refer members to the Care Management program as needs arise or are identified. We have many levels of support and tools available to assist in the outreach and education of our members, as well as clinical resources for providers in their care management.

We encourage you to contact the RROT at **1-833-464-7768**, or complete and submit a Member Intervention Request form, https://www.amerihealthcaritasoh.com/assets/pdf/provider/resources/forms/member-intervention-form.pdf, to let us know about members who are in need of:

- Assistance locating a dental or specialty provider
- A pharmacy consult on controlled substances
- Education about plan benefits and resources
- Assistance with appointment scheduling
- Support with resources identified through Social Determinant of Health (SDoH) screening
- SDoH resource follow-up (e.g., for transportation, food pantry, housing applications, etc.)
- Education about health conditions and wellness needs
- Screening for mental health or substance use services
- Crisis follow-up resources (e.g., recent suicide attempt or bereaved after a death by suicide)

Members are also referred to the Care Management program through internal Plan processes. Identified issues and diagnoses that result in a referral to the Care Coordination program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses)
- Risk score indicating over- or underutilization of care and services
- Pediatric members requiring assistance with EPSDT
- Pediatric members in foster care or receiving adoption assistance
- Infants receiving care in the NICU
- Members with dual medical and behavioral health needs
- Members with substance use disorder-related conditions
- Members who are developmentally or cognitively challenged
- Members with a special healthcare need
- Pharmacy consults on controlled substances
- Pregnant members
- Members with high trauma exposure

- Members in need of long-term services and supports to avoid hospital or institutional admission
- Screening for mental health or SUD services
- Assistance with community resources

Care Management is a voluntary program focused on prevention, education, lifestyle choices and adherence to treatment plan and is designed to support a person-centered plan of care for people such as persons living with chronic diseases including asthma, depression, diabetes, and/or coronary artery disease, those living with trauma exposure, and/or those with unmet social needs.

CARE COORDINATION DELEGATION INFORMATION

AmeriHealth Caritas Ohio delegates Care Management services for children in all 47 counties serviced by Partner for Kids (PFK), regardless of risk tier. This would include but is not limited to, completions of Health Risk Assessment and any other screening assessments, Transition of Care Events. Risk tier assignments, Case Manager, Case Manager Plus, Care Guide and Care Guide Plus role assignments. AmeriHealth Caritas Ohio has bi-weekly meetings with the PFK care coordination team to review and cover and member grievances, member concerns and process rollouts. This partnership was effective February 7, 2023. AmeriHealth Caritas Ohio covers Utilization Management and Provider enrollment and monitoring of grievances that have been reported to AmeriHealth by PFK.

INTEGRATING BEHAVIORAL AND PHYSICAL HEALTHCARE

Members with mental health and substance use disorders often experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions. AmeriHealth Caritas Ohio understands that coordination of care for these members is imperative. To meet their needs, AmeriHealth Caritas Ohio has a fully integrated Medical Management department. Under this collaboration, the Plan's integrated platform will help to seamlessly coordinate member care across the physical and behavioral health and social service areas.

Plan staff will work with the involved primary care and behavioral health providers to develop an integrated plan of care for members in need of physical and behavioral healthcare coordination. Care Managers will also work to assure that communication between the two disciplines, providers, and organizations, occurs routinely for all members with physical and behavioral health issues. Care Managers will also work to coordinate with substance use disorder providers and community resources with the appropriate member consent as needed. Care Managers will proactively and regularly follow-up on required physical and behavioral health services, joint treatment planning, and provider-to-provider communication to ensure that member needs are continuously reviewed, assessed, and updated.

When members are enrolled in the OhioRISE plan, ACOH will be an active team member to support the primary care manager from OhioRISE / the OhioRISE Care Management Entity (CME) provider. ACOH will collaborate and coordinate to help ensure members receive needed services and supports.

PERSON-CENTERED PLAN OF CARE

Through the Care Management program, AmeriHealth Caritas Ohio works with practitioners, members, and their natural supports and outside agencies as appropriate to develop a person-centered plan of care for members with special or complex healthcare needs. Our methodology is to empower members to take the lead in identifying and prioritizing their goals and interventions. AmeriHealth Caritas Ohio's plan of care specifies mutually agreed-upon goals, medically necessary physical and behavioral health services, as well as any support services necessary to carry out or maintain the plan of care, and planned care coordination activities. The person-centered plan of care also considers the cultural values and any special communication needs of the member, family, and/or the child. Additionally, social determinants of health as identified by the member are addressed.

AmeriHealth Caritas Ohio care planning is based upon a comprehensive assessment of each member's condition and needs. Each member's care is appropriately planned with active involvement and informed consent of the member, and his or her family or caregiver, as clinically appropriate and legally permissible, and as determined by the member's practitioner and standards of practice.

AmeriHealth Caritas Ohio also utilizes EPSDT guidelines in the development of treatment plans for members under age 21. AmeriHealth Caritas Ohio works with practitioners to coordinate care with other treatment services provided by State agencies.

Through AmeriHealth Caritas Ohio's Care Coordination program, the member is assisted in accessing any support needed to maintain the plan of care. The Plan and the PCP are expected to ensure that members and their families (as clinically appropriate) are fully informed of all covered and non-covered treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option. In order to make treatment decisions and give informed consent, available treatment for members will include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether AmeriHealth Caritas Ohio provides coverage for those treatments.

Person-centered plans of care for members with special healthcare needs are reviewed and updated at every contact, and at least quarterly, or as determined by the member's PCP based on the PCP's assessment of the member's health and developmental needs. The person-centered plan of care will also be updated when a member's circumstances or needs change significantly, at the member's request, when a re-assessment occurs, and upon ODM's request. The revised plan of care is expected to be incorporated into the member's medical record following each update.

COORDINATING CARE THROUGH TRANSITIONS AND DISCHARGE PLANNING

One of the most important functions of a managed care organization is to assist in coordination of care during transitions. This includes, but is not limited to:

- Changes in care settings such as from hospital to home or hospital to rehab;
- Changes in health status due to presentation of a new chronic, sometimes life-threatening, condition;

- Temporary or permanent changes in the fulcrum of care when a patient must change from a primary care physician to a specialist due to a surgical need or exacerbation of a chronic condition;
- Changes in a living situation to obtain more independence or because of a need for greater support; or,
- Caregiver and family changes.

During inpatient transitions, members are supported through the Care Coordination department. Members receive, at minimum 3 outreach calls upon day of the notification of discharge. These calls are strategically placed to help ensure the member has the appropriate resources in place and has a follow-up appointment scheduled and kept with their provider.

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.

To support the reduction of fraud, waste, and abuse within the Medicaid system, and to better support our members with complicated drug regimens or who see multiple physicians, AmeriHealth Caritas Ohio utilizes a Coordinated Services Program (CSP) for pharmacy services. Through data analysis and referrals by providers and the state, the Plan identifies members who may need additional support or who may have misused, abused, or committed possible fraud in relation to the receipt of prescription drug services.

Under these programs, a multidisciplinary team uses established procedures to review member pharmacy utilization for the purpose of identifying misuse, abuse, or potential fraud. Member prescription and medical service utilization data is reviewed against established conditions (set forth below and defined in OAC 5160-20-01) on a monthly and ad hoc basis. Members with a cancer diagnosis and actively receiving chemotherapy or radiation treatment, or in a long-term care facility or hospice are exempt. A member may be identified for review when any of the following criteria is met:

a) Received 4 of more of any combination of any OARRS reportable drugs or any muscle relaxants during a 90-day period within the last 12 months.
b) Received any combination of any OARRS reportable drugs or any muscle relaxants during a 90-day period within the last 12 months AND diagnosed with or treated for addiction or poisoning overdose within 365 days.
c) Obtained prescribed drugs from 4 or more prescribers for any combination of any OARRS reportable drugs or any muscle relaxants during a 90-day period within the last 12 months.
d) During a 90-day period within the last 12 months, an individual utilized three or more pharmacies to fill abuse potential drugs as determined by national provider identification (NPI) number.
e) Concurrently received a benzodiazepine, a muscle relaxant, and an opioid during a 90-day period within the last 12 months.

The Ohio Department of Medicaid (ODM) may, at its discretion, choose to apply additional criteria to identify individuals for CSP enrollment when utilization of services appears to exceed, or appears not to follow, nationally recognized treatment standards.

AmeriHealth Caritas Ohio accepts referrals of suspected fraud, misuse, or abuse from several sources, including physician/pharmacy providers, the Plan's Pharmacy Services, Member/Provider Services, the Special Investigations Unit, Case Management/Care Coordination, Special Care Unit, Quality Management, Medical Affairs, and the Ohio Department of Medicaid (ODM). If you suspect member fraud, misuse, or abuse of services, you are encouraged to make a referral to the Pharmacy and PCP CSP by calling the Fraud and Abuse Hotline at 1-866-833-9718.

All referrals are reviewed for potential enrollment into the CSP. If the results of the review indicate misuse, abuse, or fraud, AmeriHealth Caritas Ohio will place the member in the CSP, which means the member(s) will be restricted to one pharmacy.

SECTION X
REPORTING

X. REPORTING

MEDICAL RECORD REQUIREMENTS

Medical records of network providers are to be maintained in a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review. Provider offices are to have an organized medical record filing system that facilitates access, availability, confidentiality, and organization of records at all times.

Providers must retain all medical records, whether electronic or paper, for a period of no less than 10 years after the last payment was made for the services of the member.

Providers are required by contract to make medical records accessible to all appropriate government agencies, including but not limited to the Ohio Department of Medicaid (ODM), the United States Department of Health and Human Services (DHHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), and their respective designees in order to conduct fraud, abuse, waste and/or quality improvement activities.

Members have the right to request and receive a copy of their medical records, free of charge, and to request that they be amended or corrected, in accordance with OAC rule 5160-26-05.1

Providers must follow the medical record standards outlined below, for each member’s medical record:

- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient’s first and last name and identification number is on each page of record.
- All entries specify location, date, times of service provision and are legible.
- Identification of the type of service being provided.
- All entries are initialed or signed by the author including professional credentials, if any.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations, and illnesses.
- Allergies and adverse reactions are prominently listed or noted as “none” or “NKA.”
- Information regarding personal habits such as smoking and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each member.
- Patient’s chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.

- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Specific interventions, including name, dosage, and route of medications administered.
- Any supplies dispensed as part of the service.
- Healthcare education provided to patients, family members, or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with the Plan's Preventive Health Guidelines.
- Member's response to staff interventions.
- An immunization record is up to date (for members 21 years and under) or an appropriate history has been made in the medical record (for adults).
- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.
- Identification of the timeframe for documentation completion.
- Process to ensure units of service billed for payment are based on services provided with substantiating documentation.
- A provider may correct a medical record before submitting a claim for reimbursement; however, the correction must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

MEDICAL RECORD REQUESTS

AmeriHealth Caritas Ohio conducts medical record reviews to capture HEDIS® data not obtained through claims submission. Medical records may be audited year-round. This effort is part of health plan operations and within Plan expectations for participating providers. A written notification request may be submitted to a provider office requesting specific medical records be sent to the Plan. At least five business days' notice will be provided for a scheduled onsite audit. If requested, a member list will be provided with Medicaid ID, date of birth, and HEDIS® measure missing prior to the audit. The names of the reviewers performing the audits will also be provided, if requested.

ACCESS TO MEDICAL RECORDS

AmeriHealth Caritas Ohio's access to the medical records maintained by our providers is a critical component of our data collection as we seek to ensure appropriate and continued access to care for our member population. AmeriHealth Caritas Ohio or its designee must receive medical records from you in a timely manner for purposes of HEDIS data collection, NCQA accreditation, medical records documentation audits, and other quality-related activities that comprise our QAPI program.

AmeriHealth Caritas Ohio will reach out from time to time to request records for these purposes; it is essential that you provide requested records within the timeframes set forth in those notices.

As our technological capabilities continue to advance, AmeriHealth Caritas Ohio will seek to enhance the efficiency of our data collection activities in support of our QAPI and population health programs, including using bi-directional automated data exchange with our providers. These exchange opportunities, as available, are intended to capture data related to gaps in care, and to identify social determinants of health that may also be targets for intervention. AmeriHealth Caritas Ohio will work with our providers to identify and implement the most appropriate format and cadence for data exchange.

POLICIES AND PROCEDURES FOR MCO ACTION IN RESPONSE TO UNDELIVERED, INAPPROPRIATE, OR SUBSTANDARD HEALTHCARE SERVICES

QUALITY OF CARE CONCERNS

AmeriHealth Caritas Ohio clinical reviewers fully investigate potential quality of care (QOC) concerns, in accordance with AmeriHealth Caritas Ohio policy. Providers are required to comply with AmeriHealth Caritas Ohio QOC review process to include submitting records timely in accordance with our policy and procedures. Failure to provide records timely may result in sanctions. Your support of and participation in this critical review process helps to ensure the provision of high-quality care and service to the AmeriHealth Caritas Ohio member population.

Summaries and situational reviews are presented to the Quality Management on a monthly basis. Serious QOC concerns may result in a referral to the Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from the Plan’s network, sanctions, or corrective action. Referral to the QAPIC is the discretion of the Plan Medical or QM Director.

If the QAPIC investigation involves an action reportable to a national or State entity or database, the appropriate practitioner/provider’s case information will be reported to the National Practitioner Data Bank (NPDB) and State regulatory agencies.

The QM Department reserves the right to impose any of the following actions, based on its discretion:

- Submission of medical records.
- Requiring the practitioner/provider to submit a written description and explanation of the quality-of-care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. In the event that the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record review audit.
- Requiring that the practitioner/provider conform to a corrective action plan (CAP), which may include continued monitoring by AmeriHealth Caritas Ohio to help ensure that adverse events do not continue. The CAP will be documented in writing and may also include provisions that the practitioner/provider maintain an acceptable pass/fail score regarding a particular performance metric.

In addition, the QAPIC may recommend the following:

- Implementing formal sanctions, including termination from the AmeriHealth Caritas Ohio network if the offense is deemed an immediate threat to the well-being of Plan members.

AmeriHealth Caritas Ohio reserves the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the actions listed above.

At the conclusion of the investigation, the practitioner/provider will be notified by letter of the actions recommended by the QAPIC, including an appropriate time period within which the practitioner/provider must conform to the recommended action.

PROVIDER SANCTIONING POLICY

It is the goal of AmeriHealth Caritas Ohio to assure members receive quality healthcare services. In the event that medical or behavioral health services rendered to a member by a network provider represent a serious deviation from, or repeated non-compliance with, the Plan's quality standards, recognized treatment patterns of the organized medical community, and/or standards established by the State, the network provider may be subject to AmeriHealth Caritas Ohio's formal sanctioning process.

Except for any applicable state licensure board reporting requirements, all sanctioning activity is strictly confidential.

FORMAL SANCTIONING PROCESS

Following a determination to initiate the formal sanctioning process, AmeriHealth Caritas Ohio will send the practitioner/provider written notification of the following by certified mail or via another means providing for evidence of receipt. The notice will include:

- The reason(s) for proposed action and information on the practitioner/provider's right to request a hearing with AmeriHealth Caritas Ohio on the proposed action.
- Reminder that the practitioner/provider has 30 days following receipt of notification within which to file an appeal and instructions for how to file the appeal.

ADVERSE EVENTS REPORTING

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, with governing regulations codified at 45 CFR Parts 60 and 61, AmeriHealth Caritas Ohio sends information on reportable events, (as outlined in the NPDB Reporting Manual instructions) to the respective entity and to the State Medical Board, as appropriate, in Ohio.

CRITICAL INCIDENTS AND PROVIDER PREVENTABLE CONDITIONS

The Plan's payment policy with respect to Provider Preventable Conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA defines PPCs to include two distinct categories: Health Care Acquired Conditions; and Other Provider-Preventable Conditions.

Providers must comply with the reporting requirement established in the Older Adult Protective Services Act and the Adult Protective Services Act. All critical incidents require notification to the Plan immediately or as reasonably possible following the incident. A critical incident includes but is not limited to the following incidents:

- Unexpected death of a member, including deaths occurring in any suspicious or unusual manner, or suddenly when the deceased was not attended by a physician;
- Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities;
- Suspected physical, mental, or sexual mistreatment, or abuse and/or neglect of a member;
- Suspected theft or financial exploitation of a member;
- Severe injury sustained by a member;
- Medication error involving a member; or
- Inappropriate/unprofessional conduct by a provider involving a member.
- Restraint, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body;
- Service interruption, which includes any event that results in the participant's inability to receive services that places his or her health and or safety at risk;
- Hospitalization (other than hospital stay planned in advance);
- Member fall resulting in the need for medical treatment;
- Medical emergency involving member resulting in the need for medical treatment;
- Severe injury of member resulting in the need for medical treatment.

In addition to the list above, critical incidents include Sentinel and Serious Adverse Events as defined below:

- **Sentinel Event** – An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as "sentinel" because they signal the need for immediate investigation and response. Please note, the terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events. Examples of a sentinel event include:
    - Maternal death after delivery.
    - Suicide while inpatient.

- **Serious Adverse Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and healthcare providers for the purpose of public accountability. These events are clearly identifiable and measurable. Adverse events are outcomes determined to be unrelated to the natural course of the patient's illness or underlying condition, or the

proper treatment of that illness or underlying condition. Examples include:
  - Surgery performed on the wrong patient.
  - Surgery on the wrong body part.
  - Unintended retention of a foreign object after surgery.

See www.CMS.gov for a complete list.

HEALTHCARE ACQUIRED CONDITIONS

The category of Healthcare Acquired Conditions applies to Medicaid inpatient hospital settings only. Under this category, the Plan does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Catheter Associated Urinary Tract Infection
- Pressure Ulcers (Decubitus Ulcers)
- Vascular Catheter Associated Infection
- Mediastinitis after Coronary Artery Bypass Graft (CABG)
- Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes)
- Manifestations of Poor Glycemic Control
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures Except for Pediatric and Obstetric Populations

Under the category of Hospital-Acquired Conditions and Provider-Preventable Conditions, the Plan will not reimburse providers for a condition that meets the following criteria:

- Is identified in the Medicaid State Plan;
- Has been found, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- Has a negative consequence for the member;
- Is auditable; and
- Includes, at a minimum:
  - Surgical or Other Invasive Procedure Performed on the Wrong Body Part;
  - Surgical or Other Invasive Procedure Performed on the Wrong Patient; or
  - Wrong Surgical or Other Invasive Procedure Performed on a Patient.

Reporting of Critical Incidents, Healthcare Acquired Conditions, Hospital-Acquired Conditions, and Provider-Preventable Conditions is required.

AmeriHealth Caritas Ohio monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home healthcare agencies, and other providers of healthcare services. The

purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of the Plan.

AmeriHealth Caritas Ohio's goals are to:

- Have a positive impact on improving patient care, treatment, and services and prevent unusual occurrences.
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future.
- Increase general knowledge about unusual occurrences, their causes, and strategies for prevention.

REPORTING PROVIDER PREVENTABLE CONDITIONS OR CRITICAL INCIDENTS

All PPCs must be reported by the provider at the time a claim is submitted. Note that this requirement applies even if the provider does not intend to submit a claim for reimbursement for the service(s) rendered. Prohibition on payment for PPCs is not intended to result in a loss of access to care or services for members. Under specific circumstances, the PPC adjustment is not applied or is minimized. For example:

- No payment reduction is imposed if the condition defined as a PPC for a particular member existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a "Present on Admission" indicator.
- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; the Plan will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

FOR PROFESSIONAL CLAIMS (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in EDI equivalent of field 24D.
- Report the E diagnosis codes, such as E876.5, E876.6 or E876.7 in EDI equivalent of field 21 [and/or] field 24E.

FOR FACILITY CLAIMS (UB-04 OR 837I)

When submitting a claim which includes treatment required as a result of a PPC, inpatient and outpatient facility providers are to include the appropriate ICD-10 (or successor) diagnosis codes, including applicable external cause of injury or E codes on the claim in EDI equivalent of field 67 A – Q. Examples of ICD-10 and "E" diagnosis codes include:

- Wrong surgery on correct patient E876.5;
- Surgery on the wrong patient, E876.6;
- Surgery on wrong site E876.7;
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired."

INPATIENT CLAIMS

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired**.**

For per-diem or percent-of-charge based hospital contracts, claims including a PPC must be submitted with the member's medical record. These claims will be reviewed against the medical record and payment will be adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC from the DRG. Facilities do not need to submit copies of medical records for PPCs associated with this payment type.

INDICATING PRESENT ON ADMISSION (POA)

If a condition described as a PPC leads to a hospitalization, the hospital should include the "Present on Admission" (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator should be reported in the shaded portion of EDI equivalent of field 67 A – Q. DRG- based facilities may submit POA via 837I in loop 2300; segment NTE, data element NTE02.

Valid POA Indicators include:

- "Y" = Yes = present at the time of inpatient admission
- "N" = No = not present at the time of inpatient admission
- "U" = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission
- "W" = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not "null" = Exempt from POA reporting

INCIDENT REPORTING

MANDATORY REPORTING REQUIREMENTS

Providers are required to assure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500, and accidental/unnatural deaths. If actions were not taken to assure the immediate health and safety of the member, the provider will do so immediately. Such actions may include calling police or EMS, reporting to county Adult Protective Services (APS), the county Public Child Services Agency (PCSA) or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to AmeriHealth Caritas Ohio (Plan) within 24 hours of becoming aware of the incident in accordance with OAC rule 5160-44-05.

HOW TO SUBMIT AN INCIDENT REPORT

To make a report, providers must call the Rapid Response and Outreach Team (RROT): **1-833-464-7768**.

The Plan reports the following incidents for all members via the Ohio Incident Management System:

- Abuse
- Neglect
- Exploitation
- Misappropriation of greater than $500
- Unexplained death

COMPLIANCE RESPONSIBILITIES

AmeriHealth Caritas Ohio providers are required to comply with all applicable Plan policies and procedures, applicable federal and state regulations, and applicable contractual requirements set by Ohio and the Ohio Department of Medicaid (ODM). Although not an exhaustive list, the primary areas of compliance with policies and regulations for Plan providers are:

- Americans with Disabilities Act (ADA) / Rehabilitation Act

PROGRAM INTEGRITY/FRAUD, WASTE & ABUSE (FWA).

- False Claims Act
- Fraud Enforcement and Recovery Act

AMERICANS WITH DISABILITIES ACT (ADA) AND THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973 (“Rehabilitation Act”) and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require the Plan’s providers to make their services and facilities accessible to all individuals. AmeriHealth Caritas Ohio expects its network providers to be familiar with the requirements of the Rehabilitation Act and the ADA and to fully comply with the requirements of these statutes.

PROGRAM INTEGRITY

AmeriHealth Caritas Ohio has dedicated Program Integrity staff charged with preventing, detecting, investigating, and reporting fraud, waste, and abuse (FWA). The Program Integrity Department has cross-functional teams that support its activities to help ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with applicable federal and state regulations, contractual requirements, and Plan requirements and guidelines. The cross-functional teams that comprise the Program Integrity Department, and are responsible for conducting specified program integrity activities, include the Special Investigations Unit, Prospective & Retrospective Client and Vendor Data Management, and Internal Claims Cost Management.

As a provider participating in AmeriHealth Caritas Ohio’s network, you are responsible to know and abide by all applicable state and federal laws and regulations and by the fraud, waste, and abuse requirements of AmeriHealth Caritas Ohio’s contract with the Ohio Department of Medicaid. Violations of these laws and regulations may be considered fraud or abuse against the Medical Assistance program. Some of the federal fraud and abuse laws physicians must be familiar with include the False Claims Act (31 U.S.C. §3729-3733), the Anti-Kickback Statute (42 U.S.C. §1320a-7b (b)), the Physician

Self- Referral Law, also known as the Stark Law (42 U.S.C. §1395nn), and the federal Exclusion Statute (42 U.S.C. §1320a-7).

AmeriHealth Caritas Ohio is obligated to ensure the effective use and management of public resources in the delivery of services to its members. AmeriHealth Caritas Ohio does this in part through its Program Integrity department, whose programs are designed to ensure the accuracy of claims payments and to the detection and prevention of fraud, waste, and abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of AmeriHealth Caritas Ohio, regarding payments or the recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract, and with state and federal law. Examples of these Program Integrity initiatives include:

- **Prospective (Pre-claims payment)**
  - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical Association ("AMA"), state regulatory agencies or AmeriHealth Caritas Ohio medical/claim payment policy) are applied to prior to claims payment.
  - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
    - *Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe*.
  - Coordination of Benefits ("COB") - Process to verify third party liability to ensure that AmeriHealth Caritas Ohio is only paying claims for members where AmeriHealth Caritas Ohio is responsible, i.e., where there is no other health insurance coverage.
  - Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

- **Retrospective (Post-claims payment**)
  - Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation – As a Medicaid plan, AmeriHealth Caritas Ohio is by federal statute the payor of last resort. The effect of this rule is that AmeriHealth Caritas Ohio may recover its payments if it is determined that a member had other health insurance coverage at the time of the service.
  - Please also see Section VIII Claims for further description of TPL/COB/Subrogation.
  - Data Mining – Using paid claims data, AmeriHealth Caritas Ohio identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
  - Medical Record /Itemized Bill Review – a medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. The scope of the validation may encompass any or all of the procedures, diagnosis or diagnosis-related group ("DRG") billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.
    - *Please note if medical records are not received within the requested timeframe,* AmeriHealth Caritas Ohio *will recoup funds from the provider. Your failure to provide the necessary medical records to validate billing creates a presumption that the claim as submitted is not supported by the records.*

- **Credit Balance Issues**
    - Credit balance review service may be conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
    - Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you may be requested to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

FRAUD, WASTE, AND ABUSE

The Special Investigations Unit (SIU) team is responsible for detecting fraud, waste, and abuse throughout the claims' payment processes for AmeriHealth Caritas Ohio. The SIU staff includes experienced investigators and analysts, including Certified Professional Coders, Registered Nurses, Certified Fraud Examiners, and Accredited Healthcare Fraud Investigators.
Among other things, the SIU conducts the following activities:

- Reviews and investigates all allegations of fraud, waste, and abuse.
- Implements corrective actions for any supported allegations after thorough investigation, which may include recovery of identified overpayments, placing providers on pre-payment review of claims, and making referrals to appropriate agencies in compliance with contractual obligations.

DEFINITIONS OF FRAUD, WASTE AND ABUSE (FWA)

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal and State law.

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program.

AmeriHealth Caritas Ohio is dedicated to eradicating Fraud and Abuse from its programs and cooperates in Fraud and Abuse investigations conducted by state and/or federal agencies, including the Ohio Department of Medicaid (ODM), the Federal Bureau of Investigation, the Drug Enforcement Administration, the federal Office of Inspector General of the U.S. Department of Health and Human Services, as well as the Bureau of Program Integrity. As part of AmeriHealth Caritas Ohio's responsibilities, the Program Integrity department, and the SIU in particular, is responsible for identifying and recovering overpayments. The SIU performs several operational activities to detect and prevent fraudulent and/or abusive activities.

REPORTING AND PREVENTING FWA

AmeriHealth Caritas Ohio receives state and federal funding for payment of services provided to our members. In accepting claims payment from AmeriHealth Caritas Ohio, providers are receiving Ohio and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program.

Violations of these laws and regulations may be considered fraud or abuse against the medical assistance program. Compliance with federal laws and regulations is a priority of AmeriHealth Caritas Ohio.

If you, or any entity with which you contract to provide healthcare services on behalf of AmeriHealth Caritas Ohio beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please report your concerns or findings to:

AmeriHealth Caritas Ohio

- Call the toll-free Fraud Waste and Abuse Hotline at 1-866-833-9718.
- Email fraudtip@amerihealthcaritas.com; or
- Mail a written statement to:
  Special Investigations Unit
  AmeriHealth Caritas Ohio
  200 Stevens Drive
  Philadelphia, PA 19113

Ohio Attorney General's Office

- Call 1-614-466-0722.
- Mail a written statement to:
  Medicaid Intake Officer
  Office of the Attorney General
  30 E. Broad Street, 23rd Floor
  Columbus, OH 43215
- For additional information or to make a report online, please visit www.OhioAttorneyGeneral.gov/ReportMedicaidFraud.

Below are examples of information that will assist the Plan with an investigation:

- Contact information (e.g., name of individual making the allegation, address, telephone number)
- Name and identification number of the suspected individual
- Source of the complaint (including the type of item or service involved in the allegation)
- Approximate dollars involved (if known)
- Place of service
- Description of the alleged fraudulent or abuse activities
- Timeframe/date of the allegation(s)

WHAT TO EXPECT AS A RESULT OF SIU ACTIVITIES

The SIU must review all complaints that are received and, as a result, you may be asked to provide certain information in order for the SIU to thoroughly look at all complaints. The SIU utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from AmeriHealth Caritas Ohio, or on behalf of AmeriHealth Caritas Ohio, regarding recovery of potential overpayments and/or requesting medical records for review. Should you have any questions regarding a letter received, please use the contact information provided in the letter to expedite a response to your question or concerns.

- You may be contacted by the SIU Intake Unit to verify a complaint you filed.
- You may be contacted by investigators regarding a complaint they are investigating.
- As a provider, you may be requested to provide medical records for review. This request will be sent via a letter explaining the process to submit the records. Keep in mind that per your provider agreement, you are required to provide the records for review.

Provider agrees to cooperate with AmeriHealth Caritas Ohio in maintaining and providing to AmeriHealth Caritas Ohio or the Ohio Department of Medicaid (ODM), at no cost to them: books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to AmeriHealth Caritas Ohio Agreement as well as medical information relating to the members as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements.

After an investigation is completed, there are several things that may occur such as a determination that the complaint was unfounded, the identified/investigated issue was found to be of an educational nature only, an overpayment was identified for recoupment, or the issue was identified as a credible allegation of fraud and is referred to the appropriate authorities.

FALSE CLAIMS ACT (FCA)

FALSE CLAIMS AND FEDERAL LAW
FALSE CLAIMS ACT, 31 U.S.C. §§3729-3733

The Federal False Claims Act (FCA) is a federal law that prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. Additionally, the FCA prohibits knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. When AmeriHealth Caritas Ohio submits claims data to the government for payment (for example, submitting Medicaid claims data to the Ohio Department of Medicaid), we must certify that the data is accurate to the best of our knowledge. We are also responsible for claims data submitted on our behalf from our subcontractors, and we monitor their work to help ensure compliance.

The FCA, through amendments made under the Fraud Enforcement and Recovery Act of 2009, also prohibits knowingly concealing or knowingly and improperly avoiding the return of identified

overpayments.

The FCA contains a whistleblower provision to encourage individuals to report misconduct involving false claims. The whistleblower provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a civil lawsuit on behalf of the U.S. Government. The whistleblower provisions of the FCA protects individuals from retaliation that results from filing an action under the FCA, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

Penalties for violating the FCA include civil monetary penalties (CMPs) ranging from $11,665 to $23,331 (as last adjusted by the DOJ, on June 19, 2020, under the Federal Civil Penalties Inflation Adjustment Act—passed and amended in 1990 and 2015, respectively) per false claim, and/or exclusion from federally funded programs. In addition, violators may be subject to three times the amount of damages sustained by the Federal government because of the illegal act(s) unless the violator has voluntarily disclosed the FCA violation under certain conditions.

FALSE CLAIMS AND OHIO STATE LAW
OHIO REV. CODE § 2913.40, MEDICAID FRAUD

(1) No person shall knowingly make or cause to be made a false or misleading statement or representation for use in obtaining reimbursement from the Medicaid program.

(2) No person, with purpose to commit fraud or knowing that the person is facilitating fraud, shall do either of the following:

(i) Contrary to the terms of the person's provider agreement, charge, solicit, accept, or receive any property, money, or other consideration for goods or services in addition to the amount of reimbursement under the Medicaid program; or,

(ii) Solicit, offer, or receive any remuneration, other than any cost-sharing expenses authorized by law, in cash or in kind, including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the Medicaid program.

(3) No person, having submitted a claim for provided goods or services under the Medicaid program, shall do either of the following for a period of at least six years after reimbursement pursuant to that claim, or a reimbursement for those services, is received under the Medicaid program:

(i) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of all goods or services for which a claim was submitted, or for which reimbursement was received, by the person; or,

(ii) Knowingly, alter, falsify, destroy, conceal, or remove any records that are necessary to disclose fully all income and expenditures upon which rates of reimbursement were based for the person.

Violators are guilty of Medicaid fraud which, at a minimum, is a misdemeanor of the first degree. If the value of property, services, or funds obtained in violation of this section is one thousand dollars ($1,000) or more and is less than seven thousand five hundred dollars ($7,500), Medicaid fraud is a felony of the

fifth degree. If the value of the property, services, or funds obtained in violation of this section is seven thousand five hundred dollars ($7,500) or more and is less than one hundred fifty thousand dollars ($50,000), Medicaid fraud is a felony of the fourth degree. If the value of the property, services, or funds obtained in violation of this section is one hundred fifty thousand dollars ($150,000) or more, Medicaid fraud is a felony of the third degree.

THE FRAUD ENFORCEMENT AND RECOVERY ACT

The Fraud Enforcement and Recovery Act of 2009 (FERA) increases the government's power to investigate and prosecute any financial fraud against the government and expands liability under the FCA. FERA expanded potential liability under the FCA in several ways, most notably by:

- Expanding the definition of false/fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like AmeriHealth Caritas Ohio.
- Expanding the scope of liability for reverse false claims to include the knowing retention of overpayments.
- Expanding whistleblower ("qui tam relator") protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

PROGRAM INTEGRITY OPERATIONS TEAM

Program Integrity Operations is responsible for the identification, reporting, and collection of FWA recoveries. The team uses real-time data to identify overpayments, provide specific State or contractual reporting, and collect outstanding balances from providers. This team is made up of three subgroups: Claims Cost Management, Recoupment and Reporting, and Credit Balance.

The Internal **Claims Cost Management** team performs prospective (pre-payment) and retrospective (post-payment) analysis to validate the accuracy of claims payments.

- **Prospective analysis** - This analysis includes the development of front-end edits to identify inaccurate payments prior to payment of the claim. The team coordinates the correction of the claim payment with the AmeriHealth Caritas Ohio claims processing unit.
- **Retrospective analysis** - The team performs first-pass retrospective review of paid claims. Retrospective edits help us identify potential overpayments of professional, outpatient, and facility claims; after validation, we then submit these for recovery of the overpayment.

RECOUPMENT AND REPORTING

The Recoupment and Reporting team develops and distributes both internal, Plan and State reports related to FWA services. This team acts as the gatekeeper of all FWA inventory accountable for intake, management, and monitoring of overpayment recovery projects. This team uses a claim overpayment recovery system to track and report all related activity.

The **Credit Balance** team pursues outstanding provider credit balances that exist for more than 60 days. They perform provider outreach through outbound calls and letter mailings.

CLAIMS COST CONTAINMENT UNIT

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted by the Program Integrity department for potential recovery. Claims submitted to the Claims Cost Containment Unit for review are outside of the Subrogation and Check Reconciliation areas. Some examples of identified "waste" include:

- Incorrect billing from providers causing overpayment.
- Overpayment due to incorrect set-up or update of contract/fee schedules in the system.
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments.
- Overpayments resulting from incorrect revenue/ procedure codes, retro TPL/Eligibility.

The Claims Cost Containment Unit is also responsible for the manual review of provider-initiated overpayments. Providers who self-identify claim overpayments may submit their inquiries for review to the following address:

AmeriHealth Caritas Ohio
Attn: Claims Cost Containment
PO Box 7320
London, KY 40742

REFUNDS FOR CLAIMS OVERPAYMENTS OR ERRORS

AmeriHealth Caritas Ohio and ODM encourage providers to conduct regular self-audits to help ensure accurate payment. Medicaid Program funds that were improperly paid or overpaid **must be returned**. If the provider's practice determines that it has received overpayments or improper payments, the provider is required to make arrangements to return the funds to AmeriHealth Caritas Ohio or follow ODM protocols for returning improper payments or overpayments within 60 calendar days from the date the overpayment was identified. Overpayments not returned within 60 calendar days from the date the overpayment was identified may be a violation of state or federal law.

Contact AmeriHealth Caritas Ohio Provider Services at **1-833-644-6001** and follow the prompts to arrange the repayment.

There are two ways to return overpayments/improper payments to AmeriHealth Caritas Ohio:

1. Have AmeriHealth Caritas Ohio deduct the overpayment/improper payment amount from future claims payments; or,
2. Submit a check for the overpayment/improper amount directly to:
   AmeriHealth Caritas Ohio
   Attn: Claims Cost Containment
   PO Box 7104
   London, KY 40742

Note: Please include the member's name and ID, date of service, and Claim ID.

SECTION XI
NEXT GENERATION MANAGED CARE PROGRAM

XI. NEXT GENERATION MANAGED CARE PROGRAM

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 AmeriHealth Caritas Ohio or fee-for-service Medicaid. The OhioRISE plan, Aetna Better Health of Ohio, covers their behavioral health services. AmeriHealth Caritas Ohio is also 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 or 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 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/06-Community-and-Provider-Resources.
Aetna Better Health of Ohio can be reached by calling 1-833-711-0773 or emailing OHRISE-Network@aetna.com.

SINGLE PHARMACY BENEFIT MANAGER (SPBM)

The Single Pharmacy Benefit Manager (SPBM) is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that 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 utilizing a single set of clinical policies and prior authorization procedures, as well as a single pharmacy 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 AmeriHealth Caritas Ohio 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.

AmeriHealth Caritas®

Ohio

www.amerihealthcaritasoh.com