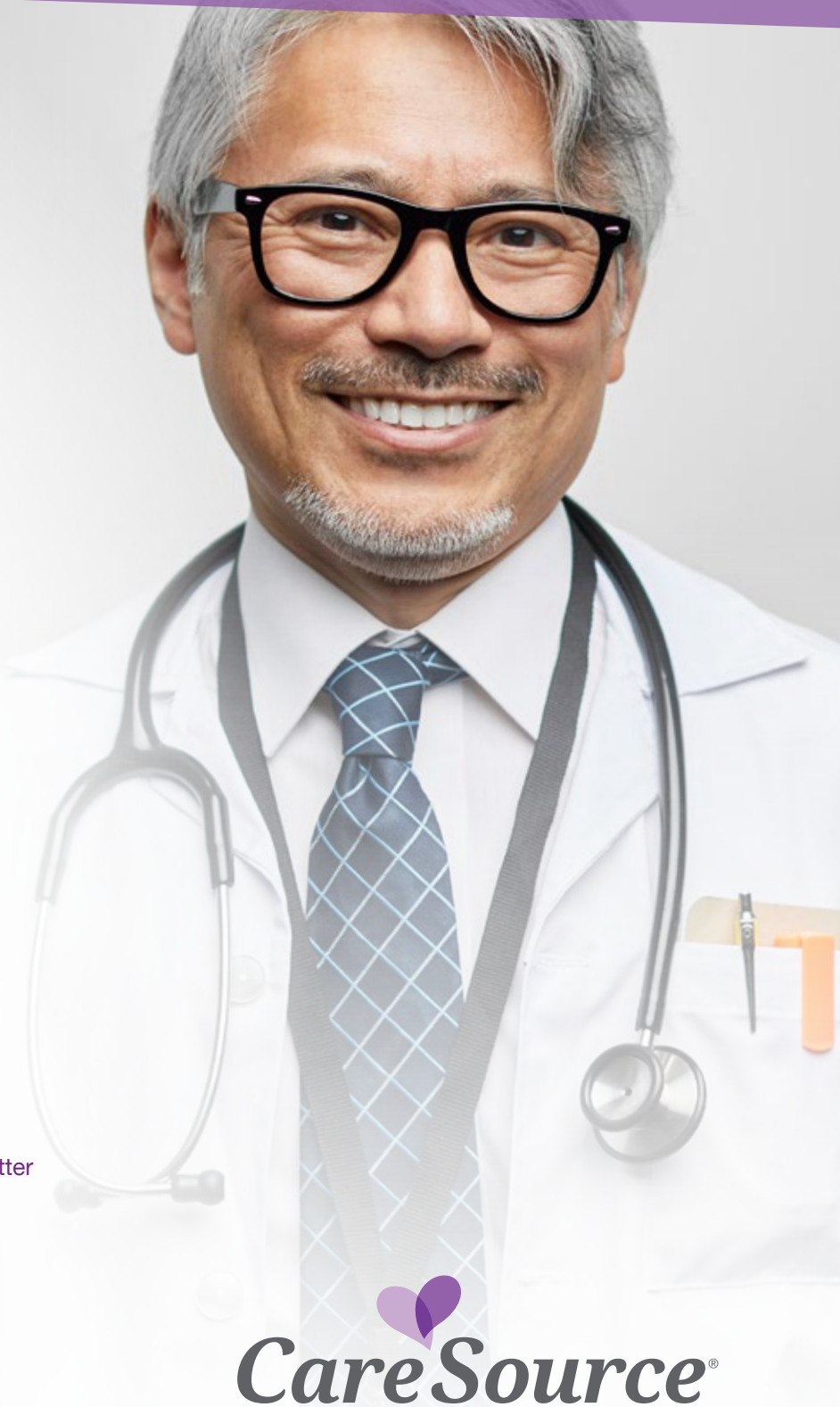
SPRING 2024

PROVIDER *Source*

A Newsletter for CareSource Health Partners



In This Issue:

CareSource®

Chief Medical Officer's Note

Thank you for your collaboration and partnership in providing health care with heart, which is what we believe in at CareSource. As you know, vaccinations play a pivotal role in safeguarding public health, particularly during the winter season when the prevalence of respiratory illnesses such as influenza, Respiratory Syncytial Virus (RSV), and COVID-19 escalate. These illnesses, characterized by similar initial symptoms, can lead to severe health complications, overburdened health care systems, and have profound socioeconomic repercussions. The importance of vaccinations during this period cannot be overstressed, as they are instrumental in reducing disease transmission, alleviating the strain on health care resources, and safeguarding vulnerable populations.

Firstly, vaccinations are crucial in reducing the transmission rates of these diseases. Winter conditions, marked by colder temperatures and indoor gatherings, create an ideal environment for the spread of respiratory viruses. Influenza and COVID-19, in particular, have demonstrated high contagion rates, leading to widespread outbreaks. Vaccinations induce an immune response without causing the disease itself, preparing the body to fight the virus promptly and effectively if exposed. By lowering the number of susceptible hosts, vaccinations can decrease the overall infection rate within a community, a concept known as herd immunity. This is particularly vital for protecting those who cannot be vaccinated due to medical conditions or age, such as newborns or individuals with certain allergies.

Secondly, vaccinations play a significant role in reducing the severity of these illnesses and alleviating the strain on health care systems. Hospitals and clinics often face overwhelming pressure during the winter months, with an influx of patients suffering from respiratory illnesses. This surge can lead to resource depletion, including hospital beds, medical supplies, and staff. By getting vaccinated, individuals not only reduce their risk of contracting these diseases but also, experience less severe symptoms that require hospitalization, if they do get sick. This helps to maintain the capacity and effectiveness of health care services, ensuring that both patients with respiratory illnesses and those with other medical needs receive timely and adequate care.

Vaccinations are especially crucial for protecting vulnerable populations, such as the elderly, infants, and those with pre-existing health conditions. These groups are at a higher risk of developing severe complications from respiratory illnesses, including pneumonia, organ failure, and even death. The COVID-19 pandemic underscored the lethal potential of novel viruses, particularly among these susceptible populations. Vaccinations not only shield these individuals from severe disease but also contribute to the broader control of disease spread within communities, thereby creating a safer environment for everyone.

As an indispensable public health tool, vaccinations are fundamental in curtailing disease transmission, especially during the winter season when the incidence of respiratory illnesses like influenza, RSV, and COVID-19 peak. Vaccines ease the burden on health care systems and protect the most vulnerable individuals in society. We thank you for advocating to keep our members healthy and safe during this season and all year long!

Sincerely,

Dr. Beejadi Mukunda

Vice President, Market Chief Medical Officer - Ohio

Kicking Off a New Year

Welcome to 2024 and a new year with CareSource! With 2024 underway, we are kicking off the year with several updates and resources you don't want to miss! We look forward to a successful year of serving our members and working with you to carry out the mission – to make a lasting difference in our members' lives by improving their health and well-being.

Meet Cuddles

Meet our mascot – Cuddles! This caring and energetic bear embodies the CareSource mission and may be at CareSource events near you. His resemblance to a teddy bear serves as a symbol of security and safety while characterizing loyalty and dependability, similar to how our members view providers like you.

Cuddles will serve as an ambassador and extension of the CareSource brand. You may see him at community events as he interacts with members and potential members in the communities we serve. Cuddles' appearances will promote wellness checks, nutrition, physical activity and oral health. If you see Cuddles at an event, make sure to say hi!

Network Notification Bulletin

CareSource regularly communicates operational updates on our website. Our goal is to keep you updated with a format that is quickly accessible and that keeps you informed about working with us. Here were some network notifications posted from the previous quarter that you may have missed:

- All D-SNP Providers – Changes in D-SNP Pharmacy Coverage: Preferred Diabetic Part B Glucometers, Test Strips and Continuous Glucose Monitors (CGMs)
- All D-SNP and Ohio MyCare Providers – Member Balance Billing
- Ohio Medicaid and MyCare Providers – ODM Medicaid Agreement Revalidations - PNM
- Ohio Marketplace Providers – Provider Training and Best Practices

Network notifications can be accessed at **CareSource.com** > Providers > Updates & Announcements.

CareSource would also like to remind you of our electronic policy postings, conveniently packaging medical, pharmacy, reimbursement and administrative policy updates into a monthly network notification for your review. You can also find our provider policies listed at **CareSource.com** > Providers > Provider Policies.

Prior Authorization Training Available!

In CareSource continues to build our Provider Education Series library, and we are happy to announce the recent addition of on-demand training for submission of prior authorization requests. **The Provider Education Series: Prior Authorization Submission Overview** reviews the steps that ensure CareSource receives all necessary information to review your request. You will find instruction on the use of the Procedure Code Lookup Tool, prior authorization submission process via the CareSource Provider Portal, and checking case status.

Go to https://www.caresource.com/providers/education/training-events/, select plan and state and look for Prior Authorization Submission Overview. Don't forget to review the list of additional training topics.

Senate Bill 267 – Relating to Prior Authorizations of Medical Services and Medications

(West Virginia Marketplace)

Senate Bill 267, a bill that modifies requirements regarding prior authorizations of medical services or medications, was signed into law on March 11, 2023, and will take effect on July 1, 2024. CareSource implemented these new requirements on Jan. 1, 2024. The bill is subject to Public Employees Insurance Agency (PEIA), Medicaid, Marketplace, and commercial health plans, and requires prior authorizations and related communications to be submitted via an electronic portal. Pursuant to the legislation, a health insurer must render a decision with respect to a completed prior authorization request within five business days. The turnaround time for urgent requests is two business days. If the prior authorization request is incomplete and the health care provider submits the necessary information within three business days causing the prior authorization request to be deemed complete, the insurer must render a decision within two business days after receipt of the additional information. With respect to appeals of a rejected prior authorization request, the time frame of the appeal process must take no longer than five business days from the date of any peer-to-peer consultation; however, a decision regarding a prior authorization appeal shall take no longer than ten business days from the date of the appeal submission.

In the event a health care provider has performed an average of thirty procedures per year and in a six-month time period during that year has received a 90% final prior approval rating, an insurer may not require the practitioner to submit a prior authorization for at least the next six months or longer if the insurer allows. This exemption is subject to internal auditing, at any time, by the insurer and may be rescinded if it is determined that the health care provider is not performing services or procedures in conformity with the insurer's benefit plan, or the insurer identifies substantial variances in historical utilization or other anomalies based upon the results of the insurer's internal audit. The insurer must provide a health care provider with a letter detailing the rationale for revocation of his or her exemption. Nothing with respect to the exemption provisions may be interpreted to prohibit an insurer from requiring a prior authorization for an experimental treatment, non-covered benefit or any out-of-network service or procedure.

Please contact your Health Partner Representative if you would like training or assistance on prior authorizations.

New Sandata Mobile Connect (SMC) Application for EVV Providers

(Ohio Medicaid)

A new SMC application was released in application stores in July 2023. This is an enhanced app with a focus on the end user experience. In addition to an updated look and feel that simplifies navigation, the update includes a simplified login process and efficient reset password process. For providers using their own devices, the old app will be available until June 30, 2024. Between now and then, no updates will be available for the old app, so be sure to download the new one.

The new SMC app can now be downloaded in either Android or Apple stores:

- *Apple*
- *Android*

Information on the new SMC app is available online at Sandata on Demand.

Telehealth Reference Guide

All Marketplace Providers

Following the COVID-19 pandemic, the entire health care system has embraced innovative ways to connect with patients and deliver timely acute, chronic, primary, and specialty care. Expansion of the use of telehealth remains an important means to connect with your patients and address quality care gaps.

In-office visits continue to be the preferred standard of care especially for new patient visits. However, telehealth claims should be coded as if the visit occurred in the office. When submitting telehealth claims ensure the appropriate CPT/CPT II code, procedure code, modifier and point of service (POS) codes are included. An in-person exam should occur at the next scheduled visit, when possible.

To support you in caring for CareSource members, we are sharing an updated **2023-2024 HEDIS® Telehealth reference guide**. This printable, online educational material provides important coding updates and criteria regarding specific HEDIS® care gaps that can be addressed through a remote visit (video or telephonic).

Together we can support more positive health outcomes through enhanced encounters with CareSource members, improve accurate reporting, and reduce the burden on providers of medical record requests during the annual HEDIS® audit. For additional assistance, please contact your **Health Partner Representative** or **Provider Services at 1-833-230-2101**.

Kick Off the New Year by Scheduling Preventive Visits and Earn Rewards

Providers, did you know that your patients get rewarded for completing healthy activities? Our rewards program supports gaps in care, and rewards members for taking charge of their health. These programs are free for the CareSource members if they are 18 and older, they are automatically signed up. Please see below for additional details on each program:

MyHealth Rewards - Ohio Medicaid & Georgia, Kentucky, Ohio and West Virginia Marketplace

- Members who are 18 years and older, are automatically signed up.
- To earn rewards, members must complete one of the eligible healthy activities such as A1C or breast cancer screening.
- Once claims are processed, the rewards will be added to their MyHealth Rewards account.
- Members will need to log in to their MyHealth account to redeem their points for electronic gift cards at participating retailers like WalMart.
- **Current year's rewards will expire in December of the following year, so please encourage members to use their hard-earned rewards!**
- To learn more about the rewards, please visit the appropriate rewards link webpage below:
  - Ohio Medicaid
  - Georgia, Kentucky, Ohio and West Virginia Marketplace

Babies First and Kids First – Ohio Medicaid

- For expecting mothers and children up through 17 years old.
- Each child or pregnancy must be enrolled.
- To earn rewards, members must complete one of the eligible healthy activities such as well visits.
- Once claims are processed, the rewards will be added to their CareSource Rewards card.
- The CareSource Rewards card can be used at various retailers to buy everyday items such as clothes, diapers, and groceries. **Rewards expire one year from issuance, so please encourage members to use their hard-earned rewards!**
- To learn more about the rewards, please visit the Rewards webpage.

My CareSource Rewards – Ohio D-SNP and Ohio MyCare Opt-In Members Only

- (Ohio MyCare Only) Opt-In members only; members are automatically signed up.
- To earn rewards, members must complete one of the eligible healthy activities such as an annual physical.
- Once claims are processed, the rewards will be added to their Health Benefits + card. Their card is a multi-purse wallet which contains their OTC, Healthy Foods and Rewards benefits.
- Their Rewards benefit can be used at participating retailers to buy everyday items such as groceries and clothing. **Encourage members to use their rewards as they expire one year from issuance!**
- To learn more about the rewards, please visit the rewards webpage below:
  - Ohio D-SNP
  - Ohio MyCare

Increasing Focus on Balance Billing Protection for Members

All D-SNP and Ohio MyCare Providers

Member Billing Policy, State and federal regulations prohibit providers from billing CareSource D-SNP members for services provided to them except under limited circumstances. CareSource monitors this activity based on reports of billing from members. We will implement a stepped approach in working with our providers to resolve any member billing issues that includes notification of excessive member complaints and education regarding appropriate practices. Failure to comply with regulations after intervention may result in potential termination of your agreement with CareSource.

Example of balance billing:

Also referred to as surprise billing, balance billing is when a provider bills a patient for the difference between the provider's charge and the allowed amount. For example, if the provider is charged $100, and the allowed amount is $70, the provider would bill the patient for the remaining $30.

To help reduce the instances of balance billing, remember the following steps:

- Verify a member's eligibility prior to each visit
- Be sure to check for a member's enrollment in **both** Medicaid and Medicare

Network providers may not balance bill CareSource D-SNP members for covered services. If you have questions regarding billing policies, please reach out to your health partner representative or call provider services at **1-833-230-2176** for D-SNP or **1-800-488-0134** for Ohio MyCare.

Prior Authorization Requests

Marketplace Providers

Prior authorization requests, related information and communications are to be submitted via an electronic portal. CareSource utilizes the Provider Portal for electronic submissions. If services require a prior authorization, this should be obtained prior to the start of services. To help streamline the prior authorization process, you can now check online utilizing our CareSource Procedure Code Lookup Tool to determine if a prior authorization is required for a service.

When utilizing the Provider Portal, a current NPI and Tax ID is needed with each prior authorization request. Provider Portal guidance can be found on **CareSource.com**.

Prior authorization requests that include all required information for review will be completed within the time frame shared below.

	Georgia Marketplace	**Kentucky Marketplace**	**North Carolina Marketplace**	**Ohio Marketplace**	**West Virginia Marketplace**
Urgent Turnaround Times	72 hours	24 hours	24 hours	48 hours	2 business days
Standard Turnaround Times	7 calendar days	5 calendar days	3 business days	10 calendar days	5 business days

For additional information on turnaround times, please utilize the Provider Manual on **CareSource.com**. Providers may check the authorization status and/or determination, as well as related notifications on the Provider Portal.

Model of Care Reminder

Georgia D-SNP, Ohio D-SNP & Ohio MyCare Providers

CareSource Dual Advantage serves people who are dually-eligible for Medicare and Medicaid. Our person-centered, integrated care model provides care coordination to a population with complicated health care needs. The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff to receive basic training about the D-SNP/MyCare Model of Care (MOC) and to complete annual refresher training.

CareSource provides this training on our website at **CareSource.com** > Providers > Training & Events. Providers are required by CMS to attest to completing the annual MOC training. Please complete the **Attestation Form** located at the end of the training presentation to receive credit for completing this training. If you have already completed this training for 2024, thank you!

For questions, please contact CareSource Provider Services
Monday through Friday, 8 a.m. to 6 p.m. ET:

- MyCare: **1-800-488-0134**
- D-SNP: **1-833-230-2176**

Where to Find It

CareSource strives to make it easy to find what you need online. Do you need to know who to reach out to when you have a need or question? There is a simple path to finding the most inclusive list of contact information. From the CareSource website select the provider drop-down menu and in the list on the left find the "Contact Us" hyperlink. Choose the appropriate plan to be connected to a full catalogue of contact information. If you are not able to find the information you are looking for you can reach out to the appropriate Provider Services phone number below.

- D-SNP: **1-833-230-2176**
- Marketplace: **1-833-230-2101**
- Ohio Medicaid & MyCare: **1-800-488-0134**

Did You Know?

The CareSource Provider Portal Functions and Features – The CareSource Provider Portal is a secure, encrypted online self-service tool that is available to all providers serving our members. Below are some of the features and capabilities available to you through the Provider Portal:

- *All plans except North Carolina Marketplace:* Verify member eligibility and confirm coordination of benefits
- Check claim payment status and submit any necessary documentation for claims processing
- Access explanation of payment and view claims payment history
- Submit updates for provider demographic and accessibility information, add a provider to a group, and check status of your submissions (including new contract status)
- View member care treatment plan and assessment information
- Manage your patient population by choosing Member Reports > Clinical Practice Registry. This is an online tool that helps identify attributed members who may have gaps in care.

New in 2024 – Providers can view a member's preferred language and/or specify a member's preferred language if is not yet indicated. This capability helps ensure that CareSource utilizes the member's preferred language through our member communication channels.

For more information about the Provider Portal, visit CareSource.com > Providers. To access the Portal or to register a new account, go to the Provider Portal Login page.

Provider Attestation: **The Key to Reliable Health Care Information**

Accurate provider data is crucial to providing high-quality health care services for our members. Given that members rely on provider directories to locate in-network providers, inaccurate provider directory data could obstruct access to care, create barriers to services critical for our members' health and well-being, and impact a member's ability to make informed health care choices. Furthermore, inaccurate provider data may negatively impact the adequacy and validity of the health plan's provider network and its compliance with Centers for Medicare & Medicaid Services (CMS) network adequacy requirements.

State and Federal regulations require that health plans must validate and update their contracted provider network every 90 days. This ensures the health plan has the most accurate information for claims payment and provider directories.

CareSource has partnered with BetterDoctor to streamline the attestation process. Providers can attest to their information via the BetterDoctor online tool – betterdoctor.com/validate. Locate the email or fax that you receive from BetterDoctor, as it has your access token to use when you attest to your information via the BetterDoctor online portal.

If you are a large group (groups with 20+ practitioners), you can submit rosters directly to Quest/BetterDoctor. Large groups can submit their rosters to rosters@questanalytics.com. The data you verify and update via the attestation process will be used to update **Find a Doctor | CareSource** provider directory and claims payment system.

If you do not attest to your information and provide updated information when applicable, this can result in claims payment issues and inaccurate provider data in the online provider directory, as well as the printed directory. With the No Surprises Act in effect as of Jan. 1, 2022, providers who do not attest quarterly risk being suppressed in their contracted payers' provider directories.

Care Management Support Tools

CareSource offers members and providers support resources from the Care Management teams. Materials include disease management guides and specialty population resources, which can be found on **CareSource.com**. These resources will allow you to view the state offerings that can be beneficial to your CareSource member and inform you of any regulatory components.

Pharmacy Updates for Medicaid and Marketplace

CareSource has a searchable drug list that is updated monthly on the website. To find out which drugs are covered under your plan, go to the Find My Prescriptions link under Member Tools & Resources. The most current updates can be found there also. If members do not have access to the internet, they can call Member Services for their respective market and plan. A CareSource Representative will help members find out if a medication is covered and how much it will cost.

Using the Prescription Drug Formulary to Improve Adherence

Marketplace Providers

Medication adherence improves patient outcomes. Prescribing for an extended days' supply and choosing lower cost medications may improve adherence. Up to a 90-day supply of medication can be dispensed by a community pharmacy if the medication is a generic maintenance medication or by a mail order pharmacy. (Specialty medications may have unique dispensing requirements and are usually limited to a 30-day supply.) You can identify lower cost medications by looking for medications in a lower tier on the formularies or on the formulary search tools. Patients pay lower costs for medications in lower tiers.

Georgia	Formulary	Formulary Search Tool	Prior authorization turnaround time = 48 hours
Indiana	Formulary	Formulary Search Tool	Prior authorization turnaround time = 72 hours
Kentucky	Formulary	Formulary Search Tool	Prior authorization turnaround time = 72 hours
North Carolina	Formulary	Formulary Search Tool	Prior authorization turnaround time = 72 hours
Ohio	Formulary	Formulary Search Tool	Prior authorization turnaround time = 72 hours
West Virginia	Formulary	Formulary Search Tool	Prior authorization turnaround time = 72 hours

You can also use the formulary to help you choose medications that do not require prior authorization which decreases administrative burden for your office and helps to get medication in your patients' hands faster. If the medication you choose does require a prior authorization, CareSource will review it and provide a decision within the designated prior authorization turnaround time from the original receipt of a standard pharmacy benefit request. The formulary search tool also includes the authorization criteria CareSource uses to approve and deny requests, and you can reference the tool to quickly see if your patient meets criteria. You can refer to the Provider Manual for more information about how prior authorization requests are processed.

How Do Your Patients Perceive You?

This article is not relevant for North Carolina Marketplace or Georgia D-SNP providers.

Every year from February through May, CareSource is required to conduct patient experience surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). In this anonymous survey, many of your CareSource patients will be asked questions about their experiences with providers and the health plan. It is the patients' chance to voice their opinion.

We know your team works hard to provide the best care for every patient on every visit! Our partnership makes a big impact on the patient's perception of their health care experience, and we are here to help.

Some things to consider:

- ✓ How would your patients rate the care you provide?
- ✓ Can patient appointments be scheduled "easily" and "as soon as needed"?
- ✓ Are your patients aware of your hours and where to go for urgent care?
- ✓ Will your patients think you are informed and participating in their health care plan?
- ✓ Will your patients think you spent time explaining things, including necessary vaccinations, test processes and results?
- ✓ How would your patients rate how well you listen carefully, show respect, and spend needed amount of time with them?

We appreciate all that you do and look forward to continuing as your partner in delivering a high standard of care!

MEDICAID ONLY - The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Health Equity Commitment, Words Matter

A new year brings thoughts of resolutions and commitments. Committing to health equity means ensuring that everyone has the opportunity to attain their highest level of health. One aspect to consider in this commitment is the environment that is cultivated by the language used in communicating with one another. In beginning a new year, contemplate a focus on employing inclusive language.

Inclusive language is language that is free from bias, stereotypes, or expressions that exclude or marginalize individuals or groups. In a health care setting, using inclusive language is essential to providing equitable care to all patients, regardless of their race, ethnicity, gender identity, sexual orientation, or any other characteristic.

Begin with this basic framework to select inclusive language:

- Use person-first language
- Rely on universally understood language, avoiding words understood only by a limited audience
- Avoid using a diagnosis in reference to everyday behavior
- Adopt gender-neutral language for all interactions

Additionally, health care providers can use language that is sensitive to the cultural and social backgrounds and circumstances of their patients.

By using inclusive language, health care providers create a more welcoming and respectful environment for all patients, building trust and improving communication between health care providers and their patients, ultimately leading to better health outcomes.

The opportunity to use inclusive language is an important step towards creating a health care system that is truly equitable and inclusive for everyone. Words matter!

To learn more about inclusive language, you can download a guide from The Association of American Medical Colleges (AAMC) at https://www.ama-assn.org/about/ama-center-health-equity/advancing-health-equity-guide-language-narrative-and-concepts.

We also invite you to visit CareSource's Health Equity webpage at https://www.caresource.com/providers/education/health-equity/.

Your Feedback is Important

Your feedback is important, and we want to hear from you! Starting in May, you may receive an email or phone call from Press Ganey requesting you to fill out the annual Provider Satisfaction Survey. This survey is an opportunity for you to share your thoughts on your experience working with CareSource. Questions include topics in finance (such as claims processing and billing), utilization management, pharmacy, member services, provider relations (such as credentialing and provider orientation), and networking. There is also a chance for you to offer suggestions on how CareSource can improve your experience.

Things to know about the survey:

- ✓ It will be conducted May through July.
- ✓ The survey will be emailed to the address on file, many times this is the credentialing office. Please update your email address.
- ✓ The sample is random.
- ✓ To minimize bias, a third-party vendor, Press Ganey, will conduct the survey.
- ✓ Three attempts will be made to reach the provider. In the event you need to return a call to complete the survey, Press Ganey can be reached at **1-866-864-8918**.
- ✓ While we ask questions about finance, we will never ask for confidential information.
- ✓ Your feedback will help guide our operation, marketing and strategic decisions.

The Patient Journey: Eliminating Disparities at Every Step

Earn CME/CE Credits for Your Commitment to Health Equity!

No patient's health care journey is the same. There are several factors that impact a patient's health outcomes such as geographic location, surroundings, social determinants of health (SDoH), and systemic bias within the health care community. Learning how these health disparities impact a member's experience can assist providers in developing patient-centered, high-quality care for our members.

CareSource, in partnership with CME Outfitters, is offering FREE training on many topics related to health equity. We encourage you, our valued health partner, to join us in this quarter's free training, The Patient Journey: Eliminating Disparities at Every Step. Check out their additional offerings here.

Upon completion of this CME/CE activity, participants should be able to:

- Analyze racial and ethnic disparities resulting in health inequities in patient care.
- Develop a team-based approach to improve the patient experience during visits.
- Determine treatment based on SDoH to improve accessibility and success of patient care and outcomes.

Digital Badging Reminder

CME Outfitters offers free digital badge credentials for completing education in Diversity & Inclusion. Learn more about this digital credential, earning criteria and skills.

Thank you for your partnership and commitment to eliminating health disparities!

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

The Centers for Medicare & Medicaid (CMS) and the National Committee for Quality Assurance (NCQA) have recognized that children/youth being prescribed/taking antipsychotics are at risk for an increased BMI, and impaired glucose and lipid metabolism. Because of this risk, the overall recommendation is for children (ages 1-17 years) on antipsychotics to be monitored annually with metabolic screenings. By incorporating this monitoring, there can be an increased recognition of potential problems, allowing for earlier intervention. For those children/adolescents that qualify for this measure, there are three rates to report:

- Outcome of blood glucose testing
- Outcome of cholesterol testing
- Outcome of both blood glucose and cholesterol testing (combined)

Often, a child's behavioral health provider is the prescribing physician of antipsychotic medications. Because of the physical component of what this measure is monitoring, it is important for the behavioral health provider and physical health provider to collaborate and coordinate care efficiently.

Codes that can be used to count toward this measure include:

- Glucose/HbA1c CPT: 80047-48, 80050, 80053, 80069, 82947, 82950-51, 83036, 3044F, 3046F, 3051F, 3052F
- LDL/Other Cholesterol CPT: 80061, 82465, 93700-07, 83704, 83718, 83721, 84478, 3048F, 3049F, 3050F

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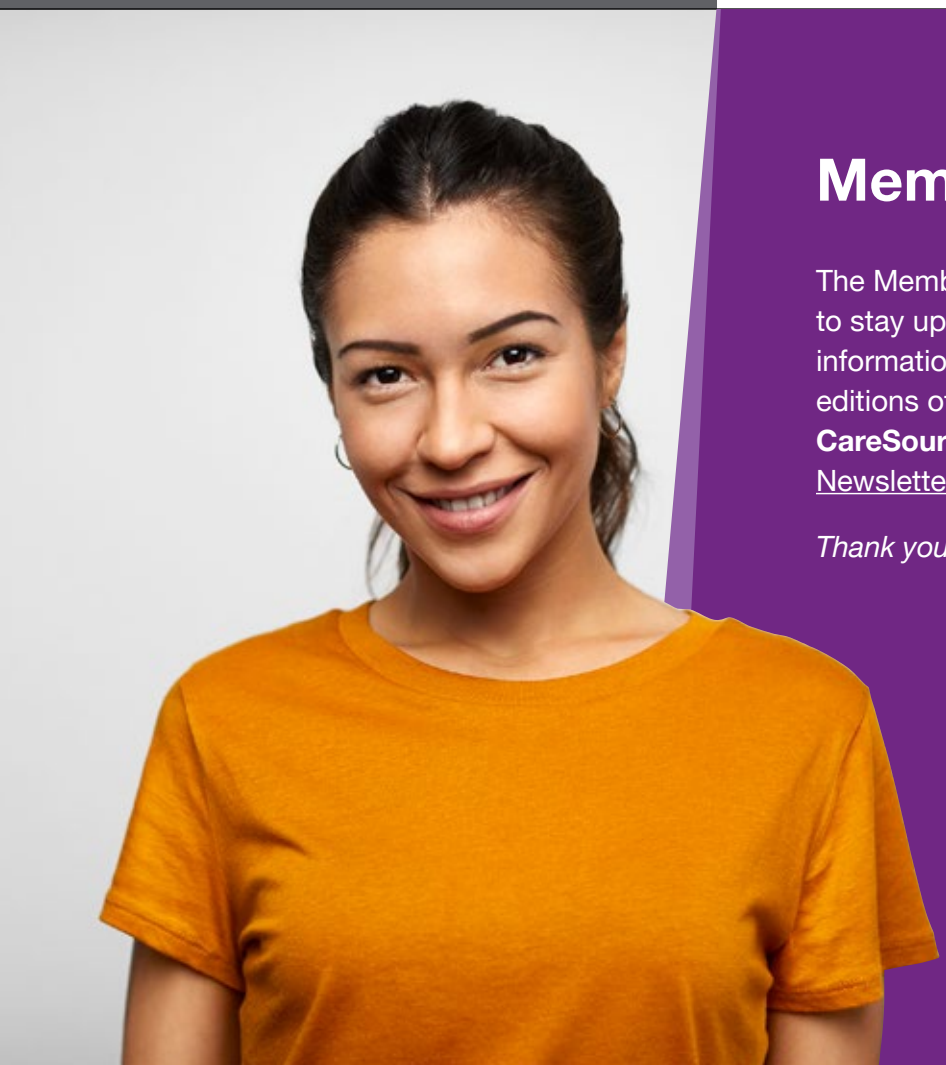

Member Corner

The MemberSource newsletter is a great resource to stay up-to-date with health, wellness and plan information for your CareSource patients. To view editions of the MemberSource newsletter, visit **CareSource.com** > Members > Education > Newsletters.

Thank you for your partnership!

Qualified Health Plans offered in North Carolina by CareSource North Carolina Co., d/b/a CareSource
Multi-Multi-P-2633753