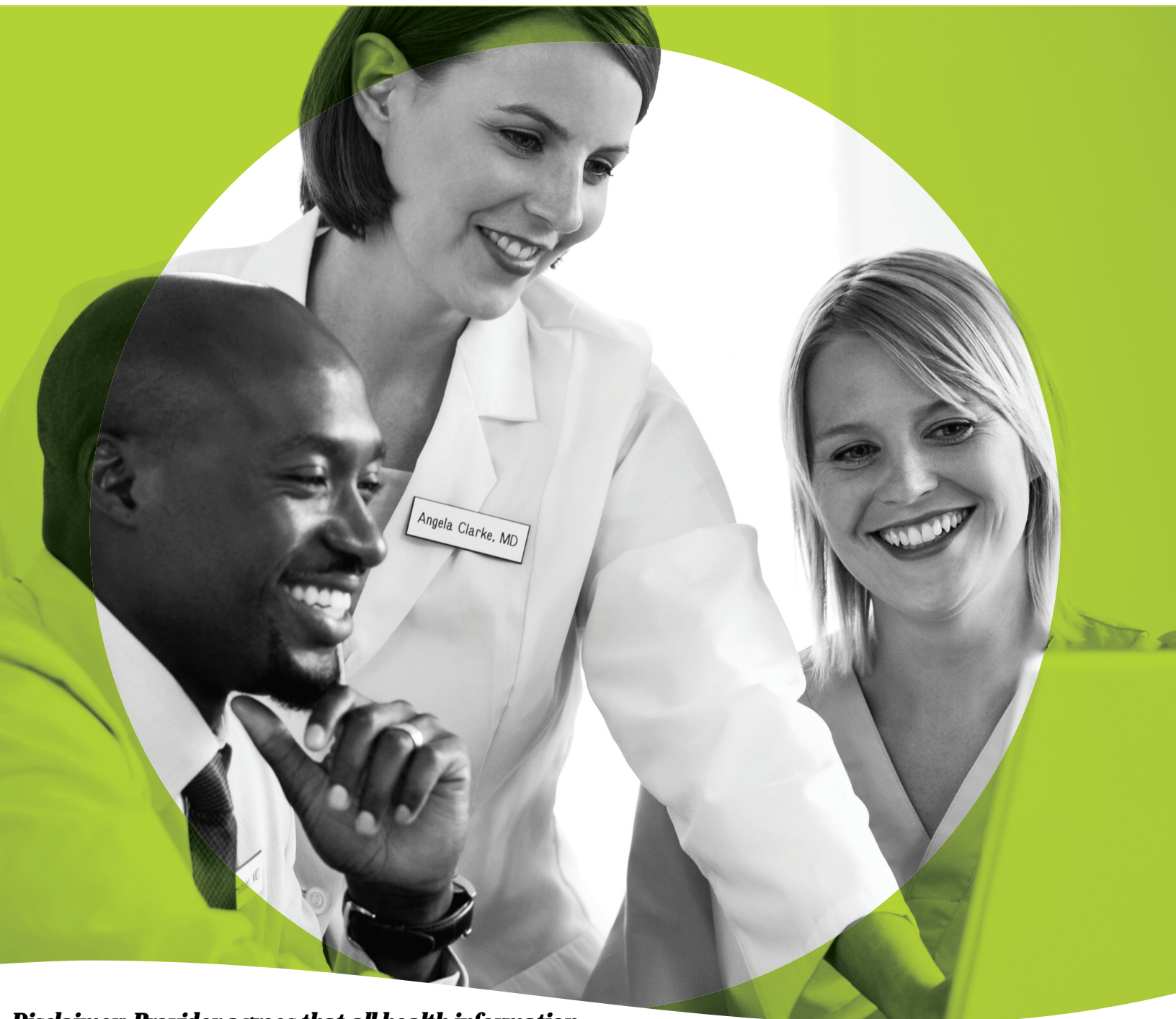


Buckeye Health Plan Provider Manual



Disclaimer: Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

BuckeyeHealthPlan.com

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Provider Manual

Buckeye Health Plan



Buckeye Health Plan

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

Goals of Buckeye

Buckeye has been designed to achieve the following goals:

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

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

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

Buckeye Mission Statement

Buckeye will be a recognized market leader in government supported physician-driven healthcare, creating an enhanced value through positive outcomes for our members and clients.

Buckeye Guiding Principles

- High quality, accessible, cost-effective healthcare for our members
- Integrity and the highest ethical standards
- Mutual respect and trust in our working relationships

- Communication that is open, consistent and two-way
- Diversity of people, cultures and ideas
- Innovation and encouragement to challenge the status quo
- Teamwork and meeting our commitments to one another

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

Buckeye Approach

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

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

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

Buckeye Summary

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

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

At Buckeye we take privacy and confidentiality of our member's health information seriously. We have processes, policies and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy law requirements. If you have any questions about Buckeye's privacy practices, please contact the Privacy Official at 1-866-246-4356.

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

You can reach Buckeye's Contracting Department at:

Phone: **1-866-246-4356 X 24291**

Fax: **1-866-719-5441**

Provider Manual

Guidelines For providers



Primary Care Provider (PCP)

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

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

Covered Physician Services

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

Covered services include:

- Professional medical services, both inpatient and outpatient, provided by the PCP, nurses, and other personnel employed by the PCP. These services include the administration of immunizations, but not the cost of biologicals.
- Periodic health assessments and routine physical examinations (performed at the discretion of the PCP, and consistent with nationally recognized standards recommended for the age and sex of the Enrollee).
- Vision and hearing screenings.
- All supplies and medications used or provided during a covered patient office visit. Injectable drugs costing over \$100 require a Prior Authorization, which can be obtained by calling 1-866-246-4359. Oncology drugs given in the office are excluded from Prior Authorization requirements.
- All tests routinely performed in the PCP’s office during an office visit.

- The collection of laboratory specimens.
- Voluntary family planning services such as examinations, counseling, and pregnancy testing.
- Well-child care and periodic health appraisal examinations, including all routine tests performed as customarily provided in a PCP's office.
- Referral to specialty care physicians and other health providers with coordination of care and follow-up after referral.
- PCP's supervision of home care regimens involving ancillary health professionals provided by licensed nursing agencies. Please note, these services are subject to prior authorization by Buckeye.
- Any other outpatient services and routine office supplies normally within the scope of the PCP's practice.

PCP Availability and Accessibility

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

PCP Coverage

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

Appointment Availability

The following standards are established regarding appointment availability:

- **A full-time practice** is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.
- **Routine appointments and physicals should be available within 28 days of request**
- **Primary care urgent appointments (non life threatening) should be available within 6 hours of request**
- **Urgent care** should be available within 24 hours.
- **Urgent Specialty care** within 24 hours of referral.
- **Referrals to Specialist should be made within 4 weeks of request**

- **Emergency care** should be received immediately and available 24 hours a day.
- **Persistent symptoms** must be treated no later than the end of the following working day after initial contact with the PCP.
- **Referrals** to a specialist should be scheduled within four (4) weeks of a request or shorter as medically indicated.
- **Non urgent care – sick calls should be available within 72 hours of request. Prenatal Care** patients should be seen within the following timeframes:
 1. Three (3) weeks of a positive pregnancy test (home or laboratory)
 2. Three (3) weeks of identification of high-risk
 3. Seven (7) days of request in first and second trimester
 4. Three (3) days of first request in third trimester
- **Behavioral healthcare** must be provided immediately for emergency services, within 24 hours of the request for urgent care, and within ten (10) days of the request for routine care.

Telephone Arrangements

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

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

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

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

Self Referrals

The following services do not require PCP authorization or referral:

- Emergency services including ambulance transportation
- OB/GYN Services
- Services provided by a Federally Qualified Health Center (FQHC)
- Services provided by a Rural Health Center (RHC)
- Services provided by a contracted Certified Nurse Midwife or Nurse Practitioner
- Mental Health Services provided by a Community Mental Health Center
- Chemical Dependency/Substance Abuse services provided by an Ohio Department of Alcohol and Drug Addiction Services (ODADAS) provider
- Family Planning Services and supplies from a qualified family planning provider
- Routine Dental Services from a contracted provider
- Non-surgical routine vision care from a contracted provider
- Routine Podiatry Services from a contracted provider
- Chiropractic Services from a contracted provider

Referrals

It is Buckeye's preference that the PCP coordinates healthcare services. However, members are allowed to self-refer for certain services (see above). Providers are encouraged to refer members when medically necessary care is needed beyond the scope of the PCP. Those referrals which require authorization by the plan are listed below under prior authorization. **A provider is also required to notify Buckeye when they are rendering prenatal care to a Buckeye member**, using the form online at:

<https://www.centenesecure.com/OHExante/nonSecureInfo/forms.isp>

To verify if an authorization is necessary or to obtain a prior authorization, call:

Medical Management Department
1-866-246-4359

No paperwork is required for a referral or prior-authorization. A Referral Specialist will issue the referral authorization number immediately

upon approval. Requests may be made by phone, fax or online at www.buckeyehealthplan.com.

Buckeye has the capability to perform the ANSI X 12N 278 referral certification and authorization transaction through Centene Corporation. For more information on conducting this transaction electronically contact:

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

Healthchek

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

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

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

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

Member Panel Capacity

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

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

Provider Termination

Providers should refer to their Buckeye contract for specific information about terminating from Buckeye.

Other PCP Responsibilities

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

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

Specialist Responsibilities

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

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

The specialist provider must:

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

Hospital Responsibilities

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

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

Advance Directives

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

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

Buckeye recommends to its providers that:

- The first point of contact in the PCP's office should ask if the member has executed an Advance Directive. The member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to bring a copy of the Directive to the PCP's office and document this request.

- An Advance Directive should be included as a part of the member's medical record.
- If an Advance Directive exists, the provider should discuss potential medical emergencies with the member and/or family member/significant other (if named in the Advance Directive and if available) and with the referring provider, if applicable. Discussion should be documented in the medical record.
- If an Advance Directive has not been executed, the first point of contact within the office should ask the member if they desire more information about Advance Directives. If the member requests further information, Member Advance Directive education/information should be provided.
- Member Services, Care Management and Member CONNECTIONS representatives will assist members with questions regarding Advance Directives. **However, no employee of Buckeye may serve as witness to an Advance Directive, or as a member's designated agent or representative.**

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

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

**Medical Management Department
1-866-246-4359**

Provider Assistance with Public Health Services

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

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in the notification or referral of any communicable disease outbreaks involving members to the local public health entity, as defined by state law.
- Referring to the local public health entity for tuberculosis contact investigation, evaluation and the preventive treatment of persons whom the member has come into contact.
- Referring to the local public health entity for STD/HIV contact investigation, evaluation and preventive treatment of persons whom the member has come into contact.
- Referring for Women, Infant and Children (WIC) services and information sharing as appropriate.

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

Additional Reporting Requirements

Buckeye in accordance with its contract with the ODJFS must report the existence of certain information regarding its membership. For example, if your patient is involved in an accident or becomes injured, this information should be shared with us. This includes any incidents that occur prior to your patient's coverage with Buckeye. To report this type of information, please call us at 1-866-246-4359. Please be prepared to supply as many details as possible including, the date and the cause of the accident, the injuries sustained by your patient and whether or not any legal proceedings have been initiated. In addition, you must immediately report the death of a Buckeye member.

Medical Records



Buckeye providers must keep accurate and complete medical records.

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

Required Information

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

- Patient's name, and/or ID number on all chart pages or electronic file.
- Personal/biographical data is present (i.e. age, sex, address, employer, home and work telephone number, spouse, etc.).
- All entries must be legible to someone other than the writer. In states that mandate medical record reviews, a second surveyor examines any record judged to be illegible by one physician surveyor. All entries in the medical record contain the author's identification, which may be a handwritten signature, unique electronic identifier or initials.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA or NKDA is documented.
- An immunization record is established for pediatric patients or an appropriate history is made in chart for adults (full Healthchek documentation for pediatric patients). .
- Evidence that preventive screening and services are offered in accordance with Buckeye's practice guidelines.
- Appropriate subjective and objective information pertinent to the patients presenting complaints is documented in the history and physical.
- Past medical history (for patients seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters. For children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses. For

patients 10 and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, there is evidence of substance abuse query). Working diagnosis is consistent with findings. Treatment plan is appropriate for diagnosis.

- Encounter forms or notes have a notation regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- There is review for under-or over-utilization of consultants.
- If consultation is requested, there is a note from the consultant in the record.
- Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere.
- Health teaching and/or counseling is documented.
- Evidence that an Advance Directive has been offered to adult patients.

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

Medical Records Release

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

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

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

Medical Records Transfer for New Patients

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

Medical Records Audits

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

Medical Management



Overview

The Buckeye Medical Management Department hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:00 p.m. For prior-authorizations during business hours, the provider should contact:

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

After-hours, holidays, and on weekends the provider can leave a message at the conclusion of the greeting or press Option 7 to be transferred to NurseWise.

Buckeye will verify demographic information each time a caller contacts Medical Management. We will verify the following: patient address; patient phone number; other health insurance (if the caller has other health insurance we will also request that); policyholder; ID number; name of insurance carrier; effective date.

A Referral Specialist will enter the demographic information and will then transfer the call to a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) for the completion of medical necessity screening. Information necessary for authorization may include but is not limited to:

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

If more information is required, the RN or LPN will notify the caller for the specific information needed to complete the authorization process.

Failure to obtain authorization may result in payment denials.

Prior- Authorization

Prior-authorization is required for certain services/procedures/diagnostic tests that are frequently over- or under-utilized, or that are costly services which indicate a need for case management. The provider must initiate prior-authorization of non-emergency services (i.e. elective/routine procedures) **at least five (5) working days prior to the requested date of service** by contacting the Buckeye Medical Management Department by phone at:

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

If a provider is unable to request prior authorization at least five (5) days in advance due to the nature of the member's condition, a prior-authorization request must be initiated as soon as possible prior to the service being rendered. Buckeye will make every effort to expedite the request. For services rendered on holidays or weekends, a prior authorization request must be initiated within two (2) business days after the service has been rendered.

For a list of services that require authorization by Buckeye, please see the Quick Reference Guide/Plan Authorization Requirements on the Buckeye website at www.buckeyehealthplan.com in the Resources/Forms section.

Please notify Buckeye Health Plan immediately upon determining a member's pregnancy using the Pregnancy Notification Form found online at: http://www.buckeyehealthplan.com/files/2009/09/6-BHP-OH_ProviderNOPRed-2015-8-27.pdf

Prior authorization requests for members under age 21 for screening, diagnostic and treatment services that go beyond the coverage and limitations are reviewed for medical necessity as defined in OAC 5101:3-1-01.

The prior authorization list is subject to periodic updates. Providers should call Buckeye Medical Management at 1-866-246-4359 if they are not clear whether a service requires prior authorization.

Referral Process

The primary care provider should coordinate healthcare services. PCPs are encouraged to refer members when medically necessary services are beyond their scope of practice. Services that require authorization by the Plan are listed under the Prior Authorization section above. Members are allowed to self-refer for certain specific services (family planning, dental, vision, etc.) A provider is also required to notify Buckeye's Care Management Department when rendering prenatal care to a Buckeye member using the Pregnancy Notification Form found online at http://www.buckeyehealthplan.com/files/2009/09/6-BHP-OH_ProviderNOPRed-2015-8-27.pdf

Buckeye encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate their member's care, and to make sure the specialist being referred to is participating with Buckeye.

Inpatient Notification Process

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

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

Admission Notification

When Buckeye receives notification for an inpatient admission past the contractual two (2) business days and the member is still in-house, Buckeye will accept the notification but the reviews will begin with the date on which Buckeye was notified. All prior days will be administratively denied due to untimely notification and will have to be appealed after the claim has been submitted. *(For example, Jane Doe was admitted on 4-1-06. Buckeye receives notification of this admission on 4-10-06 and Jane Doe is still in-house. Buckeye will begin reviews starting 4/10/06 the day we were informed. All prior days will be denied.) Providers must fax a copy of their*

facility's facesheet and discharge instructions once the member has been discharged from all inpatient stays at their facility.

Peer to Peer Review

In the event that a request for medical services is denied due to lack of medical necessity the provider can request a peer to peer review with a Buckeye Medical Director on the member's behalf. Providers will have two (2) business days from the date of the denial letter to initiate a peer to peer phone review by calling the Peer to Peer Coordinator at Buckeye at 1-866-246-4356 ext. 24084 who will attempt to connect the provider to the Buckeye Medical Director or their voicemail. Once the 2 business days to conduct a peer to peer option has expired providers can still submit a request for an appeal in writing via mail. It is not necessary to complete a peer to peer prior to submitting a paper appeal.

Delivery Information

When contacting Buckeye about deliveries, the following additional information is required:

- Location of baby i.e. well nursery or NICU
- Weight in grams
- EDC
- LMP
- Gestational age
- Apgar scores at 1 and 5 minutes
- If a C-section, is it initial or repeat AND reason

Concurrent Review

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

Hospital-To-Hospital Transfers

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

Discharge Planning

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

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

Observation Bed Guidelines

In the event that a member's clinical symptoms do not meet the criteria for an inpatient admission, but the treating physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period.

Observation Bed Services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nurse or other staff. These services are reasonable and necessary to:

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

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

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

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

Utilization Management Criteria

Buckeye has adopted utilization review criteria developed by McKesson InterQual Products. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physician members of the Quality Improvement Committee. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Criteria are used for the approval of medical necessity but not for the denial of services. The Medical Director reviews all medical necessity denials.

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

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

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

Affirmative Statement for Utilization Management (UM)

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

providers via the Provider Manual and annually thereafter to all network providers via our Provider Newsletter.

Second Opinion

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

Continuity of Care

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

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

Complex Care Management (CM) Services/Buckeye Care

Definition of Care Management Services:

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

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

Buckeye Care:

Buckeye Care is Buckeye's complex, high risk care management program that supports provider care treatment plans for our high risk care management members by having a high touch, face-to-face presence at the point of care. Beginning in 2016 the Ohio Department of Medicaid has notified the Managed Care Plans serving Ohio Medicaid recipients of the need to begin development of a model of care to transition to a Population Health based managed care program. At completion in 2018, all Medicaid recipients will be in a Care Management program tailored to their needs.

The initial phase scheduled for implementation beginning January 1, 2016 includes having 1% of our total membership in Intensive Care Management and begin the process of enrolling an additional 1% in High Risk Care Management. These two levels of Care Management will still provide high touch, face-to-face presence at the point of care. Buckeye care managers are visible in our provider offices, facilities and community agencies and accompany our high risk care management members on routine visits. Our Buckeye Care staff provides face-to-face education, advocacy and support to high risk care management members and their providers.

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

A key objective of Buckeye Care is early identification of those members who have the greatest need for care coordination and care management. This includes but is not limited to those who are classified as children or adults with special health care needs; have catastrophic, high-cost, and high-risk or co-morbid conditions; have been non-compliant in less intensive programs; or are frail and elderly, disabled, or at the end of life. Identifying members for Buckeye Care may be conducted through, but not limited to predictive modeling programs, claims or encounter data, hospital discharge data, pharmacy data, or data collected at any time through the UM process. Members may also be referred directly to the care management program through self or family, the disease management program, hospital discharge planner, Provider, hospital care management staff, Buckeye Member Connections/Community Health Worker staff, Buckeye concurrent review staff or other Buckeye staff. These multiple referral avenues can help to minimize the time between need and initiation of care management services. The Provider maintains an ongoing responsibility in identifying members who may meet Buckeye's care management criteria and refer

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

Health Risk Assessment and Care Treatment Plan

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

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

When the Provider, patient, patient's representative, and family agree, the care treatment plan is implemented. Checkpoints are put into place to evaluate and monitor the effectiveness of care coordination/care

management services and the quality of care provided, and to trigger timely revisions to the care treatment plan when necessary. Behavioral health care coordination is incorporated in the care treatment plan. The care manager also assists the member in transitioning to other care when benefits end.

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

Referring a Member to Buckeye Care:

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

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

Special Needs Care Management Programs

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

- Asthma
- Diabetes
- CHF
- CAD
- Non-mild hypertension
- COPD
- HIV/AIDS
- Severe mental illness
- Severe cognitive and or developmental limitation
- Transplants
- Teen pregnancy
- High risk or high cost substance abuse disorder
- Frequent admissions or preventable/avoidable/PCP treatable ED visits
- Start Smart for Your Baby Program
- Children with Special Health Care Needs

Asthma Program

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

Children with Special Healthcare Needs

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

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

Start Smart for Your Baby®

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

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

Identifying pregnant members as early as possible, providing them with adequate prenatal care and guidance as well as addressing complications

as effectively as possible should result in improved outcomes for both the mother and the newborn.

HIV/AIDS

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

To establish a process to enable Buckeye's members diagnosed with HIV+/AIDS to access medical services in a timely manner

To educate and monitor pregnant women to reduce perinatal transmission of HIV from mother to infant

To promote HIV prevention and early treatment of same by providing information to the Buckeye membership consistent with the member's age, sex, and risk factors as well as culturally and linguistically appropriate

To ensure that care plans are specifically developed for each member to ensure continuity of care among the various clinical and non-clinical disciplines and services

To assure the use of the most current diagnosis and treatment protocols and standards established by the DHSS and the medical community.

Teen Pregnancy

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

Referring a Member to Buckeye Care Management:

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

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

Disease Management

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

Disease Management Process

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

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

Members with a potential diagnosis applicable to the specific DM program will be identified through various sources, including, but not limited to: inpatient census reports, medical claims data (office, emergency room, outpatient, and inpatient levels of care), pharmaceutical claims data, HRA results, Laboratory reports, data from UM/CM process, new member welcome calls, member self-referral, and physician referral. Based on the data received during the identification phase, members will be stratified into risk groups that

will guide the care coordination interventions provided. Members will be stratified into either Low Risk, Moderate Risk, or High Risk categories. Definitions for each risk category are program specific and will be outlined in the program's description document. Members may change between risk groups based on data retrieved during each reporting period, as well as through collaboration/interaction with Care Manager, member, or PCP.

Members enrolled into a disease management program will receive some level of intervention from a multi-disciplinary team that includes specially trained nurses, dieticians, respiratory therapists, and certified diabetic educators. The interventions may include, but is not limited to: identification, assessment, disease specific education, reminders about preventive/monitoring services, assistance with making needed appointments and transportation arrangements, referral to specialists as needed, authorization for services and/or medical equipment, coordination of benefits, and coordination with community-based resources. Education is a crucial component of the disease management program. Education will be presented to members and their treating physician and may be provided through mailings, telephone calls, or home visits.

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

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

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

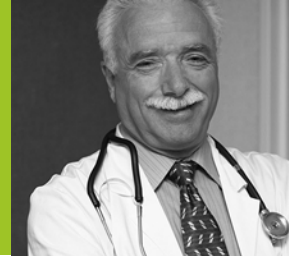
New Technology

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

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

Provider Manual

Routine, Urgent & Emergency Services



Routine, Urgent and Emergency Care Services Defined

Members are encouraged to contact their PCP prior to seeking urgent or emergent care, except in an emergency.

The following are definitions for **routine**, **urgent**, and **emergency care**.

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

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

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

1. 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;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

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

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

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



Eligibility for the Buckeye Program

The local office of the Ohio's Department of Job and Family Services (ODJFS) is responsible for determining eligibility of persons applying for the Buckeye Program. Persons interested in applying for the Buckeye Program should be referred to the local county office of the ODJFS in the county in which the individual lives.

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

Verifying Enrollment

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

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

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

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

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



US Script
BIN#008019
Pharmacies call: 1-800-460-8988

Name: Effective Date:
MMIS#: DOB:
PCP Name: PCP Phone #:

If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Buckeye for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Buckeye NurseWise toll-free at 1-866-246-4358 and follow the prompt for 'Nurse' or TTY at 1-800-750-0750. NurseWise is open 24 hours per day.

MEMBER SERVICES: 1-866-246-4358 (TTY 1-800-750-0750)

PROVIDERS: THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR AUTHORIZATION.

FOR ELIGIBILITY, CALL BUCKEYE AT 1-866-296-8731. FOR PRIOR AUTHORIZATION AND CARE MANAGEMENT REFERRAL, CALL 1-866-246-4359.

NON-PARTICIPATING PROVIDERS MUST HAVE ALL SERVICES PRIOR AUTHORIZED THROUGH BUCKEYE, EXCEPT FOR EMERGENCY SERVICES OR SERVICES THAT ARE SELF-REFERRED. PLEASE CALL BUCKEYE AT 1-866-246-4359 FOR MORE INFORMATION ON SERVICES THAT ARE SELF-REFERRED.

FOR PHARMACY PRIOR AUTHORIZATION, CALL 1-866-399-0928. FOR TRANSPORTATION AND PHARMACY CLAIMS, REFER TO THE BUCKEYE PROVIDER MANUAL.

CLAIMS SUBMISSIONS: BUCKEYE HEALTH PLAN
PO BOX 6200
FARMINGTON, MO 63640

Newborn Enrollment

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

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

Member Services
1-866-246-4358

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

Eligibility for newborns whose mothers are Buckeye members on the date of delivery are effective on the date of birth.

Frequently, Buckeye receives a claim(s) for a newborn prior to the state sending the members' eligibility information. Buckeye is committed to researching the newborn claims that are received to ensure that a claim is NOT denied for eligibility when the newborn is a Buckeye member.

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

1. When the claims department receives a claim, the members' eligibility is verified. If no member eligibility is found, the claim is pended for 120 days. The claims department will verify eligibility each day until the member information is received from the state.
2. If after 120 days there is still no record of the member information, then the claims department will notify the Eligibility Specialist.
3. The Eligibility Specialist will contact the state to obtain the information on the member.

4. At that time one of the following actions will be taken:
- If the member is eligible with Buckeye, then the Eligibility Specialist will enter the member information manually and instruct the claims department to process the claim.
 - If the member is NOT eligible with Buckeye then the Eligibility Specialist will instruct the claims department to return the claim with a notice of member ineligibility.

Enrollment Guidelines for Buckeye Providers

Buckeye providers must adhere to enrollment/marketing guidelines as outlined by the ODJFS. Those guidelines include the following:

Providers cannot:

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

Providers may:

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

Provider Manual

Non-compliant Patients



Non-compliant Patients

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

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

Upon receipt of such request, staff may:

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

An example of a reason that a PCP may request to remove a patient from their panel could include, but not be limited to:

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

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

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

Benefits Available to Buckeye Members



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

- Ambulance and ambulette transportation
- Certified nurse midwife services
- Certified nurse practitioner services
- Chiropractic (back) services
- Dental services
- Developmental therapy services for children aged birth to six years
- Diagnostic services (x-ray, lab)
- Durable medical equipment
- Emergency services
- Family planning services and supplies
- Federally Qualified Health Center or Rural Health Clinic services
- Home health services
- Hospice care (care for terminally ill, e.g., cancer patients)
- Inpatient hospital services
- Medical supplies
- Mental health and substance abuse services
- Nursing facility services for a short term rehabilitative stay
- Obstetrical (maternity care - prenatal and postpartum including at risk pregnancy services) and gynecological services
- Outpatient hospital services
- Physical and occupational therapy
- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source
- Podiatry (foot) services
- Prescription drugs, including certain prescribed over-the-counter drugs
- Preventive mammogram (breast) and cervical cancer (pap smear) exams
- Primary care provider services
- Renal dialysis (kidney disease)
- Services for children with medical handicaps (Title V)
- Shots (immunizations)
- Specialist services

- Speech and hearing services, including hearing aids
- Vision (optical) services, including eyeglasses
- Well-child (Healthchek) exams for children under the age of 21
- Yearly well adult exams

If you have any questions about these services, contact:

Provider Services
1-866-296-8731

Note: For a listing of behavioral health services, see Section entitled “Behavioral Health Services”.

Dental Services

Dental benefits are provided through Dental Health and Wellness who maintains a quality network of licensed providers. In addition, they also process claims for dental services. To access Dental Health and Wellness for provider inquiries, please call 1-844-464-5634 or visit their website at www.dentalhw.com

Vision Services

Vision services are provided through OptiCare Managed Vision who maintains a quality network of licensed providers. In addition, they also process claims for vision services. To access OptiCare Managed Vision, please call 1-800-531-2818 or visit their website at www.opticare.com

Pharmacy Services

Buckeye Health Plan Pharmacy Program Buckeye Health Plan, Inc. (Buckeye) is committed to providing appropriate, high quality, and cost effective drug therapy to all Buckeye members. Buckeye works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. Buckeye covers prescription medications and certain OTC medications when ordered by a physician/clinician. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, and maximum quantities. This section provides an overview of the Buckeye pharmacy program. For more detailed information, please visit our website at www.buckeyehealthplan.com. The following program covers both the Covered Families & Children (CFC) and Aged, Blind or Disabled (ABD) Ohio Medicaid consumers who are

Plan Preferred Drug List and Prior Authorization List

The Buckeye Preferred Drug List (PDL) describes the circumstances under which contracted pharmacy providers will be reimbursed for medications

dispensed to members covered under the program. All drugs covered under the Ohio Medicaid program are available for Buckeye members. The PDL includes all drugs available without PA and those agents that have the restrictions of Step Therapy (ST). The PA list includes those drugs that require prior authorization for coverage. The PDL applies to drugs you receive at retail pharmacies. The PDL is continually evaluated by the Buckeye Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medications. The Committee is composed of the Buckeye Medical Director, Buckeye Pharmacy Director, and several Ohio primary care physicians, pharmacists, and specialists.

The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the physician/clinician or pharmacist, or
- Relieve the physician/clinician or pharmacist of any obligation to the patient or others

US Script

With the exceptions of biopharmaceuticals and specialty drugs, Buckeye works with US Script to process all pharmacy claims for prescribed drugs. Some drugs on the Buckeye PDL and PA list require a PA and US Script is responsible for administering this process. US Script is our Pharmacy Benefit Manager.

Follow these guidelines for efficient processing of prior authorization requests:

1. Complete the Buckeye Health Plan/US Script form: Medication Prior Authorization Request Form.
2. Fax to US Script at 1-866-399-0929.
3. Once approved, US Script notifies the prescriber by fax.
4. If the clinical information provided does not explain the medical necessity for the requested PA medication, US Script will deny the request and offer PDL alternatives to the prescriber by fax.
5. For urgent or after-hours requests, a pharmacy can provide up to a 72-hour emergency supply of medication by calling 1-800-460-8988.

Prior Authorization Process

The Buckeye PDL includes a broad spectrum of brand name and generic drugs. Clinicians are encouraged to prescribe from the Buckeye PDL for their patients who are members of Buckeye. Some drugs will require PA and are listed on the PA list. In addition, all name brand drugs not listed on either the PDL or PA list will require prior authorization. If a request for prior authorization is needed the information should be submitted by the physician/clinician to US Script on the Buckeye Health Plan/US Script form: Medication Prior Authorization Request Form. This form should be faxed to

US Script at 1-866-399-0929. This document is located on the Buckeye website at www.buckeyehealthplan.com.

Buckeye will cover the medication if it is determined that:

1. There is a medical reason the member needs the specific medication.
2. Depending on the medication, other medications on the PDL have not worked.

All reviews are performed by a licensed clinical pharmacist using the criteria established by the Buckeye P&T Committee. Once approved, US Script notifies the physician/clinician by fax. If the clinical information provided does not meet the coverage criteria for the requested medication Buckeye we will notify you and your physician/clinician of alternatives and provide information regarding the appeal process.

The P&T committee has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring prior authorization. This PDL attempts to provide appropriate and cost-effective drug therapy to all members covered under the Buckeye pharmacy program. If a patient requires a brand name medication that does not appear on the PDL, the physician/clinician can make a PA request for the brand name medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions.

A phone or fax-in process is available for PA requests.

US Script Contact Information:

Prior Authorization Fax 1-866-399-0929

Prior Authorization Phone 1-866-399-0928

Mailing Address: 2425 W Shaw Ave, Fresno, CA 93711

When calling, please have patient information, including Medicaid number, complete diagnosis, medication history and current medications readily available. US Script will provide a decision to the request by fax or phone within 24 hours. When incomplete information is received to support medical necessity of a drug requiring PA, the request will be denied. If the request is approved, information in the on-line pharmacy claims processing system will be changed to allow the specific member to receive this specific drug. If the request is denied, information about the denial will be provided to the clinician.

Clinicians are requested to utilize the PDL when prescribing medication for those patients covered by the Buckeye pharmacy program. If a pharmacist receives a prescription for a drug that requires a PA, the pharmacist should attempt to contact the clinician to request a change to a product included in the PDL.

Benefit Exclusions

The following drug categories are not part of the Buckeye PDL and are not covered by the 72-hour emergency supply policy:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Immunizations and vaccines (except flu vaccine)
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that
 - are classified as ineffective
 - Infusion therapy and supplies
 - Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence

DESI drugs products and known related drug products are defined as less than effective by the FDA because there is a lack of substantial evidence of effectiveness for all labeling indications and because a compelling justification for their medical need has not been established. State programs may allow coverage of certain DESI drugs. Any DESI drugs that are covered are listed in the PDL.

Enhanced Benefits for Buckeye Members

- Care Management Services
- MemberConnections™ Program
- Asthma Program
- Teen Pregnancy/High Risk Management Program
- Non-Emergency Transportation (30-round trips per calendar year)
- Annual adult vision

Provider Manual

Healthchek/EPSDT



Ohio's Healthchek/EPSDT Program

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

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

The frequencies of these visits are as follows:

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

Preventive health is a major principal on which managed care organizations are based, *measured and held accountable*. It is the responsibility of Buckeye to encourage eligible covered Medicaid recipients to participate in the State of Ohio's preventive care program, Healthchek. Buckeye will send reminders of the need for a Healthchek examination to all Healthchek eligible members. For the first birthday, a HealthChek reminder postcard will be sent advising of the two suggested exams before the child turns three. For ages 2 through 20, reminders will be sent annually based on the month of the birth.

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

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

Newborn Testing

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

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

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

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

Immunizations

Children must be immunized during medical checkups according to the EPSDT Routine Immunization Schedule by age and immunizing agent.

Buckeye requires all members under the age of 18 to be immunized by their PCP unless medically contraindicated or against parental religious beliefs.

Vaccines for Children (VFC)

The Vaccines for Children (VFC) program is a federally-funded program. It supplies vaccines at no cost to public and private healthcare providers who enroll and agree to immunize eligible children in their medical practice or clinic. Buckeye PCPs are able to receive vaccines for immunizations free of charge through the Ohio Department of Health (ODH). You must be enrolled in the Ohio VFC Program and have a provider identification number (PIN) to order vaccines. If you are not enrolled, contact the Ohio Department of Health at 1-800-282-0546 or 614-466-4643 for more information and to enroll. Buckeye will reimburse for the vaccines in

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

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

Blood Lead Screening

Physicians are required to perform a blood lead screening test on all 12 and 24 month old Medicaid eligible children, (regardless of zip code or exposure to lead) as stated in the Ohio Administrative Code, rule 5101:3-14-03(H).

Domestic Violence

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

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

State law requires reporting by any person if he or she has “reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse”. Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report any suspected child abuse or neglect immediately to Children’s Services in the county in which the child lives or was abused. The Ohio Department of Job and Family Services has launched 855-O-H-CHILD (855-642-4453), an automated telephone directory that will link callers directly to a child welfare or law enforcement office in their county.



Behavioral Health Services

Buckeye offers our members access to all medically-necessary behavioral health services covered by the Ohio Medicaid FFS program.

Buckeye members may self-refer to outpatient services offered through Community Mental Health Centers (CMHCs) as well as substance abuse services offered through Ohio Department of Alcohol and Drug Addiction Services (ODADAS) – certified Medicaid providers. In the event that a CMHC or ODADAS physician or practitioner is unable to provide timely access for a member, Buckeye will assist in securing authorization to a physician or practitioner to meet the member's needs in a timely manner.

If you have additional questions regarding Buckeye's coverage of behavioral health services, please contact our Provider Services Department at 1-866-296-8731.

Provider Manual

General Billing Information And Guidelines



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

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

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

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

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

Claims eligible for payment must meet the following requirements:

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

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

Clean Claim Definition

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

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. These errors or omissions result in Buckeye requesting additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or access to other information necessary to resolve discrepancies. In addition, claims with issues relating to payment including but not limited to, issues regarding medical necessity or claims not submitted within the identified filing limits are also defined as non-clean.

Claims Submissions

Claim Submission Time Frame

Claims must be submitted within 365 days of the date of service or hospital discharge.

Billing Methods

Buckeye accepts claims in a variety of formats, including electronic and paper claims.

Electronic Claims Submission

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

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

- Faster claims processing

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

File Format:

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

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

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

EDI Vendors

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

NPI and Tax ID

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

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

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

Paper Claim Submission:

Billing Forms:

- Paper claims must be submitted on the following forms:
- CMS 1500 – formerly HCFA 1500 form
- CMS 1450 (UB-04) - formerly UB 92 form for facilities

Required Information:

- Patient (Member) Name
- Patient Address
- Member ID which is the member's Medicaid ID number
- Patient date of birth
- Place of service
- ICD 10 Diagnosis code(s)
- CPT code and modifiers as applicable
- Units as applicable
- Date of Service
- NPI
- Tax ID Number
- For prenatal services – date of last menstrual period
- NDC code when submitting J code for drugs administered

Claims that must be submitted on paper:

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

Abortion, Sterilization, and Hysterectomy Billing

The use of federal funds to pay for abortion, sterilization, and hysterectomies is prohibited unless the specific criteria found in 42 CFR 441 and Ohio Administrative Code rules 5101:3-17-01 and 5101:3-21-01 are met. Additionally, payment must not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion, sterilization, or hysterectomy does not qualify for payment.

Providers must contact Buckeye Medical Management at 866-246-4359 PRIOR to services being rendered for all abortions, sterilizations and hysterectomies. Buckeye will provide the authorization number to the caller and the authorization will be pended in the system if the consent form is not complete at the time of the call. Med Mgmt – this process will need to be updated with current procedure.

Consent forms can be found online at:

<http://www.buckeyehealthplan.com/files/2009/09/consent-for-sterilization-english-updated.pdf>

Helpful Hints for the Abortion Certification Form JFS 01391:

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

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

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

Helpful hints for the Acknowledgement of Hysterectomy Form JFS 3199:

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

- Out of the next three sections (section II, III, or IV), ONLY one section must be completed.

Common Billing Errors

In order to avoid rejected claims or encounters always remember to:

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

Billing Codes

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

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

Code Auditing

Buckeye uses HIPPA compliant code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting. The code auditing software will detect, correct, and document coding errors on provider claims prior to payment. Our software will analyze HCPCS Level 1/CPT-4 codes (5-digit numeric coding system which applies to medical services delivered); HCPCS Level II codes (alpha-numeric codes which apply to ambulance services, medical equipment, supplies and

prosthetics); CPT Category II (“F” codes used for tracking purposes) and CPT Category III (“T” codes or temporary codes used for new and emerging technologies) and healthcare industry standard modifiers against correct coding guidelines. These guidelines have been established by the American Medical Association (CPT, CPT Assistant, and CPT Insider View) and the Centers for Medicare and Medicaid Services (CMS).

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

Claims Mailing Information

For Buckeye members, all claims and encounters, with the exception of those services listed as “carve outs”, like routine dental services, routine vision services, outpatient mental health services, outpatient chemical dependency and outpatient substance abuse services, should be submitted to:

**Buckeye Health Plan, P.O. BOX 6200, Farmington, MO 63640-3805
ATTN: CLAIMS DEPARTMENT**

Buckeye dental claims should be submitted to:

Dental Health & Wellness, At tn: Claims P O Box 1242 Milwaukee, WI 53201

Buckeye vision claims should be submitted to:

OptiCare Managed Vision, ATTN: Claims, PO Box 7548, Rocky Mount, NC 27804

Cenpatco Behavioral Health Ohio claims should be submitted to:

Cenpatco-Ohio Claims, PO Box 6150, Farmington, MO 63640-3806

Unsatisfactory Claim Payment

If a provider has a question or is not satisfied with the information they have received related to a claim, they should contact:

Buckeye Provider Services 1-866-296-8731

- When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as “Re-submission” and include the claim number. Failure to mark the claim as a resubmission and include the claim number or EOP may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline.
- Providers may discuss questions with Buckeye Provider Services Representatives regarding amount reimbursed or denial of a particular service. Providers may also submit in writing, with all necessary documentation, including the Explanation of Payment (EOP) for consideration of additional reimbursement.
- Any response to approved adjustments will be provided by way of check with accompanying explanation of payment.

All disputed claims will be processed in compliance with the claims payment resolution procedure as described in Section XII of this manual.

For an explanation regarding how to file a complaint or make an appeal, refer to Grievances & Appeals section of this manual.

Billing the Patient

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

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

Provider Complaints And Appeals



Inquiry, Dispute and Appeal of Claim Payment

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

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

Buckeye offers providers three mechanisms to request payment evaluation and/or determination

1. **Informal claim payment dispute resolution**

A request for a change that is the result of an error in processing. For example typographical errors, contractual payment errors, or supported timely filing reconsiderations.

2. **Administrative claim appeal**

A request for reconsideration or exception to a plan policy or contract requirement such as benefit limitations, eligibility, failure to obtain authorization or appeals related to our code auditing process or unsupported timely filing.

3. **Medical necessity appeal**

A request for a review of an adverse decision made by the plan Medical Management Department.

Informal Claim Payment Dispute Resolution

If a provider believes that an improper payment of a claim for covered Medicaid services has occurred through either the omission of information, submittal of incorrect claims data, and/or systems error, an adjustment may be requested by submitting a copy of the Explanation of Payment (EOP) along with a completed adjustment form that can be found on the Buckeye web site. Adjustments should be submitted within **180 days** from the date of the EOP to the following address:

Buckeye Health Plan

P.O. Box 3000

Farmington, MO 63640-3800

Please **do not** send a copy of the disputed claim

Administrative Claim Appeal

A provider may request that a specific issue be re-evaluated by Buckeye. An administrative claim appeal should be submitted in writing, within **180 days** of the adverse finding and clearly marked “APPEAL” on the letter. Included in the letter should be why the claim or issue merits reconsideration, a copy of the EOP and if applicable, the provider should also include medical records, chart notes and/or other pertinent information to support the request for reconsideration. Please do not send a copy of the disputed claim. Administrative claim appeals should be submitted to:

**Buckeye Health Plan
Appeals Department
P.O. Box 3000
Farmington, MO 63640-3800**

An acknowledgement letter will be sent within five business days of receipt of the appeal. If the final determination is upheld, the provider will be notified within 30 days of receipt of the appeal. If the final determination is overturned, the provider will be notified via EOP.

Medical Management Appeals

Providers may file an appeal when a decision is made by Medical Management to deny a service, in whole or in part (including type or level), or to reduce, suspend, or terminate a service previously authorized for a member. If a provider wishes to speak with the physician reviewer, he or she may elect the Peer to Peer process referenced on page 23.

Medical Management Appeal Definitions for Appeals and Denials

Standard Appeal

Providers will receive an acknowledgement letter regarding all appeals with no extenuating circumstances (i.e., does not require an expedited resolution and no resolution extension has been requested).within 3 business days. The timeframe to resolve these appeals is 15 calendar days.

Standard Extended Appeal

The member requested, or Buckeye received prior approval from the Bureau of Managed Health Care (BMHC), that it was in the member's best interest to extend the standard resolution timeframe of 15 calendar days by up to an additional 14 calendar days.

Expedited Appeal

The member or provider has indicated and/or Buckeye has determined that taking the time for a standard appeal resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The timeframe to resolve an expedited appeal is three (3) working days.

Extended Expedited Appeal

The member requested, or Buckeye received prior approval from the BMHC, that it was in the member's best interest to extend the expedited appeal resolution timeframe of three (3) working days by up to an additional 14 calendar days.

If you feel that prompt resolution of an appeal is required because the time for a standard appeal resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, you may request an expedited appeal. Expedited appeals need not be submitted in writing. In the case of an expedited appeal, a decision will be made as expeditiously as the member's health condition requires, but no later than three (3) working days following receipt by Buckeye.

In cases where a member makes a request or Buckeye receives approval from the BMHC that it is in the member's best interest, the above timeframes may be extended by up to an additional 14 calendar days.

Providers wishing to appeal a Medical Management decision **on the member's behalf** should submit the request in writing, within **180 days** from the date of the Notice of Action. A provider must have the member's written consent to file an appeal as well as any necessary supporting clinical documentation. Buckeye will accept a copy of the consent signed by the member at the time of treatment to satisfy this requirement. These types of appeals should be sent to:

**Buckeye Health Plan
Attn: Appeals and Grievance Department
4349 Easton Way Suite 400
Columbus, OH 43219**

Medical Management Adverse Determinations

Buckeye will provide availability of an appropriate practitioner reviewer to discuss any UM adverse determination. Upon any adverse determination made by the Buckeye Medical Director or other appropriately licensed health care professional, a written notification, at a minimum, will be

communicated to the member and requesting provider. The notification will include the specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision.

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

Resubmitting Claims

Electronic Submission:

Resubmitted or corrected claims may be submitted electronically using the appropriate bill type in the designated field.

Paper Claims:

Paper requests for corrected or resubmitted claims should be forwarded to:

**Buckeye Health Plan
P.O. Box 6200
Farmington, MO 63640-3805**

Providers resubmitting claims must attach a statement along with documentation, including the EOP explaining the reason for resubmission.

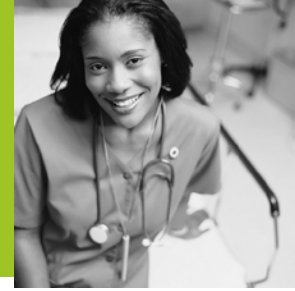
Reasons for resubmission include but are not limited to:

- Provider has corrected the claim (i.e. submitted wrong diagnosis, etc.)
- Denial for other insurance
- Problem with electronic filing, now sending paper claim
- No payment received

Claim Payment Audits

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

Credentialing



Credentialing Requirements

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

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

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

- Complete, signed and dated Council for Affordable Quality Healthcare (CAQH) credentialing form as mandated by the state House Bill 125
- Current Drug Enforcement Agency (DEA) Certificate and/or Controlled Dangerous Substance (CDS) certificate, if applicable
- Current professional liability insurance policy face sheet that includes expiration dates, amounts of coverage and practitioner's name
- Attestation of history of loss of license and/or felony convictions; history of loss or limitation of privileges or disciplinary actions; lack of present/current illegal drug use; reasons for inability to perform the essential functions of the position, with or without accommodation; current malpractice insurance coverage and to the correctness and completeness of the application
- Copy of current certificates for conducting laboratory services (CLIA), if applicable
- Standard Care Arrangement, if applicable

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

Once the application is completed and processed according to Buckeye Credentialing Policies and Procedures, the Buckeye Credentialing Sub-Committee will render a final decision following its next regularly scheduled

meeting. Practitioners will be notified of the credentialing decision within sixty (60) days of the committee's decision.

A Primary Care Provider (PCP) cannot accept member assignments until they are fully credentialed.

Specialists must be credentialed prior to becoming a participating network provider.

Credentialing Sub-Committee

The Credentialing Sub-Committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination and direction of the credentialing procedures.

Committee meetings are held monthly and more often as deemed necessary.

Criteria for Provider Participation

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

The minimum criteria include:

- An active, valid license in the state where the practice is located.
- An individual ODJFS provider number or state Provider Reporting Number.
- Current admitting privileges in good standing at an in-network in-patient facility or written documentation from the practitioner attesting that another physician, group of physicians, or hospitalists with a similar or like specialty will assume the inpatient care of all of the practitioner's Plan members who require admission and that they will do so at a participating facility.
- A current valid DEA Certificate and/or CDS Certificate, if applicable.
- Satisfactory review of a five year work history via the Practitioner Application or curriculum vitae with no unexplained gaps of employment over six (6) months.
- Current professional liability insurance with minimum limits of \$1,000,000 per occurrence/\$1,000,000 per aggregate. Minimum limits for dental providers must be at least \$200,000 per occurrence /\$600,000 per aggregate. If the practitioner is practicing outside the state of Ohio, Buckeye accepts professional liability coverage minimums required by the state in which they practice, if applicable.
- Proof of formal education and professional training, including board certification status if applicable, in the specialty they wish to practice.

- ECFMG (Educational Commission for Foreign Medical Graduates) certification or equivalent, if practitioner is a foreign medical graduate.
- History of professional liability claims/actions (pending, settled, arbitrated, mediated, litigated, etc.) within the last 10 years. When reviewing this history, the Credentialing Sub-Committee will consider the frequency of the cases(s) and their outcome.
- History of Medicare/Medicaid sanctions showing practitioner is currently in good standing and must not appear on the Medicare Opt Out Provider List, if applicable.
- An agreement to abide by the applicable Participation Provider Services Agreement.

Applicants applying for participation must include a signed application and in doing so:

- Signifies his/her willingness to appear for interviews with regard to his/her application.
- Authorizes Buckeye representatives to consult with others who have been associated with him/her and/or who have information bearing on his/her competence and qualifications.
- Releases from any liability all Buckeye representatives for their acts performed in good faith and without malice in connections with evaluation of his/her credentials.
- Releases from any liability all individuals and organizations who provide, including otherwise privileged or confidential information, to Buckeye representatives in good faith and without malice about mental health, emotional stability, and other qualifications for purposes of evaluation and participation in plan.

The credentialing process will be completed within 90 days from receipt of a complete application and the provider's national provider number issued by the Centers for Medicare and Medicaid Services.

FAILURE OF AN APPLICANT TO RESPOND TIMELY AND ADEQUATELY TO A REQUEST FOR CREDENTIALING INFORMATION MAY RESULT IN TERMINATION OF THE APPLICATION PROCESS AND A WAITING PERIOD TO REAPPLY.

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

Recredentialing

To comply with NCQA Standards, Buckeye conducts the recredentialing process for providers at least every thirty-six (36) months from the date of

the previous credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence or health status, which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners (primary care providers and specialists) and health delivery organizations previously credentialed to participate within the Buckeye network.

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

Mid-Level Practitioner Credentialing

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

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

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

Credentialing and Recredentialing of Health Delivery Organizations

Prior to contracting with the external Health Delivery Organizations (HDOs) noted below, Buckeye must receive a complete and signed Ohio Department of Insurance Standardized Credentialing Form Part B (INS5036) in order to initiate the credentialing process. As part of the credentialing process, Buckeye verifies organizations have been approved by a recognized accrediting body or meet Buckeye's standards for non-accredited organizations, are in good standing with state and federal regulatory bodies, and have current professional liability insurance with minimum limits of \$1,000,000 per occurrence/\$1,000,000 per aggregate or in accordance with state minimum requirements if located outside of Ohio, as applicable:

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

Buckeye recognizes the following accrediting bodies:*

- AAAASF - American Association for Accreditation of Ambulatory Surgery Facilities.
- AAAHC - Accreditation Association for Ambulatory Healthcare.
- ABCPO - American Board for Certification of Prosthetics and Orthotics.
- ACR - American College of Radiology.
- ACHC - Accreditation Commission for Health Care
- AOA - American Osteopathic Association.
- CAP - College of American Pathologists.
- CARF - Commission on Accreditation of Rehabilitation Facilities.
- CHAP - Community Health Accreditation Program.
- CCAC - Continuing Care Accreditation Commission
- CLIA - Clinical Laboratory Improvement Amendment certification. Please note:
Certification required, not just CLIA license.
- COLA - Commission on Office Laboratory Accreditation.
- DNV- Det Nortske Veritas Healthcare
- JCAHO - Joint Commission on Accreditation of Healthcare Organizations.
- NCQA - National Committee for Quality Assurance

* this list may not be inclusive of all accrediting organizations

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

augment the information required to assess compliance with Buckeye standards.

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

Right to Review and Correct information

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

All practitioners participating with Buckeye have the right to review information obtained by the Plan to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB), malpractice insurance carriers and the State Medical Board/Licensing Agency. This does not allow a practitioner to review references, personal recommendations or other information that is peer review protected.

Should a practitioner believe any of the information used in the credentialing/recredentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, he/she has the right to correct the erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the practitioner will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to Buckeye. Buckeye's Credentialing Sub-Committee will then include this information as part of the credentialing/recredentialing process.

Provider Manual

Quality Improvement Program



The Buckeye Quality Improvement program

The scope of Buckeye's Quality Improvement Program (QIP) is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. The scope of the QIP ensures that all demographic groups, care settings, and services are included in QI activities. The QIP is concerned with continual improvement in clinical care performance, including acute and chronic disease states, high-risk conditions, high volume care, inpatient care, ambulatory care and preventive healthcare. The various departments work together to identify enrollees/members with special health care needs, to identify, develop and implement appropriate health care services. Healthcare Effectiveness Data and Information Set (HEDIS®) measures are key monitors when considering future clinical studies and strategies. Also, referenced are sources such as, but not limited to:

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

Activities to Fulfill the Scope

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

Program Content/ Implementation

The goal of Buckeye's quality improvement program is to conduct meaningful quality improvement activities across all care settings aimed at

improving member health status/outcomes, quality of care, services delivered, and overall customer satisfaction.

Quality Improvement

Buckeye's quality improvement efforts assess and improve the level of performance of key processes and outcomes within the organization. Opportunities to improve care and service are found primarily by examining the systems by which care, services are provided, and developing procedures and implementing corrective action plans to improve overall service and outcomes within the organization. QI activities are coordinated with other performance monitoring activities and management functions including, but not limited to utilization/medical management, credentialing/recredentialing, EPSDT/HEALTHCHEK, patient safety, compliance, claims, member and provider services, network development, behavioral health and disease management. In addition, collaborative health performance improvement measures are developed by the Ohio Department for Jobs and Family Services.

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

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

QI Process

Buckeye's Quality Improvement Committee (QIC) reviews and approves the annual QI Program, QI Evaluation and Work Plan. Buckeye utilizes traditional quality/risk/medical management approaches for identifying opportunities for improvement. Initiatives are selected based on information indicating the need for improvement in a particular clinical or non-clinical area having the greatest potential for improving health outcomes and reflecting the cultural and/or special needs of Buckeye's membership. Other initiatives can be selected to test an innovative strategy. Once QI topics are selected, the QI Department, in conjunction with specific functional areas as appropriate, will present the proposed QI initiative to the QIC for approval. The QIC will select those initiatives that have the greatest potential for improving health outcomes or the quality of service delivered to Buckeye's members and network providers. Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against

established standards and guidelines. QI initiatives are designed to allow for monitoring improvement over time.

Quality of Care and Service

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

- Key indicators of care and service based on reliable data derived from claims, authorizations, inbound telephone calls, and internal tracking mechanisms, etc.
- Credentialing data
- Performance monitoring of contracted physicians/practitioners, facilities, ancillary providers and organizational providers
- Provider office site review through member complaints
- Utilization data (under-over utilization) and performance indicator reports
- Issues identified during care coordination
- Referrals from sources indicating potential problems, including those identified by affiliated hospitals and contracted providers
- Quality of Care monitoring
- Trends in member grievance and appeals
- Care Management reports
- Pharmacy data and reports
- Member satisfaction survey
- Provider satisfaction survey
- Access and availability reports
- Utilization Review Activities
- Integration/collaboration of Quality Improvement (QI), Medical Management (MM), and Care Management (CM) processes

Activities Designed to Improve Quality of Care and Service

Buckeye's QI Department, QIC and subcommittees, as appropriate, continuously monitor various internal systems and administrative processes related to medical and behavioral health care for members. A listing of key focus areas for quality improvement activities are:

Access and Availability

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

analyzes practitioner appointment accessibility (Primary Care and Behavioral Health Care providers) at least annually and Member Services (telephone accessibility). Results are reviewed by the QIC to ensure compliance with contractual, regulatory and accreditation requirements as well as appropriate appointment and availability access.

Administrative and Customer Service

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

Assessment of Utilization Patterns

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

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

denials

Continuity and Coordination of Care

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

Medical Care

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

Between Medical and Behavioral Health Care

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

Key Quality Documents and Documentation Cycle

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

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

Quality Improvement Work Plan (QI Work Plan)

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

Quality Improvement Program Evaluation (QI Evaluation)

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

Quality Improvement Committee Structure

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

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

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

- Quality Improvement Committee
- Credentialing Sub-Committee
- HEDIS/STARS Program Committee
- Grievance and Appeals Sub-Committee
- Medical Management Sub-Committee

- Pharmacy and Therapeutics Sub-Committee

Notification To Providers

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

DATA COLLECTION

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

Billing Error Abuse and Fraud (BEAF) System

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

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

Ohio Department of Job and Family Services' Bureau of Managed Care
50 West Town Street, Suite 400
Columbus, OH 43215
1-614-466-4693

Authority and Responsibility

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

Buckeye is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

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

To report potential fraud and abuse, contact:

**Ohio Department of Job and Family Services' Bureau of Managed Care
50 West Town Street, Suite 400
Columbus, OH 43215
1-614-466-4693**

Member Services



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

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

MemberConnections Program

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

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

MemberConnections representatives will:

- ☐ Contact new members by telephone to welcome them to Buckeye Health Plan.
- Educate members on Buckeye benefits including (but not limited to): Transportation, Nurse Wise, Pharmacy, and using Care Management to increase health awareness and prevention.
- Actively collaborate with Care Managers to identify the needs of members to be assessed at the time of referral. The Connections Representative will complete and/or educate members regarding:
 - Non Emergency Transportation NET
 - Tokens/Travel training program
 - PCP selection and appointments
 - Assistance with transportation options as needed
 - Connections Plus/Caring Voices telephones

- Participate in community activities centered on health education.

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

Member Materials

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

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

Providers interested in receiving any of these materials may contact:
Buckeye Provider Services **1-866-296-8731**

Member Rights & Responsibilities

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

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

- To receive all services that Buckeye must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally okayed to have the information or who you have said should be reached in an

emergency when it is not in the best interest of your health to give it to you.

- To be able to take part in decisions about your healthcare unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure that others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless Buckeye has to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or Buckeye must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing.
- To be able to get all Buckeye written member information from Buckeye:
 - at no cost to you;
 - in the prevalent non-English languages of members in Buckeye's service area;
 - in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from Buckeye and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the healthcare provider is a student and to be able to refuse his/her care.

Membership Rights



- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See the pamphlet in your new member packet which explains about advance directives. You can also contact member services for more information.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP on Buckeye's panel at least monthly. Buckeye must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that Buckeye, Buckeye's providers or ODJFS will not hold this against you.
- To know that Buckeye must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider on Buckeye's panel for covered woman's health services.
- To be able to get a second opinion from a qualified provider on Buckeye's panel. If a qualified provider is not able to see you, Buckeye must set up a visit with a provider not on our panel.
- To get information about Buckeye from us.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

**Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601
(312) 886-2359; (312) 353-5693 TTY**

**Bureau of Civil Rights
Ohio Department of Job and Family Services
30 E. Broad Street, 37th Floor
Columbus, Ohio 43215
(614) 644-2703; 1-866-227-6353; 1-866-221-6700 TTY;
Fax: (614) 752-6381**

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

- Ask questions if you don't understand your rights.
- Make any changes in your health plan and primary care provider in the ways established by the Medicaid program and Buckeye.
- Keep your scheduled appointments.
- Have ID card with you.
- Notify PCP of emergency room treatment.
- Cancel appointments in advance when you can't keep them.
- If Buckeye is providing transportation for you to a medical appointment, you must provide a car seat for any child riding with you if the child is 4 years of age or younger, or if the child weighs less than 40 pounds.
- Always contact your PCP or Buckeye's NurseWise first for your non-emergency medical needs.
- Only go to the emergency room when you think it is an emergency.
- Be sure you have approval from your PCP before going to a specialist except for self-referrals.
- To share information relating to your health status with your PCP and become fully informed about service and treatment options. That includes the responsibility to:
 - Tell your PCP about your health.
 - Talk to your providers about your healthcare needs and ask questions about the different ways your healthcare problems can be treated.
 - Help your providers get your medical records.
 - Actively participate in decisions relating to safe service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
 - Work as a team with your provider in deciding what healthcare is best for you.
 - Do the best you can to stay healthy.
 - Treat providers and staff with respect.

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

Member Grievances and Appeals

A ***grievance*** is an expression of dissatisfaction with any aspect of Buckeye's or a provider's operation, provision of healthcare services, activities, or behaviors, other than an MCP's action per OAC rule 5101:3-26-08.4 (A)(1)(a). **A member or authorized representative must file a grievance within 90 calendar days of becoming aware of the issue. Buckeye will respond to all issues raised by members, current or former, regardless of the time that has passed.*

An ***appeal*** is the request for the review of the following actions:

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

If the member does not agree with the decision/action listed in a notice of action, they may contact us within 90 calendar days to ask that we change our decision/action, this is called an appeal. Unless we tell the member a different date, we will give them an answer, in writing, within 15 calendar days from the date they contacted us.

Resolution means a final decision is made by the Buckeye and the decision is communicated to the member.

Buckeye will provide members access to a grievance and appeal resolution process. Buckeye will respond to member grievances and appeals in a timely manner and attempt to resolve all issues to the member's satisfaction. **For the purposes of filing grievances or appeals on behalf of a member under the age of eighteen, written consent to file is not required when the individual filing the grievance or appeal belongs to the member's assistance group.*

To file a grievance or an appeal a member should:

- Call the Member Service Department at **1-866-246-4358 (TTY 1-800-750-0750)**.
- Complete the Appeals and Grievances form in the Buckeye Member Handbook Write a letter explaining to Buckeye what they are unhappy about. The letter should include the member's first and last name, the number from the front of their **Buckeye** member ID card, address, and telephone number. The member should also send any information that helps explain the problem.
- Complete the grievance report on the Buckeye website at www.buckeyehealthplan.com

Mail the form or letter to:

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

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

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

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

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

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

Members Right to a State Fair Hearing

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

MyCare member grievance, appeal and state fair hearing rights

Buckeye's Member Services Member Services can help members with appeals or making a complaint (also called a grievance). To contact Member Services, members can call 1-866-549-8289 (TTY: 711), from 8 a.m. to 8 p.m., seven days a week. The call is free.

Members can visit the Buckeye website at <http://mmp.buckeyehealthplan.com> to send a complaint, or appeal, or fill out the appeal/complaint form found in their Handbook.

Members can also write a letter telling us about their complaint or appeal.

The form or letter can be mailed to:

Buckeye Health Plan – MyCare Ohio
Attn: Appeals and Grievances
4349 Easton Way, Suite 400
Columbus, OH 43219

Members must ask for an appeal within 60 calendar days after the date on the denial letter we send to the member informing them of our decision, and can request either a standard or expedited appeal. (Appeal requests for Medicaid only services may be submitted up to 90 days after the date of the denial letter.) The 60 calendar day timeline can be extended under extenuating circumstances. Our response time for a standard appeal is 14 calendar days unless the member's health requires an answer sooner (7 days for medication appeals). The timeline can be extended an additional 14 calendar days if the member or provider requests the extension. Our response time for an expedited appeal is 72 hours after receiving all the information to make a decision unless the member's health requires an answer sooner.

If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send the member a notice at least 15 days in advance of taking the action. If the member wants their benefits to be continued, the member, the member's authorized representative, or their doctor or primary care practitioner that requested the service must ask for an appeal on or before the later of the following to continue the service during the appeal:

- Within 15 calendar days of the mailing date of the notice or
- The intended effective date of the action.

If the member's benefits are continued, they can keep getting the service until one of the following happens: 1) the appeal is withdrawn; 2) 15

calendar days pass after notification the appeal was denied; or 3) the authorization expires or the member receives all of the services that were previously approved. If the appeal is denied, the member may be liable for the costs of the continued benefits.

State Fair Hearing: To request a State Fair Hearing, the member or their authorized representative must contact the Bureau of State Hearings within 90 calendar days of receiving the notice of their State Hearing rights. The 90 calendar days begins on the day after the mailing date on the notice. If the member misses the 90 calendar day deadline and has a good reason for missing it, the Bureau of State Hearings may give them more time to request a hearing. **The member does not have to ask for an Appeal before asking for a State Fair Hearing.**

Members can sign and return the State Hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748, or submit their request by e-mail to bsh@ifs.ohio.gov.

Please see the complete description of the MyCare member grievance, appeal and state fair hearing rights in Chapter 9 of MyCare Member Handbook found on the Buckeye Health Plan Website at:

<http://mmp.buckeyehealthplan.com/home/benefits/member-handbook-2/>

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES NOTICE OF DENIAL, REDUCTION, OR TERMINATION OF MEDICAL SERVICES BY YOUR MANAGED CARE PLAN			Your Right to a State Hearing			
Name	Assistance Group Name		<p>This notice is to tell you about a decision <u>Buckeye Community Health Plan</u> has made on your case. If you do not understand this decision, you should contact us. It is possible that we will change our decision or that you will agree with it.</p> <p>You can ask for a state hearing if you think we have made a mistake. At the state hearing you can tell a hearing officer from the Ohio Department of Job and Family Services why you think so. You can bring someone with you as a representative, such as a lawyer, welfare rights worker, friend or relative. The hearing officer will decide if we have made a mistake.</p> <p>If you want a hearing, your request must be received within 90 days of the mailing date on this notice.</p> <p>Note: If your hearing request is received within 15 days of the mailing date of this notice, we will not take actions proposed in this notice to reduce, restrict or stop a service until your hearing is decided. You may have to pay for what you get if the hearing officer rules against you. Your hearing request will not delay actions in this notice to deny a service, but if you win your hearing the service may then be approved.</p> <p>IF YOU WANT A HEARING, check the box below that says what you want. Fill in your signature, date and phone number. (Another person can do this for you, but you must include a statement, signed by you, that the other person is acting for you.) Then mail or fax this notice to:</p> <p style="text-align: center;">Ohio Department of Job and Family Services Bureau of State Hearings P.O. Box 182825 Columbus, Ohio 43218-2825 Fax: 614-728-9574</p> <p><input type="checkbox"/> I want to request a grievance and a state hearing. (A grievance lets you tell us informally why you think we have made a mistake. You can still have a state hearing.)</p> <p><input type="checkbox"/> I want a state hearing only.</p> <p>I want a state hearing.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Signature</td> <td style="width: 33%;">Date</td> <td style="width: 33%;">Telephone Number</td> </tr> </table> <p style="text-align: center;">FREE LEGAL HELP</p> <p>If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, at 1-800-589-5888, for the local number. This is a free call.</p>	Signature	Date	Telephone Number
Signature	Date	Telephone Number				
Street Address	Assistance Group Number	NMS Billing Number				
City, State, and Zip Code	County	Mailing Date				
<p>This notice is to tell you about action <u>Buckeye Community Health Plan</u> is taking on your medical services.</p> <p><input type="checkbox"/> We are denying your request for the following medical service(s):</p> <p>SERVICE REQUESTED</p> <p>Reason for denial:</p> <p>Supporting regulation:</p> <p>OAC TITLE AND CODE</p> <p><input type="checkbox"/> We are proposing to <input type="checkbox"/> reduce <input type="checkbox"/> stop the following medical service(s), effective:</p> <p>Reason for reduction/termination:</p> <p>Supporting regulation:</p>						
<p>If you do not understand this action, or want to talk to someone about it, you may call:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Name: Kimberly Lewis Grievances/Appeals Coordinator</td> <td style="width: 40%;">Telephone Number: 1-866-246-4350 ext 24107</td> </tr> </table> <p>Name and Address of Managed Care Plan: Buckeye Community Health Plan US Bank Building 175 South Third Street Columbus, OH 43215</p>			Name: Kimberly Lewis Grievances/Appeals Coordinator	Telephone Number: 1-866-246-4350 ext 24107		
Name: Kimberly Lewis Grievances/Appeals Coordinator	Telephone Number: 1-866-246-4350 ext 24107					

Special Services to Assist with Members

Buckeye has designed its programs and trained its staff to ensure that each day individuals' cultural needs are considered in carrying out its operations. Providers should remain cognizant of the diverse Buckeye population.

Patients' needs may vary depending on their gender, ethnicity, age, beliefs, etc. We ask that you recognize these needs in serving your patients.

Buckeye is always available to assist your office in providing the best care possible to your patients.

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

Transportation Services

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

Interpreter/Translation Services

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

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

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

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

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

NurseWise®

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

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

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

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

Provider Manual

Provider Relations Assistance



Provider Relations Department

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

- Contracting
- Maintenance of existing Buckeye Provider Manual
- Development of alternative reimbursement strategies
- Researching of trends in claims inquiries to the Buckeye
- Network performance profiling
- Individual physician performance profiling
- Physician and office staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider education, updates, and training

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Buckeye enrolled membership. To contact the Provider Relations Representative for your area contact:

Provider Services
Toll Free Help Line
1-866-296-8731

The Provider Services toll free help line staff is available to you and your staff to answer questions, listen to your concerns, assist with patients, respond to your Buckeye Plan inquiries, connect you to the Buckeye provider relations specialist for your area, etc.

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

Provider Manual

Pharmacy



Plan Preferred Drug List and Prior Authorization List

The Buckeye Preferred Drug List (PDL) describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the program. All drugs covered under the Ohio Medicaid program are available for Buckeye members. The PDL includes all drugs available without PA and those agents that have the restrictions of Step Therapy (ST). The PA list includes those drugs that require prior authorization for coverage. The PDL applies to drugs a member receives at retail pharmacies. The PDL is continually evaluated by the Buckeye Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medications. The Committee is composed of the Buckeye Medical Director, Buckeye Pharmacy Director, and several Ohio primary care physicians, pharmacists, and specialists. The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the physician/clinician or pharmacist, or
- Relieve the physician/clinician or pharmacist of any obligation to the

Pharmacy and Therapeutics Committee (P&T)

The Buckeye Pharmacy and Therapeutics (P&T) Committee continually evaluates the therapeutic classes included in the PDL. The Committee is composed of the Buckeye Medical Director, Buckeye Pharmacist, and several community based primary care physicians and specialists. The primary purpose of the Committee is to assist in developing and monitoring the Buckeye PDL and to establish programs and procedures that promote the appropriate and cost-effective use of medications. The P&T Committee schedules meetings at least twice yearly, and coordinates reviews with a national P&T Committee which meets at least 4 times a year. Changes to the Buckeye PDL are done in conjunction with the approval of the State of Ohio. Buckeye will meet with the State quarterly to review any proposed changes and update the PDL and PA lists accordingly based on the results of both the Buckeye P&T Committee and the requirements from the State of Ohio. Buckeye will follow all State policies regarding member notification when changes are made to the PA list.

Unapproved Use of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered

if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by Buckeye. Experimental drugs and investigational drugs are not eligible for coverage.

Prior Authorization Process

The Buckeye PDL includes a broad spectrum of brand name and generic drugs. Clinicians are encouraged to prescribe from the Buckeye PDL for their patients who are members of Buckeye. Some drugs will require PA and are listed on the PA list. In addition, all name brand drugs not listed on either the PDL or PA list will require prior authorization. If a request for prior authorization is needed the information should be submitted by the physician/clinician to US Script on the Buckeye Health Plan/US Script form: Medication Prior Authorization Request Form. This form should be faxed to US Script at 1-866-399-0929. This document is located on the Buckeye website at www.buckeyehealthplan.com. Buckeye will cover the medication if it is determined that:

1. There is a medical reason the member needs the specific medication.
2. Depending on the medication, other medications on the PDL have not worked.

All reviews are performed by a licensed clinical pharmacist using the criteria established by the Buckeye P&T Committee. Once approved, US Script notifies the physician/clinician by fax. If the clinical information provided does not meet the coverage criteria for the requested medication Buckeye we will notify the member and physician/clinician of alternatives and provide information regarding the appeal process.

The P&T committee has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring prior authorization. This PDL attempts to provide appropriate and cost-effective drug therapy to all members covered under the Buckeye pharmacy program. If a patient requires a brand name medication that does not appear on the PDL, the physician/clinician can make a PA request for the brand name medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. A phone or fax-in process is available for PA requests.

72-Hour Emergency Supply Policy

State and federal law require that a pharmacy dispense a 72-hour (3-day) supply of medication to any patient awaiting a PA determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication, whether or not the PA request is ultimately approved or denied. The pharmacy must call the US Script Pharmacy Help Desk at 1-800-460-8988 for a prescription override to submit the 72-hour medication supply for payment.

Newly Approved Products

We review new drugs for safety and effectiveness for the first 12 months before adding them to the Buckeye PDL. During this period, access to these medications will be considered through the PA review process. If Buckeye does not grant PA we will notify the member and physician/clinician and provide information regarding the appeal process.

Step Therapy

Some medications listed on the Buckeye PDL may require specific medications to be used before you can receive the step therapy medication. If Buckeye has a record that the required medication was tried first the ST medications are automatically covered. If Buckeye does not have a record that the required medication was tried, the member or physician/clinician may be required to provide additional information. If Buckeye does not grant PA we will notify the member and physician/clinician and provide information regarding the appeal process.

Benefit Exclusions

The following drug categories are not part of the Buckeye PDL and are not covered by the 72-hour emergency supply policy:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Immunizations and vaccines (except flu vaccine)
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Infusion therapy and supplies
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence

DESI drugs products and known related drug products are defined as less than effective by the FDA because there is a lack of substantial evidence of effectiveness for all labeling indications and because a compelling justification for their medical need has not been established. State programs may allow coverage of certain DESI drugs. Any DESI drugs that are covered are listed in the PDL.

AcariaHealth – Biopharmaceuticals and Injectables

Injections that are self-administered by the member and/or a family member and appear on the PDL are covered by the Buckeye pharmacy program. Insulin vials and pens, Glucagon Kit, Epi-pen, Ana-Kit, Imitrex, and Depo-Provera IM are covered by Buckeye and do not require a PA. All other injectables require PA.

AcariaHealth is the provider of biopharmaceuticals and injectables for Buckeye. Most injectables require PA to be approved for payment. Our Medical Director oversees the clinical review. Buckeye provides a number of biopharmaceutical products through the Biopharmaceutical Program. Most biopharmaceuticals and injectables require a PA to be approved for payment by Buckeye; however, PA requirements are programmed specific to the drug as indicated in the list provided in the Biopharmaceutical Program document located on the Buckeye website at www.bchpohio.com. Follow these guidelines for the most efficient processing of your authorization requests.

Providers can request that AcariaHealth deliver the specialty drug to the office/member. If you want AcariaHealth to deliver the specialty drug to the office/member:

1. Fax the AcariaHealth PA form to 1-855-217-0926 for PA.
2. If approved, AcariaHealth will contact the provider or member for delivery confirmation

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum 31 day supply for each new or refill non-controlled substance. A total of 80 percent (80%) of the days supplied must have elapsed before the prescription can be refilled. A prescription can be filled after 26 days. Dispensing outside the quantity limit (QL) or age limits (AL) requires PA. Buckeye may limit how much of a medication you can get at one time. If the physician/clinician feels a member has a medical reason for getting a larger amount, he or she can ask for PA. If Buckeye does not grant PA we will notify the member and physician/clinician and provide information regarding the appeal process.

Some medications on the Buckeye PDL may have AL. These are set for certain drugs based on Food and Drug Administration (FDA) approved labeling and for safety concerns and quality standards of care. The AL aligns with current FDA alerts for the appropriate use of pharmaceuticals.

Mandatory Generic Substitution

When generic drugs are available, the brand name drug will not be covered without Buckeye PA. Generic drugs have the same active ingredient, work the same as brand name drugs, and have lower copayments. If the member or physician/clinician feels a brand name drug is medically necessary, the physician/clinician can ask for PA. We will cover the brand name drug according to our clinical guidelines if there is a medical reason the member needs the particular brand name drug. If Buckeye does not grant PA we will notify the member and physician/clinician and provide information regarding the appeal process. The provision is waived for the following products due to their narrow therapeutic index (NTI) as recognized by current medical and pharmaceutical literature: Aminophylline, Amiodarone, Carbamazepine, Clozapine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-thyroxine, Lithium, Phenytoin, Procainamide, Propafenone, Theophylline, Thyroid, Valproate Sodium, Valproic Acid, and Warfarin.

Over-The-Counter Medications

The pharmacy program covers a large selection of OTC medications. All covered OTC medications appear in the PDL. All OTC medications must be written on a valid prescription by a licensed physician/clinician in order to be reimbursed.

Pharmacy Appeals

Contacts for Pharmacy Appeals/Grievances

Members: In the event that a member disagrees with the decision regarding coverage of a medication, the member may file an appeal with Buckeye by calling Buckeye Member Services at 1-866-246-4358 (TTY 1-800-750-0750).

Physicians / Clinicians: In the event that a clinician disagrees with the decision regarding coverage of a medication, the clinician may request an appeal by submitting additional information to Buckeye in writing to the Appeals Department at the following address:

Buckeye Health Plan
Attn: Appeals and Grievance Coordinator
4349 Easton Way, Suite400
Columbus, OH 43219

A decision will be rendered and the clinician will be notified with a mailed response..

An expedited appeal may be requested at any time the provider believes the adverse determination might seriously jeopardize the life or health of a member by calling Buckeye at 1-866-246-4356 ext. 24084 (TTY 1-800-750-0750). A response will be rendered the same day as receipt of complete information. In circumstances that require research, a same day response may not be possible.

Contact Information:

PHYSICIANS

PDL Questions:

US Script 1-800-460-8988

Medical Necessity: 1-866-399-0928 (phone)

US Script PA Dept. 1-866-399-0929 (Fax)

Prior Authorization: 1-866-399-0928 (phone)

US Script PA Dept. 1-866-399-0929 (Fax)

Buckeye Health Plan
Pharmacy Coordinator: 1-866-246-435

PHARMACISTS

Provider Network Questions:

US Script, Inc. 1-800-413-7721 Ext. 23717

Claims Processing Customer Service:

US Script, Inc. 1-800-460-8988

MEMBERS

Member Questions:

Buckeye Member Service 1-866-246-4358

Coordinated Services Program

Consumers eligible for Ohio Medicaid may be selected for enrollment in the Coordinated Services Program, or CSP. CSP members may need to select one pharmacy to get medications filled, select one doctor to write their scripts, or both depending on the CSP enrollment. While in CSP, the member will still be able to get all medically necessary Medicaid-covered health care services. However, the member must use the selected pharmacy or doctor for pharmacy services. Members enrolled in the CSP program will also be enrolled in Care Management to help better coordinate the member's needs. Care Managers will work with the CSP members, to help make sure all their needs are met. Except in an emergency, the member should contact their PCP before seeing other doctors. By knowing the complete medical history, the PCP can take better care of the patient.

Clinical Screening Guidelines

Buckeye has adopted a number of clinical practice guidelines to assist providers in the assessment of treatment of disorders commonly occurring among Buckeye members. Prior to the adoption of each guideline, the relevant scientific literature is reviewed by a multi-disciplinary panel that includes Board-certified psychiatrists, with input from providers in Buckeye's clinical network and from consumers and community agencies. Buckeye reviews adopted guidelines at least every two years and provides updates as necessary. As with clinical guidelines in general, Buckeye's adopted guidelines are intended to augment, not replace, sound, clinical judgment. For more complete information on the guidelines, you can visit our website www.buckeyehealthplan.com or call 866-246-4359 to request a printed copy.

Asthma: The Guidelines for the Diagnosis and Management of Asthma are organized for the treatment of asthma around four components of effective asthma management:

- Use of objective measures of lung function to assess the severity of asthma and to monitor the course of therapy
- Environmental control measures to avoid or eliminate factors that precipitate asthma symptoms or exacerbations
- Patient education that fosters a partnership among the patient, his or her family, and Clinicians
- Comprehensive pharmacologic therapy for long-term management designed to reverse and prevent the airway inflammation characteristic of asthma as well as pharmacologic therapy to manage asthma exacerbations

Diabetes: The diabetes guideline has been adopted based on nationally recognized sources and the most recent medical evidence or a consensus on clinical treatment patterns by physicians in the selected field of

practice. Buckeye adopts guidelines to help practitioners and members make decisions about appropriate health care for specific medical conditions. Guidelines are not a substitute for the advice of a physician. The recommendations include several key areas of care, including lowering blood pressure and blood glucose levels, treating high cholesterol, use of aspirin and aggressive practitioner interventions to help people who smoke find methods to help them quit.

Depression: In clinical practices that have systems in place to assure accurate diagnosis, effective treatment and follow-up, Buckeye recommends screening for depression and initiating therapy or referring for further evaluation and therapy. The APA guideline is one of the most comprehensive, evidence-based clinical practice guideline for this disorder and is widely used. Therefore, adoption of this guideline provides an excellent source of evidenced-based treatment information.

ADHD (Attention - Deficit Hyperactivity Disorder): This guideline incorporates the rapidly evolving developments in pharmacotherapy, as well as developments in other areas of psychiatric management of individuals with ADHD. The APA revision is an excellent evidence-based document that covers all areas of psychiatric management of patients with this disorder, from understanding the clinical features and epidemiology to treatment approaches and planning.

Provider Manual

Clinical Guidelines



Please visit the following CDC link for printable versions of immunization schedules:
<http://www.cdc.gov/nip/menus/vaccines.htm#Schedules>

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2011

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹	HepB	HepB										
Rotavirus ²			RV	RV	RV ²							
Diphtheria, Tetanus, Pertussis ³			DTaP	DTaP	DTaP	see footnote ³	DTaP					DTaP
<i>Haemophilus influenzae</i> type b ⁴			Hib	Hib	Hib ⁴	Hib						
Pneumococcal ⁵			PCV	PCV	PCV	PCV					PPSV	
Inactivated Poliovirus ⁶			IPV	IPV		IPV						IPV
Influenza ⁷							Influenza (Yearly)					
Measles, Mumps, Rubella ⁸							MMR	see footnote ⁸			MMR	
Varicella ⁹							Varicella	see footnote ⁹			Varicella	
Hepatitis A ¹⁰							HepA (2 doses)				HepA Series	
Meningococcal ¹¹											MCV4	

Range of recommended ages for all children

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967. Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
- Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
- Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
- The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.

2. Rotavirus vaccine (RV). (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
- The maximum age for the final dose in the series is 8 months 0 days.
- If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- Hibrix should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
- A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
- A single supplemental dose of PCV13 is recommended for all children aged 60 through 71 months with underlying medical conditions who have received an age-appropriate series of PCV7.

- The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See *MMWR* 2010;59(No. RR-11).
- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.

7. Influenza vaccine (seasonal). (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
- Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.

8. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.

9. Varicella vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

10. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

11. Meningococcal conjugate vaccine, quadrivalent (MCV4). (Minimum age: 2 years)

- Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).
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Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind—United States • 2011

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age

PERSONS AGED 4 MONTHS THROUGH 6 YEARS					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B ¹	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Rotavirus ²	6 wks	4 weeks	4 weeks ²		
Diphtheria, Tetanus, Pertussis ³	6 wks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁴	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age 15 months or older	4 weeks ⁴ if current age is younger than 12 months 8 weeks (as final dose) ⁴ if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal ⁵	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	6 months ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months			
Hepatitis A ⁹	12 mos	6 months			
PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis ¹⁰	7 yrs ¹⁰	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human Papillomavirus ¹¹	9 yrs	Routine dosing intervals are recommended (females) ¹¹			
Hepatitis A ⁹	12 mos	6 months			
Hepatitis B ¹	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks ⁶	6 months ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

1. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated.
- The minimum age for the third dose of HepB is 24 weeks.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.

2. Rotavirus vaccine (RV).

- The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
- The maximum age for the final dose in the series is 8 months 0 days.
- If Rotarix was administered for the first and second doses, a third dose is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).

- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib).

- 1 dose of Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy.
- If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.

5. Pneumococcal vaccine.

- Administer 1 dose of 13-valent pneumococcal conjugate vaccine (PCV13) to all healthy children aged 24 through 59 months with any incomplete PCV schedule (PCV7 or PCV13).
- For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV13 if 3 doses of PCV were received previously or administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
- A single dose of PCV13 is recommended for certain children with underlying medical conditions through 18 years of age. See age-specific schedules for details.
- Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant, at least 8 weeks after the last dose of PCV. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See *MMWR* 2010;59(No. RR-11).

6. Inactivated poliovirus vaccine (IPV).

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months following the previous dose.
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).

7. Measles, mumps, and rubella vaccine (MMR).

- Administer the second dose routinely at age 4 through 6 years. The minimum interval between the 2 doses of MMR is 4 weeks.

8. Varicella vaccine.

- Administer the second dose routinely at age 4 through 6 years.
- If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

9. Hepatitis A vaccine (HepA).

- HepA is recommended for children aged older than age 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

10. Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

- Doses of DTaP are counted as part of the Td/Tdap series.
- Tdap should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years or as a booster for children aged 11 through 18 years; use Td for other doses.

11. Human papillomavirus vaccine (HPV).

- Administer the series to females at age 13 through 18 years if not previously vaccinated or have not completed the vaccine series.
- Quadrivalent HPV vaccine (HPV4) may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
- Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 1 to 2 and 6 months after the first dose). The minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be administered at least 24 weeks after the first dose.

Information about reporting reactions after immunization is available online at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at <http://www.cdc.gov/vaccines> or telephone, 800-CDC-INFO (800-232-4636).

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Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2011

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, Diphtheria, Pertussis ¹			Tdap	Tdap	Range of recommended ages for all children
Human Papillomavirus ²	see footnote ²		HPV (3 doses)(females)	HPV Series	
Meningococcal ³		MCV4	MCV4	MCV4	
Influenza ⁴		Influenza (Yearly)			Range of recommended ages for catch-up immunization
Pneumococcal ⁵		Pneumococcal			
Hepatitis A ⁶		HepA Series			
Hepatitis B ⁷		Hep B Series			Range of recommended ages for certain high-risk groups
Inactivated Poliovirus ⁸		IPV Series			
Measles, Mumps, Rubella ⁹		MMR Series			
Varicella ¹⁰		Varicella Series			

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). (Minimum age: 10 years for Boostrix and 11 years for Adacel)

- Persons aged 11 through 18 years who have not received Tdap should receive a dose followed by Td booster doses every 10 years thereafter.
- Persons aged 7 through 10 years who are not fully immunized against pertussis (including those never vaccinated or with unknown pertussis vaccination status) should receive a single dose of Tdap. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid-containing vaccine are needed.
- Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Quadrivalent HPV vaccine (HPV4) or bivalent HPV vaccine (HPV2) is recommended for the prevention of cervical precancers and cancers in females.
- HPV4 is recommended for prevention of cervical precancers, cancers, and genital warts in females.
- HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
- Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).

3. Meningococcal conjugate vaccine, quadrivalent (MCV4). (Minimum age: 2 years)

- Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
- Administer 1 dose at age 13 through 18 years if not previously vaccinated.
- Persons who received their first dose at age 13 through 15 years should receive a booster dose at age 16 through 18 years.
- Administer 1 dose to previously unvaccinated college freshmen living in a dormitory.
- Administer 2 doses at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with HIV infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older).

4. Influenza vaccine (seasonal).

- For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first

time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

- Children 6 months through 8 years of age who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.

5. Pneumococcal vaccines.

- A single dose of 13-valent pneumococcal conjugate vaccine (PCV13) may be administered to children aged 6 through 18 years who have functional or anatomic asplenia, HIV infection or other immunocompromising condition, cochlear implant or CSF leak. See *MMWR* 2010;59(No. RR-11).
- The dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7.
- Administer pneumococcal polysaccharide vaccine at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition.

6. Hepatitis A vaccine (HepA).

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

7. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated. For those with incomplete vaccination, follow the catch-up schedule.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).

- The minimum interval between the 2 doses of MMR is 4 weeks.

10. Varicella vaccine.

- For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
- For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).
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Recommended Adult Immunization Schedule

UNITED STATES - 2011

Note: These recommendations *must* be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Recommended adult immunization schedule, by vaccine and age group

VACCINE ▼	AGE GROUP ▶	19–26 years	27–49 years	50–59 years	60–64 years	≥65 years
Influenza ^{1,*}		1 dose annually				
Tetanus, diphtheria, pertussis (Td/Tdap) ^{2,*}		Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs				
Varicella ^{3,*}		2 doses				
Human papillomavirus (HPV) ^{4,*}		3 doses (females)				
Zoster ⁵					1 dose	
Measles, mumps, rubella (MMR) ^{6,*}		1 or 2 doses		1 dose		
Pneumococcal (polysaccharide) ^{7,8}		1 or 2 doses				1 dose
Meningococcal ^{9,*}		1 or more doses				
Hepatitis A ^{10,*}		2 doses				
Hepatitis B ^{11,*}		3 doses				

* Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of previous infection)

Recommended if some other risk factor is present (e.g., based on medical, occupational, lifestyle, or other indications)

No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at <http://www.hrsa.gov/vaccinecompensation> or by telephone, 800-338-2382. Information about filing a claim for vaccine injury is available through the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination also is available at <http://www.cdc.gov/vaccines> or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 24 hours a day, 7 days a week.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

Vaccines that might be indicated for adults based on medical and other indications

INDICATION ► VACCINE ▼	Pregnancy	Immuno-compromising conditions (excluding human immunodeficiency virus [HIV]) ^{3,5,6,13}	HIV infection ^{9,6,12,13} CD4+ T lymphocyte count <200 cells/μL ≥200 cells/μL	Diabetes, heart disease, chronic lung disease, chronic alcoholism	Asplenia ¹² (including elective splenectomy) and persistent complement component deficiencies	Chronic liver disease	Kidney failure, end-stage renal disease, receipt of hemodialysis	Healthcare personnel
Influenza ^{1,*}								1 dose TIV or LAIV annually
Tetanus, diphtheria, pertussis (Td/Tdap) ^{2,*}	Td							Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs
Varicella ^{3,*}		Contraindicated						2 doses
Human papillomavirus (HPV) ^{4,*}								3 doses through age 26 yrs
Zoster ⁵		Contraindicated						1 dose
Measles, mumps, rubella (MMR) ^{6,*}		Contraindicated						1 or 2 doses
Pneumococcal (polysaccharide) ^{7,8}								1 or 2 doses
Meningococcal ^{9,*}								1 or more doses
Hepatitis A ^{10,*}								2 doses
Hepatitis B ^{11,*}								3 doses

* Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of previous infection)

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

No recommendation

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of January 1, 2011. For all vaccines being recommended on the adult immunization schedule, a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/pubs/acip-list.htm>).

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP).



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Footnotes

Recommended Adult Immunization Schedule—UNITED STATES • 2011

For complete statements by the Advisory Committee on Immunization Practices (ACIP), visit www.cdc.gov/vaccines/pubs/ACIP-list.htm.

1. Influenza vaccination

Annual vaccination against influenza is recommended for all persons aged 6 months and older, including all adults. Healthy, nonpregnant adults aged less than 50 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (FluMist), or inactivated vaccine. Other persons should receive the inactivated vaccine. Adults aged 65 years and older can receive the standard influenza vaccine or the high-dose (Fluzone) influenza vaccine. Additional information about influenza vaccination is available at <http://www.cdc.gov/vaccines/vpd-vac/flu/default.htm>.

2. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination

Administer a one-time dose of Tdap to adults aged less than 65 years who have not received Tdap previously or for whom vaccine status is unknown to replace one of the 10-year Td boosters, and as soon as feasible to all 1) postpartum women, 2) close contacts of infants younger than age 12 months (e.g., grandparents and child-care providers), and 3) healthcare personnel with direct patient contact. Adults aged 65 years and older who have not previously received Tdap and who have close contact with an infant aged less than 12 months also should be vaccinated. Other adults aged 65 years and older may receive Tdap. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-containing vaccine.

Adults with uncertain or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series. For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. If incompletely vaccinated (i.e., less than 3 doses), administer remaining doses. Substitute a one-time dose of Tdap for one of the doses of Td, either in the primary series or for the routine booster, whichever comes first.

If a woman is pregnant and received the most recent Td vaccination 10 or more years previously, administer Td during the second or third trimester. If the woman received the most recent Td vaccination less than 10 years previously, administer Tdap during the immediate postpartum period. At the clinician's discretion, Td may be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap may be administered instead of Td to a pregnant woman after an informed discussion with the woman.

The ACIP statement for recommendations for administering Td as prophylaxis in wound management is available at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>.

3. Varicella vaccination

All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or a second dose if they have received only 1 dose, unless they have a medical contraindication. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., healthcare personnel and family contacts of persons with immunocompromising conditions) or 2) are at high risk for exposure or transmission (e.g., teachers; child-care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).

Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) U.S.-born before 1980 (although for healthcare personnel and pregnant women, birth before 1980 should not be considered evidence of immunity); 3) history of varicella based on diagnosis or verification of varicella by a healthcare provider (for a patient reporting a history of or having an atypical case, a mild case, or both, healthcare providers should seek either an epidemiologic link with a typical varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on diagnosis or verification of herpes zoster by a healthcare provider; or 5) laboratory evidence of immunity or laboratory confirmation of disease.

Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the healthcare facility. The second dose should be administered 4–8 weeks after the first dose.

4. Human papillomavirus (HPV) vaccination

HPV vaccination with either quadrivalent (HPV4) vaccine or bivalent vaccine (HPV2) is recommended for females at age 11 or 12 years and catch-up vaccination for females aged 13 through 26 years.

Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, females who are sexually active should still be vaccinated consistent with age-based recommendations. Sexually active females who have not been infected with any of the four HPV vaccine types (types 6, 11, 16, and 18, all of which HPV4 prevents) or any of the two HPV vaccine types (types 16 and 18, both of which HPV2 prevents) receive the full benefit of the vaccination. Vaccination is less beneficial for females who have already been infected with one or more of the HPV vaccine types. HPV4 or HPV2 can be administered to persons with a history of genital warts, abnormal Papanicolaou test, or positive HPV DNA test, because these conditions are not evidence of previous infection with all vaccine HPV types.

HPV4 may be administered to males aged 9 through 26 years to reduce their likelihood of genital warts. HPV4 would be most effective when administered before exposure to HPV through sexual contact.

A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 1–2 months after the first dose; the third dose should be administered 6 months after the first dose.

Although HPV vaccination is not specifically recommended for persons with the medical indications described in Figure 2, "Vaccines that might be indicated for adults based on medical and other indications," it may be administered to these persons because the HPV vaccine is not a live-virus vaccine. However, the immune response and vaccine efficacy might be less for persons with the medical indications described in Figure 2 than in persons who do not have the medical indications described or who are immunocompetent.

10. Hepatitis A vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis A virus (HAV) infection:

Behavioral: Men who have sex with men and persons who use injection drugs.

Occupational: Persons working with HAV-infected primates or with HAV in a research laboratory setting.

Medical: Persons with chronic liver disease and persons who receive clotting factor concentrates.

Other: Persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at <http://wwwn.cdc.gov/travel/content/diseases.aspx>).

Unvaccinated persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity should be vaccinated. The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix), or 0 and 6–18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21–30, followed by a booster dose at month 12.

11. Hepatitis B vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:

Behavioral: Sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than one sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection-drug users; and men who have sex with men.

Occupational: Healthcare personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids.

Medical: Persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease.

Other: Household contacts and sex partners of persons with chronic HBV infection; clients and staff members of institutions for persons with developmental disabilities; and international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at <http://wwwn.cdc.gov/travel/content/diseases.aspx>).

Hepatitis B vaccination is recommended for all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; healthcare settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential day-care facilities for persons with developmental disabilities.

Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose Twinrix schedule, administered on days 0, 7, and 21 to 30, followed by a booster dose at month 12 may be used.

Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 µg/mL (Recombivax HB) administered on a 3-dose schedule or 2 doses of 20 µg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.

12. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used

1 dose of Hib vaccine should be considered for persons who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy, if they have not previously received Hib vaccine.

13. Immunocompromising conditions

Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, influenza [inactivated influenza vaccine]) and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>.

5. Herpes zoster vaccination

A single dose of zoster vaccine is recommended for adults aged 60 years and older regardless of whether they report a previous episode of herpes zoster. Persons with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication.

6. Measles, mumps, rubella (MMR) vaccination

Adults born before 1957 generally are considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, laboratory evidence of immunity to each of the three diseases, or documentation of provider-diagnosed measles or mumps disease. For rubella, documentation of provider-diagnosed disease is not considered acceptable evidence of immunity.

Measles component: A second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who 1) have been recently exposed to measles or are in an outbreak setting; 2) are students in postsecondary educational institutions; 3) work in a healthcare facility; or 4) plan to travel internationally. Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type during 1963–1967 should be revaccinated with 2 doses of MMR vaccine.

Mumps component: A second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who 1) live in a community experiencing a mumps outbreak and are in an affected age group; 2) are students in postsecondary educational institutions; 3) work in a healthcare facility; or 4) plan to travel internationally. Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g. persons who are working in a healthcare facility) should be revaccinated with 2 doses of MMR vaccine.

Rubella component: For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the healthcare facility.

Healthcare personnel born before 1957: For unvaccinated healthcare personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, healthcare facilities should 1) consider routinely vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval (for measles and mumps) and 1 dose of MMR vaccine (for rubella), and 2) recommend 2 doses of MMR vaccine at the appropriate interval during an outbreak of measles or mumps, and 1 dose during an outbreak of rubella. Complete information about evidence of immunity is available at <http://www.cdc.gov/vaccines/recs/provisional/default.htm>.

7. Pneumococcal polysaccharide (PPSV) vaccination

Vaccinate all persons with the following indications:

Medical: Chronic lung disease (including asthma); chronic cardiovascular diseases; diabetes mellitus; chronic liver diseases; cirrhosis; chronic alcoholism; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunocompromising conditions (including chronic renal failure or nephrotic syndrome); and cochlear implants and cerebrospinal fluid leaks. Vaccinate as close to HIV diagnosis as possible.

Other: Residents of nursing homes or long-term care facilities and persons who smoke cigarettes. Routine use of PPSV is not recommended for American Indians/Alaska Natives or persons aged less than 65 years unless they have underlying medical conditions that are PPSV indications. However, public health authorities may consider recommending PPSV for American Indians/Alaska Natives and persons aged 50 through 64 years who are living in areas where the risk for invasive pneumococcal disease is increased.

8. Revaccination with PPSV

One-time revaccination after 5 years is recommended for persons aged 19 through 64 years with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); and for persons with immunocompromising conditions. For persons aged 65 years and older, one-time revaccination is recommended if they were vaccinated 5 or more years previously and were aged less than 65 years at the time of primary vaccination.

9. Meningococcal vaccination

Meningococcal vaccine should be administered to persons with the following indications:

Medical: A 2-dose series of meningococcal conjugate vaccine is recommended for adults with anatomic or functional asplenia, or persistent complement component deficiencies. Adults with HIV infection who are vaccinated should also receive a routine 2-dose series. The 2 doses should be administered at 0 and 2 months.

Other: A single dose of meningococcal vaccine is recommended for unvaccinated first-year college students living in dormitories; microbiologists routinely exposed to isolates of *Neisseria meningitidis*; military recruits; and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the “meningitis belt” of sub-Saharan Africa during the dry season [December through June]), particularly if their contact with local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj.

Meningococcal conjugate vaccine, quadrivalent (MCV4) is preferred for adults with any of the preceding indications who are aged 55 years and younger; meningococcal polysaccharide vaccine (MPSV4) is preferred for adults aged 56 years and older. Revaccination with MCV4 every 5 years is recommended for adults previously vaccinated with MCV4 or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia, or persistent complement component deficiencies).