aetna | MyCareOhio
Connecting Medicare + Medicaid

Participating Provider Orientation Kit Overview

Below is a description of the documents included in the Participating Provider Orientation Kit. This document is intended for providers who are participating in our plan.

Provider Welcome Letter	The Welcome Letter welcomes providers to our network.
Provider Quick Reference Guide	The Provider Quick Reference Quick Reference Guide is a snapshot of the Provider Manual.
Provider Service Authorization List	The Authorization List is a snap shot of services requiring authorization.
Medical Authorization Form	The Medical Authorization Form is used by providers when asking for medical service authorization.
Pharmacy Authorization Form	The Pharmacy Authorization Form is used by providers when asking for a pharmacy service authorization.
Participating Provider Dispute Form	The Provider Dispute Form is used in the event a provider is dissatisfied with us.
Contact List	The Contact List is a document comprised of our contact information as well as our vendors.
Identifying & Reporting Abuse, Neglect, and Exploitation of a member	The Abuse, Neglect, and Exploitation training document provides important resources and information pertaining to identifying and reporting abuse.
Fraud, Waste & Abuse Training	The Fraud, Waste, and Abuse (FWA) training document was created to help us detect, report, and prevent fraud, waste, and abuse. Our training includes CMS requirements surrounding provider FWA.
Cultural Competency Training	The Cultural Competency training document assists the provider in understanding the social, linguistic, moral, intellectual, and behavioral characteristics of our enrollee.
National Provider Identification (NPI) Requirements Training	The National Provider Identification (NPI) Requirements training document is used to assist the provider with understanding how to use their NPI and HIPAA standard electronic transactions.
Access & Availability Standards	The Access & Availability Standards document outlines the requirements a provider must follow when scheduling appointments with enrollees.
HCBS Waiver Reference Manual	The HCBS Waiver Reference Manual is an overview of the waiver program.
Additional forms are available on our site at **http://www.aetnabetterhealth.com/Ohio**/	

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7400 W. Campus Rd.
New Albany, OH 43054

Aetna Better Health® of Ohio
Provider Services
Phone: **1-855-364-0974**
Toll Free Fax: **1-855-826-3809**
www.aetnabetterhealth.com/Ohio

Dear Contracted Provider:

Aetna Better Health® of Ohio, a MyCare Ohio plan is proud to have been chosen by the Ohio Department of Medicaid (ODM) to participate in the State of Ohio's MyCare Ohio program. MyCare Ohio is a managed care program that will coordinate physical, behavioral and long-term care services for individuals age 18 and older who are eligible for both Medicare and Medicaid.

The goals of Aetna Better Health of Ohio's MyCare Ohio plan are to:
- Create a person-centered care management approach to improve the quality of care members receive.
- Comprehensively manage benefits across the continuum of care, including social and community services.
- Integrate services for all physical, behavioral, long-term care, and social needs.
- Utilize a payment structure that blends Medicare and Medicaid funding.

Aetna Better Health of Ohio is offering the MyCare Ohio plan in the counties listed below. Eligible members must reside in one of these counties to participate in the health plan. Members can choose Aetna Better Health of Ohio to provide only their Medicaid benefits or we can provide their Medicare benefits as well.

Northwest Region	Central Region	Southwest Region
Fulton	Delaware	Butler
Lucas	Franklin	Clermont
Ottawa	Madison	Clinton
Wood	Pickaway	Hamilton
	Union	Warren

Our network in these areas is made up of doctors, hospitals, pharmacies, and providers of long-term and community-based services and supports. Care managers and care teams will help members receive the services that they need.

Our ability to serve our members well is dependent upon the quality of our provider network. Our providers are the cornerstone of our service delivery approach. By joining our network you help us achieve our goal of providing our members with access to high quality health care services.

We have assembled the enclosed Provider Orientation Kit to help acquaint you and your staff with the Aetna Better Health of Ohio MyCare Ohio plan. We hope you find this information to be useful. Should you have any questions or concerns, please contact us directly at: **1-855-364-0974** or via email at **OH_ProviderServices@AETNA.com**

Sincerely,

Rick Welch
Director, Provider Services
Aetna Better Health of Ohio

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Participating Provider Quick Reference Guide

This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the Aetna Better Health of Ohio Provider Manual located at **www.aetnabetterhealth.com/Ohio**.

Eligibility verification

Please contact us at **1-855-364-0974** or log into our Secure Web Portal to verify eligibility.

Tools & Resources

Website

- Provider Manual
- Evidence of coverage
- 24/7 Secure Web Portal (See below for full details)
- Clinical guidelines
- Forms
- Provider education
- News and Notices
- Sign up for provider newsletters

Secure Web Portal (24/7)

The Secure Web Portal allows participating providers to perform a variety of tasks such as:

- Verifying eligibility
- Download various forms used to submit authorization requests
- Submission and verification of prior authorization requests, including status checks
- Review prior authorization requirement search tool
- Checking claims status
- Pull PCP roster of assigned members
- Access remittance advice
- Submit claim disputes (PAR providers)

Participating providers must complete our user agreement in order to access the Secure Web Portal. The web portal registration, electronic funds transfer, and electronic remittance advice forms are included in this toolkit.

Claims

Claim inquires

Participating providers may review the status of a claim by checking the Secure Provider Web Portal located on our website at **www.aetnabetterhealth.com/Ohio**. or by calling our Claims Investigation and Research Department (CICR) at **1-855-364-0974**.

Claims and resubmissions

We require clean claims submissions for processing. To submit a clean claim, the participating provider must submit:

- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure

Participating providers are required to submit valid, current HIPAA compliant codes that most accurately identify the member's condition or service(s) rendered.

Electronic claims submission

We encourage participating providers to electronically submit claims through Change Healthcare (formerly Emdeon). Use submitter ID #50023 and provider ID #0082400 when submitting claims to Aetna Better Health of Ohio.

For electronic resubmissions, participating providers must submit with resubmission code 7.

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Paper claims submissions and/or resubmissions

Please use submitter ID #50023 and provider ID #0082400 when submitting claims to Aetna Better Health of Ohio.

Please use the following address when submitting paper claims to us:

Aetna Better Health of Ohio (MyCare Ohio Program)
PO Box 64205
Phoenix, AZ 85082

Resubmitted claims should be clearly marked “Resubmission” on the envelope.

Online claim status through our secure web portal

We encourage providers to take advantage of using our secure web portal, as it is quick, convenient, and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The secure web portal is located on our website. Providers must register to use our portal. Please see Chapter 4 of the provider manual for additional details surrounding the secure web portal.

Claim Reconsideration (Dispute)

Participating Providers may have a claim reconsidered for claims incorrectly paid or denied because of processing errors

For instructions on how to submit a dispute please refer to the Participating Provider Claim Disputes on page 15**

Providers may call our CICR Department during regular office hours to speak with a representative about their claim dispute. The CICR Department will be able to verbally acknowledge receipt of the claim dispute. Our staff will be able to discuss, answer questions, and provide details about status.

Prior Authorizations

Aetna Better Health of Ohio will not reimburse for medically unnecessary or other non-covered services or for services provided to enrollees who are not enrolled in and eligible for the MyCare Ohio Program, on the date(s) of service

How to request prior authorizations

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 secure web portal located on our website at www.aetnabetterhealth.com/Ohio.
- Fax the request form (form is available on our website) to **1-855-365-8108**.Please use a cover sheet with the practice’s correct phone and fax numbers to safeguard the protected health information and facilitate processing.
- Calling the Aetna Better Health of Ohio Prior Authorization Department at **1-855-364-0974**.

To check the status of a prior authorization you submitted or to confirm that we received the request, visit the Secure Web Portal at **www.aetnabetterhealth.com/Ohio**, or call us at **1-855-364-0974**. The secure provider portal will allow you to check status and view history.

For further information about the Secure Web Portal, please review Chapter 4 of the Provider Manual.
If response for non- emergency prior authorization is not received within 15 days, please contact us at **1-855-364-0974**.

Requesting Prior Authorization

When requesting prior authorization, please provide the following:

- Member’s identification number
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- Date(s) of service (DOS)

Important note:
- Emergency services do not require prior authorization; however, notification is required the same day.
- For post stabilization services, hospitals may request prior authorization by calling **1-855-364-0974**.
- All out of network services must be authorized.
- Unauthorized services will not be reimbursed and authorizations are not a guarantee of payment

Services that require prior authorization:
- DME
- Home Based Services/Modifications
- Hospice
- Imaging
- Injectables
- Inpatient Services (All)
- Nursing Services
- Rehabilitation
- Sleep Studies
- Surgical Services

Decision/Notification Requirements

Decision	Decision/Notification Timeframe
Urgent pre-service approval	Forty-eight (48) hours hours from receipt of request
Urgent pre-service denial	Forty-eight (48) hours hours from receipt of request
Non-urgent pre-service approval	Ten (10) calendar days from receipt of the request
Non-urgent pre-service denial	Ten (10) calendar days from receipt of the request
Urgent concurrent approval	Twenty-four (24) hours of receipt of request
Urgent concurrent denial	Twenty-four (24) hours of receipt of request
Post-service approval	Thirty (30) calendar days from receipt of the request
Post-service denial	Thirty (30) calendar days from receipt of the request
Termination, Suspension Reduction of Prior Authorization	At least fifteen (15) calendar days before the date of the action.

Exceptions may shorten the decision/notification time.”

Online Provider & Pharmacy Search Tool

For a list of participating providers, including behavioral health, please access our online search tool located on our website at: **www.aetnabetterhealth.com/Ohio.**

Please note: Laboratories and radiology participating providers are included in the online search tool.

For information on how to access behavioral services, please contact us at 1-855-364-0974.

Contact Information:
- **Health Plan Administration: 1-855-364-0974**
- For Vision, Dental, Transportation, and Behavioral questions, please call the Health Plan directly and select the corresponding option.
- **CVS (Pharmacy): 1-855-364-2975**
- **Change Healthcare: 1-800-845-6592**
- **Ohio Relay: 7-1-1**

When treating a person who is a wheelchair user:
- Provide access to exam areas.
- Provide assistance if necessary (for a full and complete exam, even if it requires more time or assistance).
- Respect personal space, including wheelchairs & assistive devices.
- Avoid propelling wheelchair unless asked.
- Obtain adjustable exam tables for your facility, if possible.

If your office is currently handicap accessible but is not identified as such on Aetna Better Health of Ohio’s directory please email us at **OH_ProviderServices@aetna.com** to request your record be updated.

Specialty Providers

It is important to remember that only covered services will be reimbursed by Aetna Better Health of Ohio for approved facilities and/or contracted providers. However, enrollees are permitted to see the following provider types even though they may not be contracted with Aetna Better Health of Ohio:

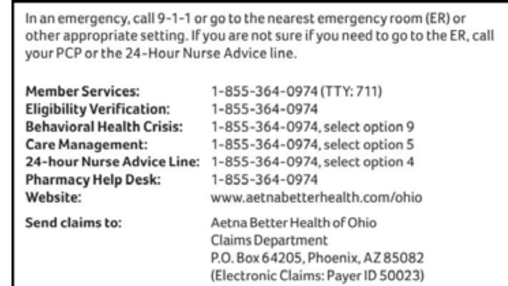
- Emergency Services
- Urgent Care (for urgent needed services)
- Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)
- Qualified Family Planning Provider (QFPP)
- An Aetna Better Health of Ohio approved out-of-network provider
- Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP)- Enrollees are assured access to these provider types. If a contracted provider is available, enrollees must see the contracted provider. If an enrollee cannot locate a contracted provider, they can contact Aetna Better Health of Ohio for assistance.

Please contact the Provider Services Department for further clarification on how members access these services at **1-855-364-0974**.

Sample of Medicare - Medicaid ID Cards

Front:

Back:



First-Tier, Downstream and Related Entities (FDR) Training

If you are a participating provider in our network, and you have not already done so, you and your staff must complete the Medicare Compliance FDR Attestation. See page number 72.

- https://www.aetna.com/health−care−professionals/medicare.html-works
- Please see link provided for more information on First Tier, Downstream and Related Entities (FDR) Medicare Compliance Program Guide.
- http://www.aetna.com/healthcare-professionals/fdr/medicare-compliance-program-guide.pdf
- Additional resources can be found on our website, please see the links below.
- https://www.aetnabetterhealth.com/ohio/providers/resources/tools

Healthchek

Healthchek is Ohio's early and periodic screening, diagnostic and treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for Aetna Better Health of Ohio members under the age of 21 years. These exams are important to make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams, and children should have exams at birth, 3-5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one exam per year.

Healthchek also covers complete medical, vision, dental, hearing, nutritional, developmental, and mental health exams, in addition to other care to treat physical, mental or other problems or conditions found by an exam. Healthchek covers tests and treatment services that may not be covered for people over age 20; some of the tests and treatment services may require prior authorization.

For more information please visit our website:
https://www.aetnabetterhealth.com/ohio/members/resources/healthchek

2018 Aetna Better Health of Ohio® Prior Authorization (PA) List

DME
Please refer to code specific listing as requirements may vary. In general the following require authorization:
- CPAP
- Hospital beds
- Oxygen
- Wheelchairs

Dental
- Apexification/recalcification
- Apicoectomy
- Casts
- Crowns
- Oral Surgery
- Orthodontics
- Prosthodontics

Home based services including hospice

Injectables
All therapy management services provided by a pharmacist. Please refer to code specific listing as requirements may vary.

Imaging
- Angiography
- MRA
- MRI
- PET scans

Inpatient services (All)
- Hospice
- Rehabilitation
- Skilled nursing
- Surgical and non- surgical

LTSS services (All)

Orthotics / Prosthetics
- Electronic devices
- Implantable breast prosthetics
- Injectable bulking agents
- Implantable devices

Outpatient Services
Services vary based upon the code and are not location specific. Please check the code specific listings for details.

Surgical services
Please refer to code specific listing as requirements may vary.

Therapy
All Therapy services require authorization with the exception of therapy diagnostic analysis and therapy evaluations.

Transportation
Please refer to code specific listing as requirements may vary

Other
- Acupuncture (requires authorization after 30 visits)
- Enteral feeding supply and formulas, additives all pumps
- Genetic or infertility counseling or testing services
- Hearing and vision services vary
- Non-Routine Dental Services
- Osteopathic manipulation and chiropractic services
- Sleep Studies
- Specialized Multidisciplinary Services
- Supply based services vary please refer to specific code
- Unlisted Codes require authorization

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Ohio Department of Medicaid's Behavioral Health Prior Authorization (PA) List:

Description and Code	Benefit Period	Authorization Requirement
Assertive Community Treatment (ACT): H0040	Based on prior authorization approval	ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees.
Intensive Home Based Treatment (IHBT) : H2015	Based on prior authorization approval	IHBT must be prior authorized.
SUD Partial Hospitalization (20 or more hours per week)	Calendar year	Prior authorization is required for this level of care for adults and adolescents.
Psychiatric Diagnostic Evaluations: 90791, 90792	Calendar year	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization once limit is reached.
Psychological Testing: 96101, 96111, 96116, 96118	Calendar year	Up to 12 hours/encounters per patient per calendar year for 96101, 96111, and 96116, and 8 hours of 96118. Prior authorization once limit is reached
Screening Brief Intervention and Referral to Treatment (SBIRT): G0396, G0397	Calendar year	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization once limit is reached.
Alcohol or Drug Assessment: H0001	Calendar year	2 hours per patient per calendar year per billing agency. Does not count toward ASAM level of care benefit limit. Prior authorization once limit is reached.
SUD Residential: H2034, H2036	Calendar year	Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay, if not, only the initial 30 consecutive days are reimbursed. Applies to first two stays; any stays after that would be subject to full prior authorization.
Any service or ASAM level of care not listed in this table is not subject to prior authorization.		

Please refer to Ohio Department of Medicaid's Provider Requirements and Reimbursement Manual final version: 1.4 published on December 4, 2017. The most recent version can be located at **bh.medicaid.ohio.gov/manuals**.

- No authorization is required for emergency services.
- This document represents the majority of services requiring authorization. Please refer to the code specific listing for details.
- Aetna Better Health of Ohio is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.
- Aetna Better Health of Ohio will publish a 30 days advance notice at **www.aetnabetterhealth.com/Ohio** of changes to the PDL, the list of drugs requiring PA or any other service or device requiring PA. In addition, 30 days prior to all PA requirement changes, Aetna Better Health will notify providers, via email or standard mail, the specific location of prior authorization change information on the website, pursuant to ORC 5160.34(B)(9-10).
- You can get this information for free in other languages. Call **1-855-364-0974**, TTY **711**, 24 hours a day, 7 days a week. The call is free.
- Puede obtener esta información en otros idiomas de manera gratuita. Llame al **1-855-364-0974** y TTY al **711**, 24 horas al día, siete días de la semana. Esta llamada es gratuita.

Prior Authorization Form

7400 West Campus Road
New Albany, OH 43054
Phone: 1-855-364-0974, TTY: 711
Fax: 1-855-734-9389

Date of Request:________________________________

For urgent requests (required within 24 hours), call Aetna Better Health of Ohio at **1-855-364-0974**.

For Inpatient Acute Physical Health and Behavioral Health Requests for ACT (H0040), IHBT (H2015), and SUD Residential Treatment (H2034, H2036) please use fax **1-855-734-9393**. For all other Physical Health and Behavioral Health Service authorization requests please use fax **1-855-734-9389**.

Member information

Name: ________________________________ ID Number: ________________________________

Date of Birth: ________________________________ Physician Name: ________________________________

Other Insurance: ________________________________ Gender (circle one): F M

Requesting physician or provider information

Referring Provider / Requesting Provider

Name: ________________________________

Address: ________________________________

Telephone #: ________________________________

Fax #: ________________________________

Specialty: ________________________________

National Provider Identification (NPI): ____________

Contact Person: ________________________________

Place of Service or Facility Name

Name: ________________________________

Address: ________________________________

Telephone #: ________________________________

Fax #: ________________________________

Specialty: ________________________________

NPI: ________________________________

Contact Person: ________________________________

Referral / authorization information

Problem / Diagnosis (ICD-10 Code(s)): ________________________________

____

Procedure / Test Requested (CPT Code(s)): ________________________________

____

Date of Appointment or Service: ____________ Number of Visits Required: ____________

Type of Procedure (circle one): Inpatient Outpatient In-Office

Other Clinical Information - Include clinical notes, lab and X-ray reports, etc. (For procedures, please attach additional pages as necessary.): ________________________________

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Ohio MyCare Authorization Form

Community Behavioral Health Services

Aetna **855-734-9389** (routine) | **855-734-9393** (expedited)
Buckeye **877-725-7751** | CareSource **937-487-1664**
Molina **866-449-6843** | UHC **855-633-3306**

Member information

Plan: ☐ MyCare ☐ Medicaid Date of Request: ____________________ Request Type: ☐ Initial ☐ Concurrent

Member Name: ______________________________ DOB: ______________________

Member ID #: ______________________________ Member Phone: ________________

Service Is: ☐ Routine ☐ Expedited/Urgent**
(Please mark expedited for ACT, IHBT, or SUD Residential request

Provider information

BillingProvider/AgencyName and Service Location: ______________________________

Provider NPI/Provider Tax ID# (number to be submitted with claim): ______________________

Contact Name: ______________________________Phone#/Fax#: ________________

Provider Status: ☐ PAR ☐ Non-PAR Member Court Ordered? ☐ Yes ☐ No

Member information

Service is for: ☐ Mental Healty ☐ Substance Use

Assertive Community Treatment*	H0040			
Intensive Home-Based Treatment*	H2015			
SUD Partial Hospitalization	H0015			
SUD Residential Treatment	H2034	H2036		
Behavioral Health Respite*	S5150	S5151		
Psychological Testing	96101	96111	96116	96118
SBIRT Services	G0396	G0397		
Psychiatric Diagnostic Evaluation	90791	90792		
Alcohol or Drug Assessment	H0001			
Specialized Recovery Services Program	T1016	H0038	H2023	H2025
Partial Hospitalization (Medicare only)	G0410	G0411		
Other Services/Out of Network Providers:				
Primary Diagnosis (ICD-10)				

**Providers should attach clinical documentation (e.g. Assessment Summary, ISP with Diagnostic Summary, Clinical Summary) to provide justification that the member meets criteria for a service. Services marked with an asterisk (*) may require additional assessment results to be provided (e.g. ANSA, CANS [including CIP-IHBT version], Achenbach).

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Clinical Symptoms & Social Barriers

- ☐ Suicidal ideations/plan/attempt
- ☐ Homicidal ideations/plan/attempt
- ☐ History of Suicidal/Homicidal actions
- ☐ Hallucinations/Delusions/Paranoia
- ☐ Self-Mutilation (ex. cutting/burning self)
- ☐ Mood Lability
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Appetite Changes
- ☐ Significant Weight Gain/Loss
- ☐ Panic Attacks
- ☐ Poor Motivation
- ☐ Cognitive Deficits
- ☐ Somatic Complaints
- ☐ Anger Outbursts/Aggressiveness
- ☐ Inattention
- ☐ Impulsivity
- ☐ Legal Issues
- ☐ Problems with Performing ADL's
- ☐ Poor Treatment Compliance
- ☐ Social Support Problems
- ☐ Learning/School/Work Issues
- ☐ Substance Use Interfering with Functioning
- ☐ Homeless/Housing Instability

**Providers should attach clinical documentation (e.g. Assessment Summary, ISP with Diagnostic Summary, Clinical Summary) to provide justification that the member meets criteria for a service. Services marked with an asterisk (*) may require additional assessment results to be provided (e.g. ANSA, CANS [including CIP-IHBT version], Achenbach).

Request for Medicare prescription drug coverage determination

This form may be sent to us by mail or fax:

Address:
Aetna Better Health of Ohio
Part D Coverage Determination
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Fax Number:
Part D Coverage Determinations
1-855-365-8108

You may also ask us for a coverage determination by phone at **1-855-364-0974** or through our website at **aetnabetterhealth.com/ohio**.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

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Type of Coverage Determination Request

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

☐ I request prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower

☐ copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

Additional information we should consider *(attach any supporting documents)*:

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☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature:	Date:

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature	Date	

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	
Height/Weight:	Drug Allergies:	Diagnosis:

Rationale for Request

☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome]

☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason]

☐ **Request for formulary tier exception** [Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome]

☐ Other (explain below)

Required Explanation ____

____

____

____

Aetna Better Health of Ohio is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

You can get this information for free in other languages. Call **1-855-364-0974**, TTY **711**, 24 hours a day, 7 days a week. The call is free.

Puede obtener esta información en otros idiomas de manera gratuita. Llame al **1-855-364-0974** y TTY al **711**, 24 horas al día, siete días de la semana. Esta llamada es gratuita.

Waxaad macluumaadkaan oo lacag la'aan ah ku heli kartaa luqado kale. Wac **1-855-364-0974** (TTY: **711**) 24 saac maalintii, 7 maalin halkii todobaad. Wicidda waa lacag la'aan.

Participating Provider Claim Disputes

Aetna Better Health of Ohio and our participating providers are responsible for timely resolution of any disputes between both parties. Disputes, also known as reconsiderations, will be settled according to the terms of our contractual agreement and there will be no disruption or interference with the provision of services to enrollees as a result of disputes.

We will inform providers through the Provider Manual and other methods including provider Newsletters, trainings, provider orientation, webinars, the website, and through provider inquiries to their Provider Services Representative about the claims dispute process.

Our Provider Services Representatives are available to discuss a provider's dissatisfaction with a decision based on this policy and contractual provisions, inclusive of claim disputes.

To have a claim reconsidered through our claim dispute process for par providers, the contracted provider may submit using one of two methods:

1. The PAR Provider Claims Dispute Form (provided on page 16)
   - This form is accessible on our website under the "For Providers" link, under "Forms" and then PAR Provider Dispute Form.
   - Complete and submit the PAR Provider Claims Dispute Form along with the claim and any appropriate supporting documentation (if applicable) to:
     Aetna Better Health of Ohio
     P.O. BOX 64205
     Phoenix, AZ 85082
2. Providers may also submit disputes electronically
   - Please log into the Secure Provider Web Portal located on our website under the 'For Providers' link at **https://www.aetnabetterhealth.com/ohio/providers/portal**.
   - For instructions, please visit our website under the 'For Providers' link, and click on Resources, then Tools & Resources. Here, you will find a PDF document under Online Provider Dispute Instructions to walk you through the process. You will also be required to upload any supporting documentation required for the reconsideration of your claim related to your Dispute.

Claims Disputes for Participating providers are delegated to the Claims Investigation / Claims Research Department for review, research and analysis. Providers will be notified of the decision for a Claim Dispute via remit (along with claim edits and descriptions) for reprocessed claim, or if the Claim Dispute was incomplete, a letter will be sent to the provider indicating that the Dispute could not be processed and will need to be resubmitted.

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PAR Provider Dispute Form

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If you are a PAR (Contracted) Provider, you may use this DISPUTE Form to have your claim reconsidered. Please be sure to fill this form out completely and accurately to ensure proper handling of your Dispute. NOTE: For faster processing, you may also submit your Dispute thru our Secure Provider Web Portal. Instructions can be found on our website at **https://www.aetnabetterhealth.com/ohio/providers/resources/tools**.

Send To:
AETNA BETTER HEALTH OF OHIO
P.O. BOX 64205
PHOENIX, AZ 85082

Select the appropriate reason for your Dispute (Incomplete or missing information may result in your Dispute being returned or decision upheld):

- ☐ Incorrect Denial of Claim or Claim Line(s)
- ☐ Incorrect Denial of Authorized Service
- ☐ Code or Modifier Issue
- ☐ Medical Necessity
- ☐ Incorrect Rate Payment
- ☐ Other ______________________

Your Dispute Must Include:

- This Completed Form
- Factual or legal basis for dispute statement (separate page)
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation, CMS or Medicaid references as needed, for Opt-Out members: EOB from primary Medicare payer, copy of auth, etc.)

You may use this form to supply necessary information, along with your attachments as indicated above, to enable a thorough reconsideration of all disputes.

Provider Name:	
Provider NPI:	
Submitter's name:	
Provider Street Address:	
Provider City, State & ZIP	
Provider Phone Number:	
Date(s) of Service:	
Remittance Advice Date:	
Amount Billed:	
Amount Paid:	
Claim Number(s):	
Member Name:	
Member ID #:	

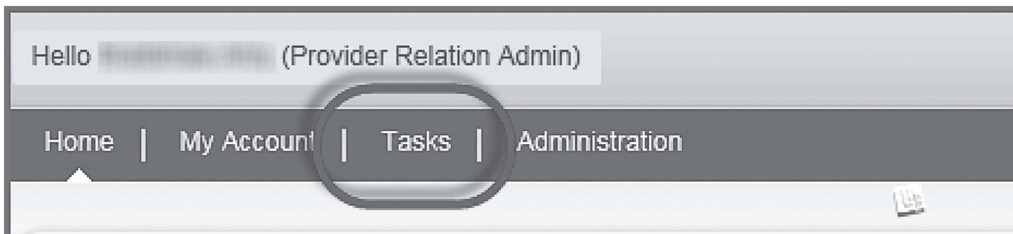
Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-855-364-0974 Monday - Friday, 8:00 AM to 5:00PM EDT. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.

Please see below for instructions on how to submit a Participating Provider Dispute through the Secure Provider Portal:

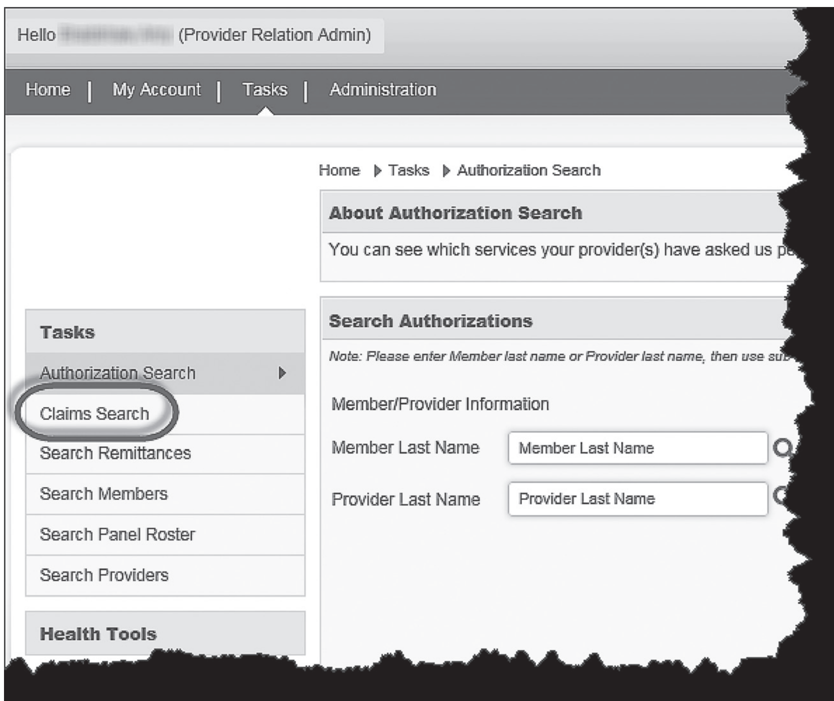
Dispute Steps though Web Portal

(Please note, this is not the process for a corrected claim. Corrected claims can be submitted through the same process as submitting a new claim using our WebConnect tool and designating the claim as a corrected claim.)

1. The Provider logs into the Secure Provider Portal **Medicaid Web Portal (MWP)**.
2. Click on **Tasks** from the banner on the top



3. Click on **Claims Search** located in the left pane under "Tasks".



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4. The **Provider Name** should default to the logged in provider. Enter **Claim ID**, and click the **search** button at the lower right.

5. The Search results grid will load.

6. The Provider will see "**Claim Deliverable**" link under the **Claim Deliverable** column in the Search results grid. Click on the **Claim Deliverable** link to begin the Dispute process for the selected claim.

7. This will take the Provider to the Upload Claim Deliverables screen.
8. Most of the information on the screen will be 'Auto populated' based on the claim number
9. Provider will select a Type of Claim Resubmission (Dispute) from the dropdown and enters the information in the relevant Mandatory fields;
   a. **Submitter's First Name,**
   b. **Submitter's Last Name, &**
   c. **Submitter's Phone Number**

Upload Claim Deliverables

This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals

Claim Number	14210E32035	Type of Claim Resubmission	---Select---	NPI	1043293632
Provider Name	OLIN, KEVIN S	Submitter's First Name		Submitter's Last Name	
Submitter's Phone Number		Provider Street Address	6225 S Rural Rd Ste 111	Provider City	Tempe
Provider State	AZ	Provider ZIP	85283	Provider Contact Number	4807207488
Remittance Advise Date		Date of Service (From)	04/02/2014	Date of Service (To)	04/02/2014
Amount Billed	235.0000	Amount Paid	124.9800	Member Name	QSYSYT33, PQOFJS32
Member ID	932865088	Comments			

Browse...

Submit

10. The **Comments** field is a mandatory input required, when the selected Type of claim Resubmission (Dispute) is "Other"

Upload Claim Deliverables

This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals

Claim Number	14210E32035	Type of Claim Resubmission	---Select---	NPI	1043293632
Provider Name	OLIN, KEVIN S	Submitter's First Name		Submitter's Last Name	
Submitter's Phone Number		Provider Street Address	6225 S Rural Rd Ste 111	Provider City	Tempe
Provider State	AZ	Provider ZIP	85283	Provider Contact Number	4807207488
Remittance Advise Date		Date of Service (From)	04/02/2014	Date of Service (To)	04/02/2014
Amount Billed	235.0000	Amount Paid	124.9800	Member Name	QSYSYT33, PQOFJS32
Member ID	932865088	Comments			

Browse...

Submit

11. The Provider can upload supporting documentation (any type of file) from here by clicking the "**Browse**" button and thus activating the Browse functionality.

Upload Claim Deliverables

This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals

Claim Number	14210E32035	Type of Claim Resubmission	---Select---	NPI	1043293632
Provider Name	OLIN, KEVIN S	Submitter's First Name		Submitter's Last Name	
Submitter's Phone Number		Provider Street Address	6225 S Rural Rd Ste 111	Provider City	Tempe
Provider State	AZ	Provider ZIP	85283	Provider Contact Number	4807207488
Remittance Advise Date		Date of Service (From)	04/02/2014	Date of Service (To)	04/02/2014
Amount Billed	235.0000	Amount Paid	124.9800	Member Name	QSYSYT33, PQOFJS32
Member ID	932865088	Comments			

Browse...

Submit

12. On successful attachment of the supporting documentation, the Provider clicks "**Submit**" at the bottom and receives a **Confirmation message** window. Upon clicking "**Yes**" the provider receives a success message, completing the workflow for submission.

Confirmation

Are you sure you want to Submit this Claim deliverable?

✔Yes ✖ No

Upload Claim Deliverables

This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals

Claim Deliverable has been submitted successfully !!!

13. The Provider can view a previously submitted document (any type of file) from the below screen through clicking the link under the **Claim ID** column of the displayed grid, thus activating the **View Deliverable** functionality.

14. The submitted resubmission form is displayed, and the user can view the previously submitted information on the form and download the attachment by clicking the **Download File** button or through the **Button** below the **View Deliverable** column of the displayed Grid.

Resubmission Form ✖

Claim Number(s):	14210E32035
Type of Claim Resubmission:	Medical Records Required
NPI:	1043293632
Provider Name:	OLIN, KEVIN S
Submitter's name:	Tejas, Moola
Submitter's Phone Number:	7654329876
Provider Street Address:	6225 S Rural Rd Ste 111
Provider City:	Tempe
Provider State:	AZ
Provider Zip:	85283
Provider Phone Number:	4807207488
Date of Service (From):	4/2/2014 12:00:00 AM
Date of Service (To):	4/2/2014 12:00:00 AM
Remittance Advise Date:	
Amount Billed:	235.0000
Amount Paid:	124.9800
Member Name:	QSYSYT33, PQOFJS32

Contact List

Important Contacts	Phone Number	Hours and Days of Operation (excluding state of Ohio holidays)
Aetna Better Health of Ohio through Voice Mail inbox	**1-855-364-0974** (follow the prompts in order to reach the appropriate departments)	8 a.m.-5 p.m. EST Monday-Friday
Aetna Better Health of Ohio Compliance Hotline (Reporting Fraud, Waste or Abuse)	**1-866-253-0540**	24-hours-a-day 7-days-a-week
Aetna Better Health of Ohio Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse)	**1-800-338-6361**	24-hours-a-day 7-days-a-week

Aetna Better Health of Ohio Department Fax Numbers	Facsimile
Member Services	**1-855-259-2087**
Provider Services & Provider Claim Disputes	**1-855-826-3809**
Care Management (includes behavioral health services)	**1-855-734-9392**
Medical Prior Authorization	**1-855-734-9389**
Pharmacy Prior Authorization	**1-855-365-8108**

Community Resource	Contact Information
State of Ohio Quit Line	**1-800-QUIT-NOW (1-800-784-8669)** Website: **https://ohio.quitlogix.org/en-US/**

Contractors	Phone Numbers	Facsimile	Hours and Days of Operation
DentaQuest **www.dentaquest.com**	**1-800-341-8478**	N/A	
Interpreter Services Language interpretation services, including: sign language, special services for the hearing impaired, oral translation, and oral interpretation.	Please contact our Member Services Department at **1-855-364-0974** (for more information on how to schedule these services in advance of an appointment)	N/A	24-hours-a-day 7-days-a-week

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Contractors	Phone Numbers	Facsimile	Hours and Days of Operation
Vision Service Plan (VSP) **www.vsp.com**	**1-800-877-7195**	N/A	Monday-Friday 5 a.m.-8 p.m. PST Saturday 7 a.m.-8 p.m. PST Sunday 7 a.m. – 7 p.m. PST
LogistiCare **www.logisticare.com**	Facility Line: **1-866-910-7680** (facilities call to make standing order reservations for patients)	Facility Fax: **1-866-910-7681** (facilities fax over standing orders for transportation)	8 a.m.-5 p.m. EST Monday-Friday Transportation assistance for urgent and same day reservations is available 24-hours-a-day, 7-days-a-week.

Agency Contacts & Important Contacts	Phone Number	Facsimile	Hours and Days of Operation
The Ohio Department of Medicaid (ODM) Main Website: **http://medicaid.ohio.gov/** Provider Website: **http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderAssistance.aspx** 50 West Town Street, Suite 400 Columbus, Ohio 43215	Provider Hotline: **1-800-686-1516** Please note: Authorizations, Claims and any other Aetna Better of Ohio MyCare Ohio plan inquiry, please call our Provider Services line noted in the beginning of this chapter.	N/A	8 a.m.-4:30 p.m. EST Monday-Friday
Change Healthcare Customer Service Email Support: **hdsupport@webmd.com** **Submit Electronic Claims:** **https://office.emdeon.com**	**1-800-845-6592**	N/A	24-hours-a-day 7-days-a-week
Ohio York Relay	Dial 711	N/A	24-hours-a-day 7-days-a-week

Reporting Suspected Neglect or Fraud			
Ohio Attorney General Complaints Hotline To report online: http://**www.ohioattorneygeneral.gov/About-AG/Service-Divisions/Health-Care-Fraud/Report-Medicaid-Fraud**	**1-800-282-0515**	N/A	8 a.m.-7 p.m. EST Monday-Friday (Excluding Holidays and weekends. Voice mail service will be Available whenever the Hotline is closed)
The National Domestic Violence Hotline	**1-800-799-SAFE (7233)**	N/A	24-hours-a-day, 7-days-a-week
The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	**1-800-HHS-TIPS (1-800-447-8477)**	N/A	24-hours-a-day, 7-days-a-week

Important Addresses	
Aetna Better Health of Ohio Participating Provider Disputes	Aetna Better Health of Ohio Attn: PAR Provider Disputes PO Box 64205 Phoenix, AZ 85082 -ORSecure Provider Web Portal **www.aetnabetterhealth.com/ohio/providers/portal** Access our Par Provider Dispute Form at **www.aetnabetterhealth.com/ohio/providers/forms**
Aetna Better Health of Ohio Appeals (Nonparticipating providers)	Aetna Better Health of Ohio, a MyCare Ohio plan Attn: Grievance & Appeals Manager 7400 West Campus Road Mail Code: F494 New Albany, OH 43054
Aetna Better Health of Ohio (Claims Submission & Resubmission)	Aetna Better Health of Ohio, a MyCare Ohio plan PO Box 64205 Phoenix, AZ 85082

Identifying & Reporting Abuse, Neglect & Exploitation of a Member

Aetna Better Health's policy is to promote the education of network providers including long term care facilities on the identification and reporting of actual and suspected abuse, neglect, and exploitation of our members.

Definitions:

Neglect means intentional or unintentional failure to fulfill a caregiver's obligation or duty to an elderly person. "Self-neglect" can also occur when an elderly person is unable or unwilling to make provision for proper care for themselves.

Abuse constitutes the intentional infliction of physical harm, causing injury as a result of negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault of an individual 18 years of age or older who is unable to protect himself or herself from abuse, neglect or exploitation by others because of a physical or mental impairment.

Aggravating circumstances (such as cruelty, recklessness, and malice in causing injury to others) are often considered by the courts in imposing a more severe sentence than is typical for similar offenses.

Bodily harm means physical pain or injury, illness, or any impairment of physical condition.

Imminent danger is a condition which could cause serious or life-threatening injury or death.

Financial exploitation is when someone uses coercion, harassment, or deception to misuse or steal a person's money or property.

Mandated reporters are professionals who, in the ordinary course of their work and because they have regular contact with children, disabled persons, senior citizens, or other identified vulnerable populations, are required to report (or cause a report to be made) whenever financial, physical, sexual or other types of abuse have been observed or are suspected, or when there is evidence of neglect.

Major unusual incidents are defined as any alleged, suspected, or actual occurrence of an incident that adversely affects the health and safety of an individual.

Neglect

Types of neglect:

- The intentional withholding of basic necessities and care
- Not providing basic necessities and care because of lack of experience, information, or ability

Signs of neglect:

- Malnutrition or dehydration
- Unkempt appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of neglect:

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

Abuse

Examples of abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (bed sores)
- Missing teeth
- Broken bones/sprains
- Spotty balding from pulled hair
- Marks from restraints

Behaviors of abusers (caregiver and/or family member):

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

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Financial exploitation

Examples of financial exploitation:

- Caregiver, family member, or professional expresses excessive interest in the amount of money being spent on the member
- Forcing member to give away property or possessions
- Forcing member to change a will or sign over control of assets

State and Federal Agencies

- Public Children Services Agency (CPSA) **http://jfs.ohio.gov/county/cntydir.stm**
- The Public Children Services Association of Ohio (PCSAO) **http://www.pcsao.org/index.htm**
- Adult Protective Services (ODJFS) **http://jfs.ohio.gov/factsheets/APS_FactSheet.pdf**
- The Ohio Department of Developmental Disabilities (DODD) **https://doddportal.dodd.ohio.gov/reportabuse/Pages/default.aspx**
- Ohio Department of Health (ODH) **http://dodd.ohio.gov/default.aspx**

Timeframes For Reporting

Within four (4) hours after the time the incident and/or event was first discovered by the staff.

- DODD Abuse/Neglect Hotline 1-866-313-6733

Elderly (Age 60 and over)

Within four (4) hours after the time the incident and/or event was first discovered by the staff. Review the web address to find the contact information that services your service area.

- Adult Protective Services (APS) **http://jfs.ohio.gov/County/County_Directory.pdf**

Long-Term Care Facilities

Serious Bodily Injury - 2 Hour Limit: If the incident and/or events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion.

All Others - Within 24 Hours: If the incident and/or events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion. (Section 1150B of the Social Security Act) Ohio Department of Health (ODH) Hotline 1-800-342-0553

Aetna Better Health's Compliance Hotline

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health.

- **1-866-253-0540**

What Should be Reported?

- Information the reporter should have ready to provide:
  - Names, birth dates (or approximate ages), race, genders, etc.
  - Addresses for all victims and perpetrators, including
  - current location.
  - Information about family members or caretakers if available
  - Specific information about the abusive incident or the
  - circumstances contributing to risk of harm (e.g., when the
  - incident occurred, the extent of the injuries, how the member
  - says it happened, and any other pertinent information)

Additional Resources

- **http://dodd.ohio.gov/HealthandSafety/Pages/default.aspx**
- **http://ohiohopes.org/reporting/**

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Provider Fraud, Waste and Abuse Training

Welcome

We designed this training to assist you in helping Aetna Better Health of Ohio detect, report, and prevent fraud, waste, and abuse.

The Centers for Medicare and Medicaid Services (CMS) has outlined requirements that must be followed by everyone who participates in any way with the Medicare-Medicaid Program.

Following these requirements protects our members from harm and helps to keep health care costs down.

Definitions

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

Waste: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Criminal fraud: knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 United States Code § 1347)

What does that mean?

Intentionally submitted false information to the government or a government contractor in order to get money or a benefit.

Waste and abuse

Requesting payment for items and services when there is no legal entitlement to payment. Unlike fraud, the provider has not knowingly and intentionally misrepresented facts to obtain payment.

Differences between fraud, waste and abuse

There are differences between fraud, waste and abuse.

One of the primary differences is intent and knowledge.

Fraud requires the person to have an intent and obtain payment and knowledge that their actions are wrong.

Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

What are my responsibilities as a provider?

You are a vital part of our effort to prevent, detect, and report non-compliance as well as possible fraud, waste, and abuse.

First, you are required to comply with all applicable statutory, regulatory, including adopting and implementing an effective compliance program.

Second, you have a duty to the program to report any violations of laws that you may be aware of.

Third, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

A provider's best practice for preventing fraud, waste, and abuse is to (also applies to laboratories as mandated by 42 CFR 493):

- Develop a compliance program
- Monitor claims for accuracy - ensure coding reflects services provided
- Monitor medical records - ensure documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members

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- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem

Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

How can I prevent fraud, waste and abuse?

- Make sure you are up to date with laws, regulations, and polices.
- Ensure data/billing is both accurate and timely
  - Monitor claims for accuracy, ensuring coding reflects services provided.
- Verify information provided by you
  - Monitor medical records, ensuring documentation supports services rendered
  - Perform regular internal audits
  - Be on the lookout for suspicious activity
  - Establish effective lines of communication with colleagues and staff members
- Make sure you understand and follow Aetna Better Health of Nevada's policies and procedures.
- Comply with Aetna Better Health of Nevada's compliance program.
- Ensure policies and procedures are in place at your facility to address fraud, waste, and abuse.

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste, and abuse, and in responsible to investigate cases of alleged fraud, waste, and abuse. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators; field fraud (claims) analysts; a full-time, a dedicated information technology organization; and supporting management and administrative staff.

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information, or want to report potential fraud, waste, or abuse. The number is **1-800-338-6361**. The hotline has proven to be an effective tool, and Aetna Better Health of Ohio encourages providers and contractors to use it.

Examples of fraud, waste and abuse

Billing for services and supplies that were never performed or provided.

- Billing for a higher-level treatment than was actually provided.
- Billing separately for services that are already included in the primary procedure.
- Health care provider not providing enough care or delaying needed care. This is done in order to maximize the health care provider's service funds.
- Billing for services or procedures that are not needed.
- Utilizing false or inflated diagnosis codes for encounter information to increase premiums.
- Writing scripts from brand name pharmaceuticals even though generic is stated in the plan formulary.
- Use of medical benefits by an unauthorized individual.

Reporting fraud, and abuse

Participating providers are required to report to Aetna Better Health of Ohio all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone to the confidential Aetna Better Health of Ohio Compliance Hotline at **1-866-253-0540**
- By phone to our confidential Special Investigation Unit (SIU) at **1-800-338-6361** or by email aetnaSIU@aetna.com

Note: If you provide your contact information, your identity will be kept confidential.

Laws you need to know about

The False Claim Act (FCA)

Prohibits:

- Knowingly presenting a false or fraudulent claim for payment or approval
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

Anti-Kickback Statue

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Self-Referral Prohibition Statute (Stark Law)

Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.

Exclusions

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General. (42 U.S.C. § 1395(e0(1), 42 C.F.R. §1001.1901)

HIPAA

Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry. Safeguards to prevent unauthorized access to protected health care information. As a provider who has access to protected health care information, you are responsible for adhering to HIPAA.

Consequences of committing fraud, waste or abuse

The following are potential penalties. The actual consequences depend on the violation.

- Civil money penalties
- Criminal convictions/fines
- Imprisonment
- Loss of provider license
- Exclusion from Federal Health Care Program

Additional References

Aetna Better Health of Ohio Provider Manual
Code of Federal Regulations (C.F.R.), Title 21

Cultural Competency

To improve patient health and build health communities, providers need to recognize and address the unique culture, language and health literacy of diverse patients and communities.

Aetna Better Health promotes cultural competency and education in an effort to help eliminate health care inequalities.

Provider-focused cultural competency resources can be found on the U.S. Department of Health and Human Services (HRSA) website at **https://www.hrsa.gov/cultural-competence/index.html**.

Furthermore, the Communication Guide offered by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) at **www.thinkculturalhealth.hhs.gov/educatio**n is a guide that will help provider offices interact more effectively with culturally and linguistically diverse individuals. The guide covers strategies for communication in a way that is considers the cultural, health literacy, and languages needs of your patients and their families.

The U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) also offers free continuing education e-learning programs which are designed to help providers offer culturally and linguistically appropriate services (CLAS). For a full list of resources, please visit **www.thinkculturalhealth.hhs.gov/resources/library**.

To access an online cultural competency tutorial, please visit: **https://youtu.be/dOZLf-RYvHk**

If your office is currently certified in cultural competency but is not identified as such on Aetna Better Health of Ohio's directory please email us at **OH_providerservices@aetna.com** to request your record be updated.

Things to Remember:

Providers and their office staff are responsible for ensuring all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all patients. This includes those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Providers should ensure that patients are effectively receiving understandable, respectful and timely care compatible with their cultural health beliefs, practices and preferred languages from all staff members. Providers should also honor member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds.

For additional questions, please contact Aetna Better Health directly.

Providers are prohibited from segregating Medicaid patients from other persons receiving services. Examples of practices which are prohibited if based on race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, and health status, physical or mental disability, except where medically indicated. This includes but may not be limited to, the following:

- Denying or not providing to a member any covered service or access to a facility
- Providing to a member a similar covered service in a different manner or at a different time from that provided to other members, other public or private patients, or the public at large
- Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service

Aetna Better Health expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid.

When treating a person with a disability, remember to:

- Talk to the patient, not someone who accompanies them
- Avoid making assumptions
- Ask, "How can I help you?" and respect the answer
- Ensure that educational materials are easily accessible
- Allow time for history taking and exam

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When treating a person who is blind or visually impaired, provide written material:

- In an auditory format
- On computer disc
- In Braille or large print

When treating a person who is deaf or hard of hearing:

- Ask how to best communicate
- Provide written educational material
- Look at the person while speaking
- Avoid shouting
- Minimize background noise
- Provide interpreter, if necessary for effective communication
- Patients cannot be charged for interpretation
- Family members should NOT interpret

When treating a person who is a wheelchair user:

- Provide access to exam areas
- Provide assistance if necessary (for a full and complete exam,
- even if it requires more time or assistance)
- Respect personal space, including wheelchairs and
- assistive devices
- Avoid propelling wheelchair unless asked
- Obtain adjustable exam tables for your facility, if possible

Tools:

- **Interpreter services** - Aetna Better Health offers twenty-four (24) hour interpreter access available through our call center to communicate with those members with communication-affecting disorders.
- **State Relay systems** - available by dialing 711.

Resources

- Health Resources, and Service Administration (HRSA): **http://www.hrsa.gov/culturalcompetence/index.html**
- World Institute on Disability (WID): **http://wid.org**
- U.S. Department of Health & Human Services (HHS), Office of Minority Health (OMH): **https://www.thinkculturalhealth.hhs.gov/education**
- U.S. Department of Health and Human Services (HRSA): **http://www.hrsa.gov/culturalcompetence/index.htm**l

National Provider Identification (NPI) Requirements

Welcome!

We designed this training to assist you with understanding how to use your NPI in HIPAA standard electronic transactions.

Federal regulations require you to submit HIPAA standard electronic transactions with only your NPI number. Additional information on this requirement follows.

General

Which HIPAA standard electronic transactions have to include the NPI?

- Claim
- Encounter
- Eligibility
- Claim Status Inquiry
- Electronic Remittance Advice (ERA)
- Precertification Add
- Referral Add

How do I use my NPI?

Health care providers must use their NPIs on electronic transactions adopted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Additionally, health care providers need an NPI so they can be identified on electronic transactions performed by other entities. For example, pharmacies must use the NPI of the prescribing physician to submit a claim.

Also, health care providers need the NPIs of referring physicians to submit their own claims electronically. And hospitals need the NPIs of admitting and attending physicians to submit electronic claims to a health plan. We strongly urge providers to share their NPIs with these other entities. For additional information, see our guidance below on submitting NPIs for organizations in transactions (Appendix A).

Does the NPI replace the tax ID number?

The billing provider's tax ID number and NPI are always required on claims. Any other providers identified on the claim, such as rendering provider or service facility, must be identified with their NPI only. Their tax ID number should not be included.

For eligibility, claim status inquiry, referral and precertification, only the NPI (no tax ID number) is used. However, we must have been informed of the provider's NPI, and it must have been loaded into our business application system.

Is Aetna Better Health maintaining old and generating new Aetna Better Health provider identification numbers?

We continue to maintain old and generate new Aetna Better Health provider ID numbers in our systems since they are needed for other processes not encompassed by the NPI regulation.

Are providers allowed to send other identification numbers, such as PIN, PVN and TIN, in electronic transactions?

To be compliant with the regulations, covered entities must use the NPI of any health care provider (or subpart) that has been assigned an NPI to identify that health care provider in HIPAA standard transactions. The use of other IDs is only permitted to identify:

- An entity or individual "as a taxpayer" using the TIN (for example, Social Security number or employer identification number (EIN)). This exception only applies to billing providers in claims and payees in remittance advices. An NPI must also be used to identify covered health care providers "as providers" in these situations.

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- Providers acting in a way that is not considered to be a "provider" role, such as information submitter or receiver or utilization management organization.
- Non-covered health care providers. For example, a referring provider who does not conduct any electronic transactions is a non-covered provider who may have chosen not to obtain an NPI.
- Individuals and entities who are not considered health care providers (also known as atypical providers). Atypical providers are persons or groups whose services may be paid for by health benefits plans but who do not directly provide health care. Some common examples include:
  – Personal care workers (for example, aides providing assistance with daily living)
  – Non-medical living arrangements (for example, assisted living, certified family homes, boarding homes, supervised independent living and community residential facilities)
  – Non-emergency transportation providers (for example, taxi services)
  – Entities that administer health benefits but do not directly provide health care, such as:
    - Other health plans
    - Individual practice associations (IPAs)

I submit electronic transactions but am not eligible for an NPI. How do I notify Aetna Better Health?
Notify us by using calling our Provider Services Department.

My organization has multiple NPIs. Which should I use in transactions?
View our help document for guidance on submitting transactions with NPIs for organizations below (Appendix A).

Claims & encounters

Does the NPI replace the tax ID number on claims?
The billing provider's tax ID number and NPI are always required on claims. Any other providers identified on the claim, such as rendering provider or service facility, must be identified with their NPI only. Their tax ID number should not be included.

Has the NPI changed the way Aetna Better Health pays claims and to whom?
No, the NPI did not cause any change to claims adjudication. We use the billing provider tax ID number and provider name and address. The NPI can also be used to identify the appropriate provider.

Does Aetna Better Health require the NPI on paper claims?
Regulations only require the use of NPIs on electronic transactions. However, the professional and institutional paper claims forms were revised to allow NPIs to be included. We recommend you send, but do not require, NPIs on the revised forms (CMS 1500 version 08/2005 and UB-04). Additional information on the CMS 1500 form is available at www.nucc.org. Select "1500 Claim Form," then "1500 Instructions." You may also subscribe to the UB-04 manual; visit www.nubc.org.

We also accept, but do not require, the use of legacy ID number on paper claims forms. To ensure timely, accurate claims payment, we recommend that paper forms be completed with either the NPI or the legacy ID.

Does Aetna Better Health require the referring physician's NPI on claims?
No. While we do not require this information for claims adjudication, it may be necessary for you to send it in order to comply with regulations.

How is Aetna Better Health processing claims that were previously submitted with Medicare OSCAR numbers?
Note: OSCAR numbers, commonly referred to as UPIN or MPN, are six-digit Medicare provider numbers issued to facilities. To comply with the regulations, use of a Medicare provider number is not permitted on electronic claims. Because of this, we require an NPI, or an NPI and taxonomy code, on institutional claims where the submission of a Medicare provider number was required by Aetna Better Health. Depending on your current setup, you may or may not be required to submit a taxonomy code to Aetna Better Health.

Another payer has notified me that in addition to my NPI, I must submit a different tax ID number on my claims. Should I make the same change in my Aetna Better Health claims submissions?
Some providers have multiple tax ID numbers, for example, SSN and EIN or multiple EINs. We are aware that other payers, such as Medicare, have asked some providers to submit claims with a different tax ID number than they used in the past. However, if you make changes to the tax ID number on your Aetna Better Health claims, it may affect our ability to process your claims in a timely manner.

If you want to change your tax ID number for Aetna Better Health, you can communicate this change as you do any other demographic update by contacting our Provider Services Department.

My claim was rejected for missing "Billing Provider" NPI. What action do I need to take on these claims to have them processed?
For claims that reject for National Provider Identifier, use the NPI as the primary ID for the Billing Provider and resubmit electronically.

Remittance advice

If an electronic remittance advice (ERA) can have a different NPI than submitted on the claim, how can I tell which claim the ERA is responding to?
The submitter's claim number (from CLM01 in an 837 EDI claim) is returned in the CLP01 element in the 835 ERA, and this is not affected by the NPI regulations or related changes. The 835 ERA implementation guide states the following about the CLP01: "This data element is the primary key for posting the remittance information into the provider's database. We also recommend that it be used for that purpose rather than matching by provider IDs." Matching remittances to claims using the provider ID is normally not necessary.

Is the NPI from the claim included on the payee's electronic remittance advice (ERA), or does Aetna derive the NPI from its internal database?
ERAs include the billing provider's NPI unless you request otherwise. You can request that the payee NPI on the ERA be an NPI you shared with us.

Do new agreements need to be signed for electronic funds transfer (EFT) as a result of the NPI?
No, new agreements do not need to be signed as a result of the NPI.

Eligibility, Claim Status Inquiry, Referral, and Precertification.

Does the NPI replace the tax ID number on eligibility, claim status inquiry, referral and precertification transactions?
For eligibility, referral and precertification transactions, federal regulations require submission of the provider's NPI number unless the provider is not considered a health care provider as defined under HIPAA. However, we must have been informed of the provider's NPI, and it must have been loaded into our provider database. For claim status inquiry, NPI is required in the servicing provider field (it should be the same NPI that was submitted on the claim you are inquiring about), but the billing provider ID can be an NPI, Tax ID or PIN/PVN.

What should I do if I get an error message when I try to transmit my NPI in an eligibility, claim status inquiry, referral or precertification transaction?
In these instances, you should confirm that we have received and loaded your NPI into our database. You can confirm that your NPI is in our system by calling our Provider Services Department.

How does NPI affect the referral inquiry and precertification inquiry transactions?
Although the referral inquiry and precertification inquiry transactions are not covered by the regulations, we can process them using the NPI as the provider identifier.

When authorization details are returned in response to these inquiries, the providers will be identified by an NPI, when an NPI is available in our database.

Contact

For additional information, please contact the Provider Services Department.

Note:
Providers who provide services to our enrollees must obtain identifiers. Aetna Better Health of Ohio requires each provider to have a unique identifier, and qualified providers must have a National Provider Identifier (NPI) on or after the compliance date established by the Centers of Medicare and Medicaid (CMS). We understand that some provider types (i.e., assisted living, certified family homes, boarding homes, supervised independent living, and community residential facilities) may not have NPI numbers. If a provider does not have an NPI number due to their provider type, we will associate the provider to a system default NPI for atypical providers (9999999995). For questions, please contact our Provider Services Department at **1-855-364-0974**.

Appendix			
Transaction Type	**Scenario**	**Aetna Better Health Processing Explanation**	**Guidance**
Claims	A health care provider has multiple Organizational (type 2) NPIs and uses one or more of them in claims.	Aetna Better Health uses the tax ID number and provider name and address information to identify the billing provider. If needed, the NPI is also used to identify the billing provider.	Use the most appropriate Organizational NPI for the billing provider on claims. Unless you have told Aetna Better Health that you want a particular NPI used on your electronic remittance advice (ERA), the billing provider NPI you use on the claim will be returned on your ERA.
Claim Status Inquiry	A health care provider has multiple Organizational (type 2) NPIs. The provider submits an Organizational NPI in a claim and later submits a claim status inquiry transaction using the same Organizational NPI and is unable to locate claims.	Aetna Better Health may have selected a provider record associated with a different NPI. If no claim status inquiry requests are associated with that record, no claims will be found.	For professional claims, submit claim status inquiry transactions using the provider's Individual (type 1) NPI or use the NPI associated with the entire organization.
Eligibility	A health care provider organization, including individual providers with differing reimbursement levels, is enumerated with a single Organizational (type 2) NPI. That Organizational NPI is used in the eligibility transaction.	Aetna Better Health's response will not contain benefit detail levels specific to particular providers within the organization	Submit eligibility inquiry Transactions using the provider's Individual (type 1) NPI.
Precert Add	The requesting provider shares a single NPI across multiple providers or specialties. The requesting facility shares a single Organizational (type 2) NPI across multiple facilities, departments or specialties. The admitting or attending provider or facility shares a single Organizational (type 2) NPI across multiple providers, specialties, departments or facilities.	Aetna Better Health must select one provider record for processing and response. The selected record may not be the intended facility, department or specialty, resulting in an unexpected provider name returned in the response.	The requesting provider/ facility name returned in the response will not affect the validity of the precert add request. Use an Individual (type1) NPI, if available, for attending and admitting providers.

Appendix			
Transaction Type	**Scenario**	**Aetna Better Health Processing Explanation**	**Guidance**
Precert Inquiry	The inquiring entity shares a single Organizational (type 2) NPI across multiple facilities, departments or specialties.	Aetna Better Health must select one provider record from among those linked to the Organizational NPI to compare with the member's precert history. The selected record may not be the intended facility, department or specialty, resulting in no matches being returned.	Inquire using the Individual (type1) NPI, if available, of one of the attending, admitting or primary care providers. Or, use your Aetna Better Health provider ID number (PIN) if your system offers this option. Precertification inquiry transaction is not a HIPAA mandated transaction. It does not require an NPI for provider identification purposes.
Referral Add	A referring provider shares a single NPI across multiple providers or specialties. The "referred to" organization shares a single Organizational (type 2) NPI across multiple departments or specialties	Aetna Better Health must select one provider record for processing and response. The selected record may not be the intended facility, department or specialty, resulting in an unexpected provider name returned in the response.	Use the Individual (type 1) NPI for the referring provider (PCP/Gyn.) Use the Individual (type1) NPI of any provider in the appropriate specialty who is affiliated with the organization to which the member is being referred. Or, refer to a specialty/ taxonomy code.
Referral Inquiry	The inquiring entity shares a single Organizational (type 2) NPI across multiple facilities, departments or specialties.	Aetna Better Health must select one provider record from among those linked to the Organizational NPI, to compare with the member's referral history. The selected record may not be the intended facility, department or specialty, resulting in no matches being returned.	Use the Individual (type 1) NPI of any provider in the appropriate specialty who is affiliated with the organization to which the patient was referred. Or, Use your Aetna Better Health provider ID number (PIN) if your system offers this option. **Referral inquiry is not a HIPAA mandated transaction. It does not require an NPI for provider identification purposes. Appendix A**

Appointment Availability Standards

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards, and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standard. Providers are contractually required to meet the Ohio Department of Medicaid (ODM) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services.

The table on the below shows appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Mental Health Clinics and Mental Health/Substance Abuse (MH/SA) providers.

Provider Type	Emergency Appointment Timeframe	Urgent Appointment Timeframe	Routine Appointment Timeframe	Appointment Wait Time (Office Setting)
Primary Care	Same Day	Within 2 calendar days	Within 3 weeks	No more than 60 minutes
Specialist Care	Immediate	Within 2 calendar days	Within 3 weeks	No more than 60 minutes
OB/GYN	Immediate	Within 2 calendar days	Initial Prenatal Care • 1st Trimester: Within 3 weeks • 2nd Trimester: Within 7 calendar days • 3rd Trimester: Within 3 calendar days • High Risk: Within 3 days • Routine Care: Within 3 weeks • Postpartum Care: Within 6 weeks	No more than 60 minutes
Behavioral Health	Potentially suicidal individual: immediate treatment Non-life threatening emergency: within 6 hours	Within 48 hours		No more than 60 minutes
EPSDT (Early Periodic Screening Diagnosis & Treatment)				No more than 60 minutes

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Provider Type	Emergency Appointment Timeframe	Urgent Appointment Timeframe	Routine Appointment Timeframe	Appointment Wait Time (Office Setting)
Physical Therapy	Within 24 hours	Within 72 hours		No more than 60 minutes
Occupational Therapy	Within 24 hours	Within 72 hours		No more than 60 minutes
Sports Medicine	Within 24 hours	Within 72 hours		No more than 60 minutes
Audiology				No more than 60 minutes

Our waiting time standards require that enrollees, on average, should not wait at a PCP's office for more than sixty (60) minutes (1 hour) for an appointment for routine care. On rare occasions, if a PCP encounters an unanticipated urgent visit, or is treating an enrollee with a difficult medical need, the waiting time may be expanded. The above access and appointment standards are provider contractual requirements. Our Provider Services Department monitors compliance with appointment and waiting time standards, and works with providers to assist them in meeting these standards.

Telephone Accessibility Standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available, or having on-call arrangements in place with other qualified participating Aetna Better Health of Ohio providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services including, authorizing care and verifying enrollee enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on-call coverage. On call coverage response for routine, urgent, and/or emergent health care issues are held to the same accessibility standards regardless if after hours coverage is managed by the PCP, current service provider, or the on-call provider.

All Providers must have a published after hours telephone number and maintain a system that will provide access to primary care 24-hours-a-day, 7-days-a-week. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between enrollees, their PCPs, and practice staff. We will routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if an enrollee may need care
- Management intervention.
- Our compliance and provider management teams will evaluate enrollee, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.
- Providers must comply with telephone protocols 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)
  - Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient
  - Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental staff to provide covered services within normal working hours.
  - Protocols should be in place to provide coverage in the event of a provider's absence.

Provider must make certain that their hours of operation are convenient to, and do not discriminate against, MyCare Ohio enrollees. This includes offering hours of operation that are no less than those for non-enrollees, commercially insured or public fee-for-service individuals.

In the event that a PCP fails to meet telephone accessibility standards, a Provider Services Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.

Covering Providers

Our Provider Services Department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health of Ohio. This notification must occur in advance of providing authorized services. Failure to notify our Provider Services Department of the covering provider's affiliation may result in claim denials and the provider may be responsible for reimbursing the covering provider.

Home & Community Based Services Waiver Reference Manual

Welcome!

This quick reference guide was prepared to give you an overview of the MyCare Ohio Medicaid Home and Community-Based Services Waiver program with Aetna Better Health of Ohio. The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits Ohio to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

Services

The following waiver services are available, as applicable to the enrollees needs:

- Adult Day Health Services
- Alternative Meals Services
- Assisted Living Services
- Choices Home Care Attendant Services
- Chore Services
- Community Transition Services
- Emergency Response Services
- Enhanced Community Living Services
- Home Care Attendant
- Home Delivered Meals
- Home Medical Equipment & Supplemental Adaptive & Assistive Devices
- Home Modification Maintenance & Repair
- Homemaker Services
- Independent Living Assistance
- Nutritional Consultation
- Out of Home Respite Services
- Personal Care Services
- Pest Control
- Social Work Counseling
- Waiver Nursing Services
- Waiver Transportation

Eligibility

MyCare Ohio Waiver services provided through Aetna Better Health of Ohio are designed to meet the needs of enrollees 18 years or older, who are fully eligible for both Medicare and Medicaid, enrolled in a MyCare Ohio Plan, and who are determined by the State of Ohio, or its designee, to meet an intermediate or skilled level of care. These services help individuals to live and function independently. The below information provides additional details surrounding eligibility:

The following individuals are eligible for the waiver:

- Individuals currently enrolled on one of Ohio’s five HCBS-based waivers (i.e., the PASSPORT, Choices, and Assisted Living Waivers administered by ODA; and individuals currently enrolled on the Ohio Home Care and Transitions II Aging Carve-out Waivers administered by OMA);
- “Community Well” individuals participating in the ICDS demonstration who experience a significant change that presents a new need for LTSS;

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- Current NF residents who are transitioning into the community and have a need for LTSS; and Individuals who are newly eligible for either or both Medicare and Medicaid, are otherwise eligible for the ICDS demonstration, and are enrolled on an HCBS waiver during their Fee-For-Service (FFS) period before they are enrolled on an ICDS plan.

Care Management

Enrollee's enrolled with Aetna Better Health of Ohio in the My- Care Ohio Waiver will receive assistance with coordinating their waiver services. Enrollees will be contacted by either their Care Manager, and receive an in-person visit to review their care needs within no more than 75 days after they are enrolled in the MyCare Ohio Waiver.

Care management includes, but is not limited to, the following:
- Monitoring the enrollees health and welfare
- At least annually, assessing the enrollee needs, goals, and objectives
- Scheduling, coordinating and facilitating meetings with the enrollee and their care team
- Authorizing Waiver services in the amount, scope, and duration to meet the enrollees needs
- Linking and referring the enrollee to needed service providers
- working with the enrollee and their care team to develop your Service Plan
- Monitoring the delivery of all services identified in the enrollees Service Plan
- Ensuring adjustments are made as appropriate in the event the enrollee encounters significant changes, including but not limited to, significant life milestones such as entering/exiting school, work, etc.
- Identifying and reporting incidents, as well as prevention planning to reduce the risk of reoccurrence.
- Assisting the enrollee in developing a backup plan in the event their provider is unable to show up for work.

Waiver Service Plan

The Waiver Service Plan is a written outline of the waiver services necessary to keep an enrollee safely in the community. It identifies goals, objectives, and outcomes related to their health, as well as the treatments and services they receive.

The service plan documents how the enrollees needs will be met. It will address the following:
- Care, including the enrollees medical and personal care needs
- How the enrollee's living environment will be kept clean and safe
- Mental/behavioral health, including any behavior interventions
- School, work, or other daytime activities
- Home modifications and/or adaptations
- Medication management
- Medical and personal care supplies, including equipment
- Back-up plan for when a provider is unable to furnish services as scheduled

The service plan will identify the specific tasks and activities the enrollees service provider(s) will deliver to meet the enrollees needs. It will also specify how much, how often, and how long the enrollee will receive the services.

After the enrollee's service plan is developed and approved, the enrollees Waiver Service Coordinator will help arrange for the delivery of services to implement the plan.

Transition Plan

The following individuals may be eligible for the special transition processes:
- Group 1- Individuals currently enrolled on the PASSPORT, Choices, and Assisted Living Waivers administered by ODA; and individuals currently enrolled on the Ohio Home Care and Transitions II Aging Carve-out Waivers administered by OMA;
- Group 2- "Community Well" individuals participating in the ICDS demonstration who experience a significant change that presents a new need for LTSS;
- Group 3- Current NF residents who are transitioning into the community and have a need for LTSS; and
- Group 4- Individuals who are newly eligible for either or both Medicare and Medicaid, are otherwise eligible for the ICDS demonstration, and are enrolled on an HCBS waiver during their Fee-For-Service (FFS) Medicaid period before they are enrolled on an ICDS plan. Individuals who present a need for HCBS, prior to their enrollment in the ICDS program will receive services on a FFS basis until a plan selection is made.

Individuals in groups 2 and 3 will move directly onto Aetna Better Health of Ohio without a "transition period".

For individuals in groups 1 and 4, however, Aetna Better Health of Ohio will contract with each individual's established providers upon enrollment in the plan for the periods of time described below at the rate approved under the individual's currently approved waiver service plan.

Transition Period

- Waiver personal care assistance, nursing, out-of-home respite, enhanced community living, adult day services, social work/counseling and independent living skills providers will be maintained for 365 days unless a change is required.
- All other waiver service levels will be maintained for 365 days, and providers will be maintained for 90 days.

Changes in Provider during Transition Periods:

Individuals may initiate a change in waiver service provider at any time. However, any change in services or service providers may occur only after an in-home assessment and the development of a plan for the transition to a new provider.

In cases where the health and welfare of the individual is judged to be in danger, expedited service authorization time frames will apply. During the transition periods listed above, a change from an existing provider may occur in the following circumstances:

- The individual has a significant change in status
- The provider gives appropriate notice of intent to discontinue services to an individual
- Provider performance issues that affect an individual's health and welfare are identified

Home and Community Services - Interruption of Service

There may be times when an interruption of service may occur due to an unplanned hospital admission or short term nursing home stay for the enrollee. While services may have been authorized for caregivers and agencies, providers should not be billing for any days that fall between the admission date and the discharge date or any day during which services were not provided. This could be considered fraudulent billing.

Example:
Enrollee is authorized to receive 40 hours of Personal Assistant per week over a 5 day period. The enrollee is receiving 8 hours of care a day.

The enrollee is admitted into the hospital on January 1, 2018 and is discharged from the hospital on January 3, 2018. There should be no billable hours for January 2, 2018, as no services were provided on that date since the enrollee was hospital confined for a full 24 hours.

Caregivers would not be able or allowed to claim time with the enrollee on the example above, since no services could be performed on January 2, 2018. This is also true for any in-home service.

Personal Assistants and Community Agencies are responsible for following this process. If any hours are submitted when an enrollee has been hospitalized for the full 24 hours, the Personal Assistants and Agencies will be required to pay back any monies paid by Aetna Better Health of Ohio. Aetna Better Health of Ohio will conduct periodic audits to verify this is not occurring.

Billing

Aetna Better Health of Ohio uses Change Healthcare. Change Healthcare is a web based solution set that simplifies the everyday tasks the provider practices by integrating eligibility and benefits verification, claims and payment management as well as clinical tools all into one easy to use application. Please visit Change Healthcare to gain access: **https://office.emdeon.com/secure/scripts/inq.dll**

Please use the following Provider ID and Submitter ID when submitting claims to Aetna Better Health of Ohio:

- Submitter (payer) ID# 50023

The UB-04 CMS- 1450 Form can be located through the following website: **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1196256.html?DLPage=1&DLEntries=10&DLFilter=1450&DLSort=0&DLSortDir=ascending**

The CMS 1500 Form can be located through the following website: **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf**

Waiver services codes include:
Please refer to your Home and Community-Based Services Waiver Program reference manual at **www.aetnabetterhealth.com/ohio/providers/resources/tools** for more details.

Waiver Service	CPT Code
Adult Day Health Services	S5501, S5102, S5100
Assisted Living	T2031
Choices-Home Care Attendant Service (CHCAS)	S5121,T2025,S5120
Chore Services	S5121
Community Transition Services	T2038
Home Medical Equipment (DME)/Supplemental Adaptive & Assistive Device Services Medication Dispensing Device (non-electronic)	T2029
Emergency Response Services	S5160/S5161 (Installation and Testing/Service Fees per month)
Enhanced Community Living Services	T2025
Homemaker Services	S5130
Home Care Attendant	S5125
Home Delivered Meals	S5170
Home Modification, Maintenance & Repair	S5165
Independent Living Assistance (ILA)	S5135
Out of Home Respite	H0045
Personal Care Attendant/services	T1019
Pest Control	S5121
Social Work Counseling (or psychologist)	G0155
Waiver Nursing	T1001/T1002 RN/T1003 LPN
Waiver Transportation	S0215
Non-emergency Medical transportation	T2003
Vehicle Modifications	T2029
Nutritional Consultation	S9470
Incontinent Supplies	T2029

Service	Care Management Department	Prior Authorization Department	Physician's Orders required for this service
Adult day Service	X		
Assisted Living Service (Supported Living facility)	X		
Behavioral Services	X		
Day Habilitation	X		
Environmental accessibility Adaptations	X		
Home Delivered Meals	X		
Home Health Aids	X		X
Homemaker	X		
Nursing Home (Nursing Facility)	X		X
Nursing, Intermittent	X		X

Service	Care Management Department	Prior Authorization Department	Physician's Orders required for this service
Nursing, Skilled	X		X
Personal Care (Personal Assistant)	X		
Personal emergency Response System	X		
Physical, Occupational, and Speech Therapy		X	X
Prevocational Services	X		
Respite	X		
Specialized Medical Equipment and Supplies		X	X
Supported Employment	X		

Definitions and Provider Responsibilities:

Adult Day Health Services (ADHS)

ADHS are regularly scheduled services delivered at an ADHS center to individuals age eighteen or older. Services are provided in a non-institutional, community-based setting. The ADHS provider may provide waiver nursing and/or personal care services. The provider must also furnish recreational and educational activities to support individual health and independence. Providers must also furnish at least one meal, but no more than two meals, per day that meet the individual's dietary requirements. The ADHS center may also make available skilled therapy services and transportation of the individual to and from ADHS center.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.1 (adult day service specifications)
- OMA approved provider: OAC Chapters 5160-45, 5101:3-46, Including OAC rules 5101:3-46-04 (Definitions of Covered Services and Provider Requirements and Specifications) and 5160-46-06 and (Reimbursement)

Alternative Meals Service

Alternative Meal Service assists the individual with procuring one to two nutritious meals per day. Alternative meals service offers the individual the option to obtain meals from nontraditional providers, such as restaurants. Alternative meals are not meals served at an Adult Day Center. Unlike the agency-based home delivered meals service, the alternative meals service is a self-directed service.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.02 (alternative meals service)

Assisted Living Services

The service furnishes 24-hour on-site response capability, personal care, supportive services (homemaker and chore), and the coordination of the provision of three meals a day and snacks. Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management including medication administration, and the delivery of part-time intermittent nursing and skilled nursing up to the maximum allowed in Ohio Administrative Code (OAC) Rule 3701-16-09.1, when not available through a third party. The scope of the service does not include 24-hour skilled care, one-on-one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications or over the counter medications. Individuals reside in single occupancy living units with full bathrooms in a setting that provides supervision and staffing to meet planned and unscheduled needs. The individual is required to pay the room and board obligation directly to the provider. The maximum room and board payment the provider may collect is established in OAC 5160-33-03.

Shared occupancy of a living unit is only permitted under these circumstances:
- The waiver participant requests the double occupancy at the time of the assessment AND
- There is an existing relationship between the waiver participant and the individual.

The service is limited to one unit per calendar day.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.16 (assisted living service)

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The Choices - Home Care Attendant Service

This service consists of supportive activities specific to the needs of a medically stable, disabled adult, which are designed to address ADL and IADL impairments. Choices Home Care Attendant substitutes for the absence, loss, diminution or impairment of a physical or cognitive function and may include one or more of the following types of activities:

- Personal Care including: assistance with bathing, dressing, and grooming, caring for nail, hair and oral hygiene, shaving, deodorant application, skin care with lotions and/or powders, foot care and ear care, feeding, assistance with elimination, assistance with ambulation, changing position in bed, assistance with transfers, normal range of motion, and adequate nutrition and fluid intake;
- General Household Activities including: planning, preparation and clean-up of meals, laundry, bed making, dusting, vacuuming, shopping and other errands, replacing furnace filters, waste disposal, seasonal yard care and snow removal, and other routine household maintenance activities and other routine household chores;
- Heavy Household Chores including: washing floors, windows, and walls, taking down loose rugs and tiles, moving heavy items or furniture to provide safe access and egress, and other heavy household activities;
- Assistance with money management and correspondence;
- Escort services and transportation to enable consumers to gain access to waiver and other community services, activities, and resources. This activity is offered in addition to medical transportation available under the State Plan and does not replace it. Whenever possible, other sources will be utilized.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:

- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.04 (Choices home care attendant)

Chore services

Chore services are services needed to maintain a home in a clean, sanitary and safe condition. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and floor tiles, moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and when no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to a lease agreement, is examined prior to any authorization of service.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:

- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.5 (chore service)

Community Transition Services

These services are non-recurring set-up expenses for individuals who are transitioning from an institutional setting or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- security deposits that are required to obtain a lease on an apartment or home;
- essential household furnishing and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual’s health and safety such as pest eradication and one-time cleaning prior to occupancy;
- moving expenses;
- necessary home accessibility adaptations “that are not the responsibility of the landlord”; and
- activities to arrange for and procure needed resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the waiver service plan development process. All items and services obtained through this service must be clearly identified in the waiver service plan.

Community transition services may be available to up to 180 days prior to the individual's discharge from an institution. This service is only available if the individual is unable to meet such expenses or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household appliances or items that are intended for purely diversion/recreational purposes. Individuals may use this service in lieu of, but not in addition to the community transition service available through Ohio's Home Choice (MFP) Demonstration Program.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), and 173-39-02 (conditions of participation)

Emergency Response Services (ERS)
Emergency intervention services composed of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the individual and an emergency response center. Personnel at the emergency response center intervene in an emergency when the center receives an alarm signal from the ERS equipment. ERS can meet the needs of individuals who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision.

ERS includes installation, testing and equipment rental, and monitoring fees.

ERS equipment shall include a variety of remote or other specialty activation devices from which the individual can choose in accordance with their specific needs. All ERS equipment shall have an internal battery that provides at least twenty-four hours of power without recharging and sends notification to the emergency response center when the battery's level is low.

Equipment includes, but is not limited to:
- Wearable waterproof activation devices; and
- Devices that offer:
  - Voice-to-voice communication capability,
  - Visual indication of an alarm that may be appropriate if the consumer is hearing impaired, or
  - Audible indication of an alarm that may be appropriate if the consumer is visually impaired.

ERS does not include the following:
- Equipment that connects the individual directly to 911.
- Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the ERS equipment.
- Remote monitoring services.
- Services performed in excess of what is approved pursuant to the individual's waiver services plan.
- New equipment or repair of previously-approved equipment that has been damaged as a result of confirmed misuse, abuse or negligence.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.6 (ERS services)
- OMA approved provider: OAC Chapters 5160-45 and 5160-46 including OAC rules 5160-46-04 (Definitions of Covered Services and Provider Requirements and Specifications) and 5160-46-06 (Reimbursement)

Enhanced Community Living Service
These are Services provided by a designated team of nurses and direct care staff in a multi-family housing setting. Enhanced Community Living integrates the delivery of direct service interventions and health status monitoring activities. The ECL service includes eight elements:
- The establishment of measurable health goals;
- The identification of modifiable healthcare risks;
- The implementation and regular monitoring of specific interventions related to achieving the measurable health goals and modifiable healthcare risks;
- Assistance with accessing additional allied health services;
- The provision of, or arrangement for, education on self-managing chronic diseases or chronic health conditions;

- Daily wellness checks. “Daily wellness check” means a component of the service through which a direct service staff enrollee has face-to-face contact with the individual to observe any changes in the individual’s level of functioning and determine what, if any, modifications to the day’s service delivery plan are needed;
- Access to planned and intermittent assistance with the Personal Care Service (PCS) under rule 173-39-02.11 of the Administrative Code.

The scope of personal care tasks includes assistance with ADLs (mobility, bathing, grooming, toileting, dressing, and eating) and the provision of any component of the Homemaker Service (HMK) under rule OAC 173-39-02.8 to assist the consumer with IADLs if the component is incidental to the care furnished or essential to the health and welfare of the consumer. The scope of homemaker tasks include assistance with meal planning, laundry, and house cleaning. Since personal care and homemaker service tasks are included in the scope of the enhanced community living service, the concurrent use by an individual of either the personal care service or the homemaker service as a distinct additional service is not permitted. The service authorization process will prevent the case manager from authorizing

PCS and HMK services that are concurrent with an ECL service authorization.
- Activities to assist an individual who is returning home following a hospital or nursing facility stay.

The ECL service does not provide 24 hour on-site protective oversight, 24 hour supervision or 24 hour assistance. Access to the Enhanced Community Living service is not contingent upon the individual’s receipt of the state plan home health service.

The Enhanced Community Living (ECL) service provides the individual who resides in their own private residence in a multi-family housing setting, with on-site access throughout the day to individually tailored supportive and health-related interventions necessary to avoid institutionalization and maintain optimal health status.
- Multi-family housing is defined as a housing site that uses a landlord-tenant rental agreement, provides a minimum of six units of housing under one roof; and receives assistance through a federally-assisted housing program (as defined under 24 C.F.R.5.100), a project-based voucher program (as defined in 24 C.F.R. 983) or a low-income housing tax credit program (that is based on Section 42 of the Internal Revenue Code). This waiver service is not furnished in facilities that are subject to Section 1616(e) of the Social Security Act.
- On-site access to the service produces increased service flexibilities for an individual by delivering the elements of the service in smaller blocks of time and more frequently throughout the day; and the scope/duration/and frequency of the service delivery can be quickly modified in response to the individual’s intermittent and/or unplanned needs.
- The integration of the delivery of direct service interventions and health status monitoring activities is intended to support the transition of individuals from institutional settings and to reduce the risk for permanent institutionalization by: expanding access to services and supports delivered on an intermittent basis; empowering the individual to be an active participant in achieving his/her health care goals and reducing modifiable health risks; increasing the likelihood of timely identification of changes in health status; reducing the risks for acute exacerbation of chronic health conditions that result in hospitalization or nursing facility care; and increasing the continuity of care across sites of care.

The service differs from the Medicaid state plan benefits, specifically private duty nursing and home health aide, in these areas:
- The waiver service provides interventions which focus on the prevention of deteriorating or worsening medical conditions and the management of stabilized chronic conditions; and
- The waiver service does not provide continuous (more than four hours) blocks of service to individuals.

The mechanisms to prevent duplicate billing for similar services include:
- Prior authorization requirement by the state Medicaid agency for the private duty nursing; and
- Requirement for the waiver service plan to include home health aide service in order for the service to be reimbursable.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.20 (enhanced community living)

Home Care Attendant Services

Services that include all of the following tasks when provided by an unlicensed home care attendant, and authorized by a licensed physician or an RN (hereafter referred to as the authorizing health care professional):

- Assistance with the self-administration of medications in accordance with OAC rule 5160-46-04.1
- The performance of certain nursing tasks in accordance with OAC rule 5101:3-46-04.1 or 5101:3-50-04.1; and
- Personal care aide tasks as set forth in OAC rule 5160-46-04

While this service includes personal care aide tasks, it is more involved because of the provision of assistance with self-administration of medication and the performance of certain nursing tasks - tasks that have, until the passage of RC 5111.88-5111.8811 (Am. Sub. H.B. 1, 128th General Assembly), and the addition of this service, had to be performed by an RN, or licensed practical nurse at the direction of an RN, as waiver nursing, private duty nursing or home health nursing services.

Home care attendants are non-agency providers (i.e., independent contractors) who bill OMA directly for reimbursement for services provided. The service doesn't require a financial management service (FMS) provider, and OMA issues the 1099 directly to the home care attendant. Individuals who receive home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services.

A home care attendant shall assist an individual with the self-administration of only the following medication: oral medications; topical medications; subcutaneous injections of routine doses of insulin; programming of a pump used to deliver routine doses of insulin; medication administered via stable, labeled gastrostomy or jejunostomy tubes using pre-programmed pumps; and doses of schedule II, III, IV and V drugs only when administered orally or topically.

A home care attendant shall not assist an individual with the performance of any of the following nursing tasks: intravenous (IV) insertion, removal or discontinuation; intramuscular injections;

IV medication administration; subcutaneous injections (except for routine doses of insulin as described in the previous paragraph); programming of pumps used to deliver medications, including but not limited to epidural, subcutaneous and IV (and except for routine doses of insulin as described in the previous paragraph); insertion and initiation of infusion therapies; and central line dressing changes.

Providers will be required to adhere to the following requirements as outlined in the ORC:

- ORC Sections 5111.88 to 5111.8811 and OAC Rule 5160-46-04.1

Home Delivered Meals (HDM)

Home Delivered Meals provides individuals with safe and nutritious meals (either regular or therapeutic) that meet one-third of the dietary reference intake (DRI) and meet the current dietary guidelines for Americans and the recommended daily allowances (RDA). HDM service does not constitute a full nutritional regimen.

Eligible participants include those who have an assessed need for a home delivered meal due to one or more of the following:

- An ADL and/or IADL deficit results in the inability to safely prepare a meal and/or
- A cognitive impairment results in the inability to safely prepare a meal;
- The individual is at risk for malnutrition;
- The individual requires meals that are prepared to meet specialized dietary or therapeutic needs.

The service includes the preparation, packaging and delivery of a safe and nutritious meal(s) to an individual at his or her home. The meal may be hot, frozen, vacuum packaged, or shelf stable.

Specialized meals include, but are not limited to, specialized diets due medical conditions (i.e. reduced sodium, diabetic diet), or specialized textures.

Home delivered meals shall not:

- Include services or activities performed in excess of what is approved on the individual's waiver service plan.
- Supplement or replace meal preparation activities that occur during the provision of waiver nursing, personal care aide, adult day health center, home care attendant or any other similar services.
- Supplement or replace the purchase of food or groceries.

- Include bulk ingredients, liquids and other food used to prepare meals independently or with assistance. Bulk ingredients and liquids include, but are not limited to: food that must be proportioned out and prepared, or any food that must be cooked or prepared.
- Be provided while the individual is hospitalized or is residing in an institutional setting.
- Duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.14 (home delivered meals)
- OMA approved provider: OAC Chapters 5160-45 and 5160-46 including OAC rule 5160-46-04 (Definitions of Covered Services and Provider Requirements and Specifications) and 5101:3-46-06 (Reimbursement)

Providers must meet all Federal, State and local regulations for preparation, handling and transport of food; must meet ORC chapter 3117 and OAC chapter 3117-1; must meet Ohio Uniform Food Safety Code; must pass all local health department inspections; and must pass all Ohio department of agriculture meat and poultry inspections.

Home Medical Equipment and Supplemental Adaptive and Assistive Device Services
Medical equipment, devices and supplies, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that promote accessibility, enabling the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. Adaptive and Assistive Devices, in particular, are contingent upon completion of and recommendations resulting from an evaluation. Some adaptive/assistive devices including, but not limited to, vehicle modifications may be provided prior to the individual's discharge from an institution into the community. In such instances, the adaptive/assistive device can be imitated up to 180 days prior to discharge, and the date of service for allowable expenses shall be the date on which the individual leaves the institution and enrolls on the waiver.

Adaptive and Assistive Devices and Medical Supplies do not include:
- Items considered by the federal Food and Drug Administration as experimental or investigational
- Funding of down payments toward the purchase or lease of any adaptive and assistive devices
- New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of confirmed misuse, abuse or negligence
- New vehicle modifications or repair of previously approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence
- Payment toward the purchase or lease of a vehicle except as set forth in the service definition above
- Routine care and maintenance of vehicle modifications and devices
- Permanent modification of leased vehicles
- Vehicle inspection costs
- Vehicle insurance costs

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.7 (home medical equipment and supplies)
- OMA approved provider: OAC Chapters 5160-45 and 5160-46 including OAC rule 5160-46-04 (Definitions of Covered Services and Provider Requirements and Specifications) and 5101:3-46-06 (Reimbursement)

Home Modification, Maintenance and Repair
This service includes physical adaptations to the individual's place of residence for accessibility purposes that permit an individual to live safely and independently. Environmental modifications must include a one-year warranty from the date of completion of the work against defective workmanship, and providers must guarantee that all materials/products/appliances installed or furnished perform their advertised function. Some environmental modifications can be initiated up to 180 days prior to discharge, and the date of service for allowable expenses shall be the date on which the individual leaves the institution and enrolls on the waiver.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.9 (minor home modification)
- OMA approved provider: OAC Chapters 5160-45 and 5160-46 including OAC rule 5160-46-04 (Definitions of Covered Services and Provider Requirements and Specifications) and 5101:3-46-06 (Reimbursement)

Homemaker Services

Services consist of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Homemaker service providers shall meet such standards of education and training as are established by the State for the provision of these activities. Homemaker service providers may also help the individual manage personal appointments, day-to-day household activities, and to ensure that the individual maintains his/her current living arrangement by acting as a travel attendant.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.8 (homemaker services)
- OMA approved provider: OAC Chapters 5160-45 and 5160-46 including OAC rule 5160-46-04 (Definitions of Covered Services and Provider Requirements and Specifications) and 5160-46-06 (Reimbursement)

Independent Living Assistance

This service provides individuals with a range of information and educational training and supports they need to increase their ability to live more independently. Training focuses on financial, health and home management skill-building, as well as the development of social, personal care (such as self-administering medications) and community living skills.

The service also provides one-on-one coaching that gives the individual the tools and confidence to make informed/independent choices, set/achieve short and long-term goals, manage multiple tasks, identify options and solve problems, identify/link to community resources and connect to potential job opportunities. The service can be provided one-on-one, in a group or in a classroom setting, or over the phone, and may include travel attendant activities. The independent living skills training provider is not the individual's care manager.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.15 (independent living assistance)

Nutritional Consultation Services

These are services that provide personalized guidance to an individual who has special dietary needs. Nutritional consultation takes into consideration the individual's health, cultural, religious, ethnic and socioeconomic background and dietary preferences and/or restrictions.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.10 (nutritional consultation)

Out-of-Home Respite Services

These are services delivered to individuals in an out-of-home setting to provide respite for caregivers normally providing care. The service must include an overnight stay. The services the out-of home respite provider must make available are:
- Waiver nursing
- Personal care aide services
- Three meals per day that meet the consumer's dietary requirements.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- OMA approved provider: OAC Chapters 5160-45 and 5160-46 including OAC rule 5160-46-04 (Definitions of Covered Services and Provider Requirements and Specifications) and 5160-46-06 (Reimbursement)

Personal Care

The service furnishes hands-on assistance with activities of daily living (ADLs) in the home and in the community. Tasks include: Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output. The service also furnishes hands-on assistance with instrumental activities of daily living (IADLs) in the home and in the community that are incidental to the provision of the hands-on assistance with ADLs, but may not comprise the entirety of the service. Tasks include: general homemaking activities including, but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming and waste disposal; Household chores including, but not limited to washing floors, windows and walls, tacking down loose rugs and tiles; and moving heavy items to provide safe access and exit.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- Compliance with OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.11 (personal care service specifications)

Pest Control Services

Services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/or annoys humans and causes or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice. Services to control pests are services that prevent, suppress, or eradicate pest infestation.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.03 (pest control)

Social Work/Counseling Services

Transitional services provided to the individual, authorized representative, caregiver and/or family member on a short-term basis to promote the individual's physical, social and emotional well-being. Social work/counseling services promote the development and maintenance of a stable and supportive environment for the individual. Social work/counseling services can include crisis interventions, grief counseling and/or other social service interventions that support the individual's health and welfare.

Social work/counseling services shall not:
- Take the place of case management services; or
- Include services provided in excess of what is approved on the individual's services plan.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- ODA certified provider: OAC chapter 173-39 including OAC rules 173-39-03 (ODA provider certification), 173-39-02 (conditions of participation) and 173-39-02.12 (social work counseling service)

Waiver Nursing Services

These services are defined as services provided to individuals that require the skills of a registered nurse (RN), or licensed practical nurse (LPN) at the direction of an RN. All nurses providing waiver nursing services to individuals on the ICDS waiver shall provide services within the nurse's scope of practice

as set forth in Chapter 4723. of the Revised Code (Ohio's Nurse Practice Act) and Administrative Code rules adopted there under, and shall possess a current, valid and unrestricted license with the Ohio Board of Nursing. Waiver nursing provides part-time, intermittent and/or continuous nursing services.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:
- OMA approved provider: OAC Chapters 5160-45 and 5160-46 including OAC rule 5160-46-04 (Definitions of Covered Services and Provider Requirements and Specifications) and 5160-46-06 (Reimbursement)

Waiver Transportation Services

Services that promote an individual's full participation in the community through access to waiver services, community activities, and medical appointments as specified by the individual's service plan when not otherwise available or funded by state plan or any other source. The service is offered in addition to transportation service under the State Plan as defined at 42 CFR$440.170(a) (if applicable), and does not replace it. Whenever possible family, neighbors, friends or community agencies that can provide this service without charge are utilized.

Providers will be required to adhere to the following requirements as outlined in the Ohio Administrative Code:

- OMA approved provider: OAC Chapters 5160-45 and 5160-46 including OAC rule 5160-46-04 (Definitions of Covered Services and Provider Requirements and Specifications) and 5160-46-06 (Reimbursement)

Reference

- Alternative Meals Service
  http://codes.ohio.gov/oac/173-39-02.2
- Home Modification, Maintenance and Repair
  http://codes.ohio.gov/oac/5101%3A3-46 (Home Care Waiver)
- Home Medical Equipment and Supplemental Adaptive Assistive Devices
  http://codes.ohio.gov/oac/173-39-02.7
- Waiver Transportation (Non-Medical Transportation Service)
  http://codes.ohio.gov/oac/173-39-02.18
- Waiver Nursing Service
  http://codes.ohio.gov/oac/5101:3-46-04
- Community Transition
  http://codes.ohio.gov/oac/173-39-02.17
- Enhanced Community Living
  http://codes.ohio.gov/oac/173-39-02.20
- Nutritional Consultation
  http://codes.ohio.gov/oac/173-39-02.10
- Social Work Counseling
  http://codes.ohio.gov/oac/173-39-02.10
- Independent Living Assistance
  http://codes.ohio.gov/oac/173-39-02.10

Provider Secure Web Portal & Member Care Information Portal Registration Form

Thank you for your interest in registering for the Aetna Better Health® Provider Secure Web Portal and the Aetna Better Health® Member Care Information Portal. Aetna Better Health® of Ohio is committed to protecting the privacy of our providers and members who use our websites. We use our best efforts to ensure that the information you submit to us is used only for the purposes of these websites and remains private. During registration, we ask for specific information about you. We do not disclose any information provided to us to any outside parties, except to manage the health plan or when the law may require it.

Providers should designate a **Primary Representative** (an "Administrator") from their office for the web portal. The primary representative will have the ability to add authorized representatives ("Staff"), within their office to the online account.

Registration Instructions: Both the information below and acceptance (with a representative's signature) of the attached agreement is required in order to complete registration.

Contracted Provider Name:		
Provider Office Name:		
Provider Tax ID/SSN:		
Provider NPI:		
Address:		
City:	State:	ZIP:
Phone:	Fax:	E-mail:

Provider Type: ☐ Group or ☐ Individual

Please print the full name and contact details of the primary representative below:

Name:	
Date of birth:	Phone:
Email address:	
Requested Secure Web Portal User Name:	

Email Opt-In Choice: I would like to receive marketing information directly from Aetna Better Health® of Ohio specifically for providers. I understand that I am able to unsubscribe at any time. I understand that by providing my initials, I will receive marketing emails from Aetna Better Health® of Ohio. I also understand that Aetna Better Health® of Ohio will secure my email address and only use my email for specific Aetna Better Health® provider marketing materials.

_______ - (Initial Here) My initials indicate my preference in opting in for emails.

Signature:	Date:
Print Name:	

aetnabetterhealth.com/ohio

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Please fax your completed form and attached agreements to our Provider Services Department at **1-855-826-3809**, or email to OH_ProviderServices@aetna.com. If you have questions about this form, please contact Provider Services at **1-855-364-0974**.

* * IMPORTANT NOTICE * *

You may use the Aetna Better Health® of Ohio Provider Secure Web Portal service only if you agree to the terms and conditions below. You indicate that you understand and agree to follow the terms and conditions by registering to use Aetna Better Health® Member Care Information Portal. If you do not agree to these terms and conditions, you may not register to use or use the Provider Secure Web Portal service.

Aetna Better Health® Member Care Information Portal and Provider Secure Web Portal Agreement

Definitions

In this Agreement, the words:

- “Administrator” or “Plan” means Aetna Better Health® and any owners, affiliates or direct or indirect subsidiaries.
- “Authorized Representative” means a person that a Provider has authorized to use Aetna Better Health® Member Care Information Portal under this Agreement on Provider’s behalf.
- “Member” means the person who is receiving medical services or supplies.
- “Primary Representative” means the Authorized Representative in the Provider’s office who has responsibility for adding, deleting and maintaining the names of the Provider’s Authorized Representatives within the Internet site supporting Aetna Better Health® Member Care Information Portal.
- “Provider” means the person signing this form with whom Aetna Better Health® has a contract to provide medical this services or supplies to Aetna Better Health® members
- “Service” means Aetna Better Health® Member Care Information Portal under this Agreement and the Web site that supports it.
- “Treatment” is defined pursuant to 45 CFR 164.501 the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Introduction

This Provider Secure Web Portal Agreement contains the terms and conditions that govern use of this Secure Web Portal service between the plan and an authorized user(s) for access to information on Aetna Better Health® of Ohio member eligibility, claims payments and prior authorization. Aetna Better Health® of Ohio maintains this site as part of its administration of Aetna Better Health® of Ohio’s MyCare Ohio plan.

Use of the Secure Web Portal Service

The portal provides access to information on plan member eligibility, claims payments and prior authorization through the internet. Provider shall use the service solely in connection with its health care services to members of the MyCare plan. End users (aka providers and office staff) shall use the portal solely in the course and scope of employment or agency with provider. Users shall use the portal subject to the following:

1) The terms and conditions of this agreement; and
2) The applicable provisions of provider’s contract with plan to provide health care services to plan members (the “provider contract”). The applicable provisions of the provider contract include, but are not limited to, use and disclosure of protected health information under the HIPAA privacy standards, member eligibility verification, utilization management standards within plan policies and the provider handbook, and timelines for submission and resubmission of claims.
3) In the event of a conflict between a term and condition under this agreement and a provision under the provider contract, the former shall govern.

Provider shall require the assigned users (“office staff”) to (1) keep confidential and not disclose the provider’s password to any person except provider or the primary user in the office; (2) use the portal solely in connection with provider’s health care services to members of plan and within the course and scope of employment or agency with provider; and (3) use the portal pursuant to the terms and conditions of this agreement.

Upon learning that the user(s) has violated (1), (2) or (3) or no longer works for or represents provider, provider shall immediately revoke such person's authority to use the portal. Provider shall also notify the plan when it has revoked the primary user's authority to use the portal for any other reason. The provider shall revoke the user's authority to use the portal if directed to do so by administrator.

If a user's authority is revoked, the provider shall immediately delete such person's access to the portal following and designate a new primary user following procedures provided by administrator.

Use of the Aetna Better Health® Member Care Information Portal Service
The service provides access to health information. The provider shall use the service solely for purposes of providing treatment to plan members.

The primary representative and each authorized representative shall use the service solely in the course and scope of employment with the provider or the agency. The provider, the primary representative and each authorized representative shall use the service subject to the terms and conditions of this agreement and the applicable provisions of the provider's contract with the plan to provide health care services to plan members (aka "Provider Contract"). In the event of a conflict between a term and condition under this agreement and a provision under the provider contract, the former shall govern.

The provider shall treat all member health information displayed on the Member Care Information Portal according to the applicable provisions of the HIPAA Privacy Standards, 42 CFR Part 2, and any other applicable state or federal law governing the privacy of health information.

With respect to member health information relating to treatment for drug or alcohol abuse or addiction, this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The provider shall require the primary representative and each authorized representative to (1) keep confidential and not disclose the provider's secure password to any person except the provider or the primary representative; (2) use the service solely in connection with the provider's health care services to members of the plan and within the course and scope of employment or agency with the provider; and (3) use the service pursuant to the terms and conditions of this agreement.

Upon learning that the primary representative or an authorized representative has violated (1), (2) or (3) or no longer works for or represents the provider, the provider shall immediately revoke such person's authority to use the service. The provider shall also notify Aetna Better Health® when they (he/she) has revoked the primary representative's or an authorized representative's authority to use the service for any other reason. The provider shall revoke the primary representative's or an authorized representative's authority to use the service if directed to do so by administrator.

If an authorized representative's authority is revoked, the primary representative shall immediately delete such person's access to the service following procedures provided by administrator. If the primary representative's authority is revoked, the provider shall immediately delete such person's access to the service and designate a new primary representative following procedures provided by administrator.

Changes to the Aetna Better Health® Member Care Information Portal and Provider Secure Web Portal Service or this Agreement
The administrator may, at any time, make changes to the portal , the terms and conditions in this agreement, or any other policies or conditions that govern the use of the service at any time. The provider should review the portal and these terms periodically for any updates or changes. The provider's continued access or use of the portal site shall be deemed as the provider's acknowledgement, notification and acceptance of these changes.

Warranties
The site Administrator uses reasonable methods to provide accurate and current information on member eligibility, claims payments and prior authorization(s) available through the Aetna Better Health® Member Care Information Portal and Provider Secure Web portal. However, because of the possibility of technical and human error, as well as other factors, there is no implied warranty of any kind, including of representation about the accuracy, completeness, or appropriateness or fitness for a particular purpose of

the portal, and non-infringement. While the Administrator uses reasonable methods to secure the portal, there is no warranty that the portal will be free from corrupted data, computer viruses or similar destructive or contaminating code.

IN PARTICULAR, THE MEMBER HEALTH INFORMATION APPEARING ON AETNA BETTER HEALTH® MEMBER CARE INFORMATION PORTAL MAY NOT REPRESENT A FULL OR ACCURATE PICTURE OF A MEMBER'S HEALTH HISTORY. PROVIDERS SHOULD RELY UPON ALL AVAILABLE SOURCES OF INFORMATION BEFORE RECOMMENDING, IN THEIR OWN PROFESSIONAL JUDGMENT, ANY COURSE OF TREAMENT FOR A MEMBER.

The provider assumes full responsibility for using the portal, and understands and agrees that neither plan nor administrator are responsible or liable for any claim, loss, or damage resulting from its use. The provider agrees to use the portal on an "AS IS" and an "AS AVAILABLE" basis. While the administrator uses reasonable methods to secure the service, there is no warranty that the service will be free from corrupted data, computer viruses or similar destructive or contaminating code.

Please note that some jurisdictions may not allow the exclusion of implied warranties, so some of the above exclusions may not apply to you.

Liabilities

Neither plan nor administrator will be liable for any delay, difficulty in use, inaccuracy or incompleteness of information, computer viruses, malicious code, loss of data, compatibility issues, or otherwise. The plan and the administrator will not be liable even if someone has advised of the possibility of such damages or loss, and/or someone has informed of a problem with the portal or its content. Providers are to uses the portal at their (his/her) own risk. The plan and the administrator will not be liable for any direct, indirect, incidental, consequential, or punitive damages arising out of provider's use of or access to the portal, or any other link provided to another site.

By using the portal, the provider accepts at their (his/her) own risk that the internet may not perform as intended despite the best efforts of the administrator, the provider or any internet service providers.

Ownership, License and Restrictions on Use of Materials

As between the plan, the administrator and the provider, all rights, titles and interests (including all copyrights, trademarks and other intellectual property rights) within the portal belong to the plan and or the administrator. In addition, the names, images, pictures, logos, and icons are proprietary marks that belong to the plan and or the administrator. Except as expressly provided below, nothing contained herein shall be construed as conferring any license or right, by implication, estoppel or otherwise, under copyright or other intellectual property rights.

The provider is hereby granted a nonexclusive, nontransferable, limited license to view and use information retrieved from the portal solely in connection with their (his/her) health care services to the members of the plan. Except as expressly stated above, no part of the information in or about the portal, including but not limited to materials retrieved from it and the underlying code, may be reproduced, republished, copied, transmitted, or distributed in any form or by any means. In no event shall materials from this site be stored in any information storage and retrieval system without prior written permission from the administrator.

The provider's use of this site allows the plan and the administrator to gather certain limited information about the provider and their (his/her) usage of the service. The provider agrees and consents to the use of such information in aggregated form.

Site System Integrity

The provider may use the portal for normal use in connection with their (his/her) health care services to members of the plan. The provider may not use any device, software, routine, or agent to interfere or attempt to interfere with the proper working of the service. The provider may not take any action, which imposes an unreasonable or disproportionately large load on the infrastructure. The provider may not disclose or share their (his/her) password(s) to or with third parties, except an authorized representative, or use their (his/her) password(s), or allow their (his/her) password(s) to be used, for any unauthorized purpose. The provider shall take reasonable precautions to secure its password from any unauthorized use. The provider may not attempt to log in with a user name or password other than their (his/her) own.

Continuous, uninterrupted access to the portal is not guaranteed. Numerous actions beyond the plan's control may interfere with the portal.

Governing Law; Legal Jurisdiction; and Statute of Limitations
The laws of Ohio govern this agreement, without regard to conflict of law principles, and the provider's access to and use of the portal under this agreement. The provider submits to the exclusive jurisdiction of the courts in Ohio and waives any jurisdictional venue or inconvenient forum objections to such court.

Before seeking legal recourse for any issue the provider believes they (he/she) may have suffered from use of the portal, the provider will give the plan written notice specifying the issue incurred directly relating to portal usage. The provider will allow thirty (30) days for the plan to correct the issue after being provided such a notice. In the event that the provider believes the service has irreparably harmed the provider, the provider agrees to inform the plan and to give the plan thirty (30) days to correct the issue before initiating action. The provider must initiate cause of action within one (1) year after the claim has arisen, or the provider will be prohibited from pursuing any cause of action.

Service Restriction
Subject to all applicable law, the plan and the administrator reserve the right to suspend or deny, in their singular or joint discretion, provider's access to all or any portion of the portal with or without notice. The provider agrees that any termination of the provider's access to the portal may be effected without prior notice. The provider acknowledges and agrees that the plan or the administrator may immediately prohibit any further access to the portal. Further, the provider agrees that the plan and the administrator shall not be liable to the provider or any third party for any termination of the provider's access to the portal.

Agreement Termination
Either party may cancel this agreement at any time. The administrator may immediately issue a warning, temporarily suspend, indefinitely suspend, or cancel this agreement with the provider and provider's access to the portal if, in the sole discretion of the administrator, the provider breaches this agreement.

Upon termination of this agreement, the provider agrees to destroy all materials obtained from use of the portal site, as well as all related documentation, copies, and installations, whether or not made under this agreement.

The person(s) signing this agreement warrants that he or she has full authority to do so and that the signature below binds the provider, including the provider's owners, employees, agents and representatives, on whose behalf the person below signs.

Acknowlegment of Acceptance

Signature:	Date:

NEITHER Aetna Better Health® OF OHIO NOR ANY OF ITS AFFILIATES, EMPLOYEES, AGENTS, LICENSORS OR CONTENT PROVIDERS MAKES ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND REGARDING THE WEBSITE AND SERVICES. THE WEBSITE AND SERVICES ARE PROVIDED ON AN "AS IS" AND "AS AVAILABLE" BASIS. PLAN SPECIFICALLY DISCLAIMS ANY EXPRESS OR IMPLIED WARRANTIES, INCLUDING WITHOUT LIMITATION, WARRANTIES OF FITNESS FOR A PARTICULAR PURPOSE, WARRANTIES OF MERCHANTABILITY, OR WARRANTIES AGAINST INFRINGEMENT.

TO BE COMPLETED BY THE HEALTH PLAN

This area to be completed by Aetna Better Health® of Ohio (Provider Services):

Provider ID# ______________________ Web Portal Intake PRS Signature ___________________________________

Hard Copy File Location ___________________________ Date Forwarded to PDS ______________________________

This area to be completed by Aetna Better Health® of Ohio (PDS):

Care Portal Data Intake PDS Signature ____

Hard Copy File Location ____

Date Completed ____

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Instructions for Electronic Funds Transfer (EFT) Enrollment/Change/Cancellation Page 1

7400 W. Campus Rd., New Albany, OH 43054
1-855-364-0974 | Fax: **844-252-9565** | Email: OHEFTFinanceEnrollment@aetna.com

Please use this guide to prepare/complete your Electronic Funds Transfer (EFT) Authorization Agreement Form. Missing, illegible or incomplete information within the agreement form will delay the benefits of participating in EFT. If you have questions about the authorization agreement form or the enrollment process, please call the Provider Relations Department at **1-855-364-0974** or email us at **OH_ProviderServices@aetna.com**.

Please note that the descriptions for the data elements contained in the Electronic Funds Transfer (EFT) Authorization Form have been placed in an Appendix to make it easier to complete the form. Please refer to the Appendix when completing the form.

☐ **Are you using one authorization agreement form per tax id number?**
- Enrollment forms containing more than one tax id will be returned.

☐ **Did you remember to put the NPI # on the authorization agreement form?**
- Enrollment forms without an NPI number (if the provider is required to have an NPI) will be returned.
- List additional NPI numbers to be enrolled in the space provided at the end of the enrollment form.

☐ **Have you attached an updated W9 with current mailing address?**
- Enrollment requests cannot be processed without this information.
- Blank W9 form provided in packet

☐ **Have you attached a pre-printed voided check with the account holder imprinted on the check or bank letter for new enrollments or changes in bank information?**
- Enrollment requests cannot be processed without this information.
- A voided check/bank letter must accompany the form. Deposit Slips, starter checks, handwritten or altered checks will not be accepted. The banking information on the voided check/bank letter must match what is listed on the form.

☐ **Has the form been signed by the appropriate individuals?**
- Unsigned forms will be returned.

☐ **Have you completed all sections?**
- Please type or print all requested information clearly. Incomplete and/or illegible fields will cause the form to be returned.

☐ **Have a completed form to submit? Forms can be submitted by fax or email.**
- Completed new or change authorization agreement forms with voided check and/or bank letter and completed cancellation authorization agreement forms can be submitted through one of the following methods:
  Fax to: Aetna Better Health of Ohio Finance at **1-844-252-9565**. Only one form per fax. Faxes containing multiple forms will be returned.
  Email to: OHEFTFinanceEnrollment@aetna.com. Only one form per email. Emails containing multiple forms will be returned.

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☐ **Need to change or cancel an existing enrollment?**

- Complete a new authorization agreement form to make changes to an existing enrollment or to cancel an existing enrollment. Complete all parts of the form and mark the appropriate choice in the Submission Information section of the form. You are responsible for notifying Aetna Better Health of Ohio of any changes in your information.

☐ **Need to check the status of your EFT enrollment?**

- Please allow 10-15 business days for processing once enrollment is received. Processing times may vary depending on number of enrollments received, accuracy of the information provided and how legible the form is.
- A confirmation email or letter will be sent to the Provider contact information on the enrollment form once setup is complete.
- A $0.00 pre-note test transaction will be sent to your financial institution. The pre-note period can take 10-15 days from the processing date of the approved Electronic Funds Transfer (EFT) Authorization Agreement Form.
- Changes to existing banking information will trigger a new 10 to 15 day pre-note period.
- The online instructions on our website at **www.aetnabetterhealth.com/ohio** will instruct you to contact the Provider Relations Department at **1-855-364-0974** or email **OH_ProviderServices@aetna.com** with any questions or to check enrollment status.

☐ **Have you contacted your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements from the NACHA ACH/EFT payment file?**

- Your financial institution must be a participating member of the Automated Clearinghouse Association (ACH) and accept the CCD+ format. You must proactively contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for the successful reassociation of the EFT payment with the ERA remittance advice.

☐ **Do you have a Late or Missing EFT payment or ERA remittance advice?**

- If you have not received your EFT payment or the corresponding ERA remittance advice by the 4th business day after you receive either the EFT payment or ERA remittance advice, contact your Provider Relations representative at **1-855-364-0974** or email us at **OH_ProviderServices@aetna.com** or fax us at **1-855-826-3809**.

Electronic Funds Transfer (EFT) Authorization Agreement Form

Page 3 – Definitions for DEG group data elements contained in Appendix.

DEG1	Provider Information
Provider Name	
Doing Business As Name (DBA)	
Provider Address Street	
City	
State/Province	
ZIP Code/Postal Code	

DEG2	Provider Identifiers Information									
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)										
National Provider Identifier (NPI)										

DEG3	Provider Contact Information
Provider Contact Name	
Telephone Number	
Email Address	
Fax Number	

DEG7	Financial Institution Information								
Financial Institution Name									
Financial Institution Address Street									
City									
State/Province									
ZIP Code/Postal Code									
Financial Institution Routing Number									
Type of Account at Financial Institution									
Provider's Account Number with Financial Institution									

Account Number Linkage to Provider Identifier - Select from one of the two below

☐ **Provider Tax Identification Number (TIN)**

☐ **National Provider Identifier (NPI)**

Electronic Funds Transfer (EFT) Authorization Agreement Form

Page 4 - Definitions for DEG group data elements contained in Appendix.

DEG8	Submission Information
Reason for Submission – Select from below	
☐ **New Enrollment**	
☐ **Change Enrollment**	
☐ **Cancel Enrollment**	
Include with Enrollment Submission – Select from below	
☐ **Voided Check**	
☐ **Bank Letter**	
Authorized Signature	
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	
Printed Title of Person Submitting Enrollment	

Authorization Agreement – By signing above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below. In addition, I represent and warrant that all of the information that I have provided to Aetna Better Health is accurate and complete.

Electronic Funds Transfers (EFT) Authorization Agreement

We, the Provider, certify that the bank account information listed on this form is under our direct control. We authorize Aetna Better Health of Ohio to initiate credit entries to the account at the bank listed on this form for all claims payments. We authorize and request the bank to accept credit entries by Aetna Better Health of Ohio to such account and to credit the same to such account.

We, the Provider, understand that if our account is closed and a new Electronic Funds Transfer (EFT) Authorization Agreement Form has not been submitted and processed, we will not receive payment until our bank returns the funds to Aetna Better Health of Ohio. This authorization remains in effect until we submit an updated Electronic Funds Transfer (EFT) Authorization Agreement Form requesting termination or change and until such time that Aetna Better Health of Ohio has had a reasonable opportunity to act on such request or Aetna Better Health of Ohio notifies us that this service has been terminated. If our depository information changes, we agree to submit an updated Electronic Funds Transfer (EFT) Authorization Agreement Form to that effect.

Aetna Better Health of Ohio will not debit or deduct funds directly from my bank account for claim overpayments and or refund requests but, If Aetna Better Health of Ohio credits more money than the correct benefits amount to the account, due to duplicate electronic funds transfers (where “duplicate” is defined as multiple electronic funds transfers received for the same services rendered, the same membership and the same dates of service) or erroneous electronic funds transfers (where “erroneous” is defined as complete electronic funds transfers received in error), Aetna Better Health of Ohio will pursue immediate repayment with the Provider.*

* Aetna Better Health of Ohio strictly adheres to the National Automated Clearing House Association (NACHA) guidelines.

Additional National Provider Identification (NPI) to be enrolled

NPI	NPI	NPI
NPI	NPI	NPI
NPI	NPI	NPI
NPI	NPI	NPI
NPI	NPI	NPI

DEG1	PROVIDER INFORMATION
Data Element Name	**Description**
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person(s) who actually own it and are responsible for it
Provider Address - Street	The number and street name where a person or organization can be found
Provider Address - City	City associated with provider address field
Provider Address – State/Province	ISO 3166-2 two character code associated with the State/Province/Region of the applicable Country

DEG2	PROVIDER IDENTIFIERS INFORMATION
Data Element Name	**Description**
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identifier Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digits number). This means that the numbers do not carry other information about the healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

DEG3	PROVIDER CONTACT INFORMATION
Data Element Name	**Description**
Provider Contact Name	Name of a contact in provider office for handling EFT issues
Telephone Number	Associated with contact person
Email Address	An electronic mail address at which the health plan might contact the provider
Fax Number	A number at which the provider can be sent facsimiles

DEG7	FINANCIAL INSTITUTION INFORMATION
Data Element Name	**Description**
Financial Institution Name	Official name of the provider's financial institution
Financial Institution Address - Street	Street address associated with receiving depository financial institution name field
Financial Institution Address - City	City associated with receiving depository financial institution address field
Financial Institution Address – State/Province	ISO 3166-2 two character code associated with the State/Province/Region of the applicable Country
Financial Institution Address – ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice

DEG8	SUBMISSION INFORMATION
Data Element Name	**Description**
Include with Enrollment Submission – Voided Check	A voided check is attached to provide confirmation of Identification/Account Numbers
Include with Enrollment Submission – Bank Letter	A letter on bank letterhead that formally certifies the account owners routing and account numbers
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment
Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

a Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type.
See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) a ________

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) a

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** a **Date** a

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

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Instructions for Electronic Remittance Advice (ERA) Enrollment/ Change/Cancellation Page 1

7400 W. Campus Rd., New Albany, OH 43054
1-855-364-0974 | Fax: **844-252-9565** | Email: OHEFTFinanceEnrollment@aetna.com

Please use this guide to prepare/complete your Electronic Remittance Advice (ERA) Authorization Agreement Form. Missing, illegible or incomplete information within the agreement form will delay the benefits of participating in ERA. The following is a reference guide only, do not fax, or email the instructions with the completed authorization form. Return Pages 2-3 ONLY. If you prefer to enroll/ change/cancel electronically, please go to our website at www.aetnabetterhealth.com/ohio for the electronic form and instructions. If you have questions about the authorization agreement form or the enrollment process, please contact the Provider Services Department at 1-855-364-0974 or email us at OH_ProviderServices@aetna.com.

Please note that the descriptions for the data elements contained in the Electronic Remittance Advice (ERA) Authorization Form have been placed in an Appendix to make it easier to complete the form. Please refer to the Appendix when completing the form.

☐ **Are you using one authorization agreement form per tax id number?**
- Enrollment forms containing more than one tax id will be returned.

☐ **Did you remember to put the NPI # on the authorization agreement form?**
- Enrollment forms without an NPI number (if the provider is required to have an NPI) will be returned.
- List additional NPI numbers to be enrolled in the space provided at the end of the enrollment form.

☐ **Additional Information**
- Please contact your vendor for additional information on which distribution method to utilize as each vendor/clearinghouse may have a different distribution method.
- If you do not use a vendor and have questions, please contact the Provider Services Department at **1-855-364-0974** or email **OH_ProviderServices@aetna.co**m.
- If you would like to link directly with Emdeon please contact Emdeon Sales at **1-877-363-3666**. There may be an additional cost associated with linking directly with Emdeon.

☐ **Need to change or cancel an existing enrollment?**
- Complete a new authorization agreement form to make changes to an existing enrollment or to cancel an existing enrollment. Complete all parts of the form and mark the appropriate choice in the Submission Information section of the form. You are responsible for notifying Aetna Better Health of Ohio of any information changes.

☐ **Has the form been signed by the appropriate individuals?**
- Unsigned forms will be returned.

☐ **Have you completed all sections?**
- Please type or print all requested information clearly. Incomplete and/or illegible fields will cause the form to be returned.

☐ **Have a completed form to submit? Forms can be submitted by fax or email.**
- Completed new, change and cancellation authorization agreement forms can be submitted through one of the following methods: Fax to: Aetna Better Health of Ohio, Provider Services Department **Fax**: **1-855-826-3809**. Only one form per fax. Faxes containing multiple forms will be returned. **Email to: OH_ProviderServices@aetna.com**. Only one form per email. Emails containing multiple forms will be returned.

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- [ ] **Need to check the status of your ERA enrollment?**
    - Please allow 10-15 business days for processing once enrollment is received. Processing times may vary depending on number of enrollments received, accuracy of the information provided and how legible the form is.
    - The online instructions on our website at www.aetnabetterhealth.com/ohio will instruct you to contact the Provider Services Department at **1-855-364-0974** or email **OH_ProviderServices@aetna.com** with any questions or to check enrollment status.

- [ ] **Have you contacted your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements from the NACHA ACH/EFT payment file?**
    - Your financial institution must be a participating member of the Automated Clearinghouse Association (ACH) and accept the CCD+ format. You must proactively contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for the successful reassociation of the EFT payment with the ERA remittance advice.

- [ ] **Do you have a Late or Missing EFT payment or ERA remittance advice?**
    - If you have not received your EFT payment or the corresponding ERA remittance advice by the 4th business day after you receive either the EFT payment or ERA remittance advice, contact your Provider Services representative at **1-855-364-0974**, email us at **OH_ProviderServices@aetna.com** or fax us at **1-855-826-3809**.

Electronic Remittance Advice (ERA) Authorization Agreement
Page 3 – Definitions for DEG group data elements contained in Appendix.

DEG1	PROVIDER INFORMATION
Provider Name	
Doing Business As Name (DBA)	
Provider Address Street	
City	
State/Province	
Zip Code/Postal Code	

DEG2	PROVIDER IDENTIFIERS INFORMATION
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	
National Provider Identifier (NPI)	

DEG3	PROVIDER CONTACT INFORMATION
Provider Contact Name	
Telephone Number	
Email Address	
Fax Number	

DEG7	ELECTRONIC REMITTANCE ADVICE INFORMATION
Preference For Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) - Select from below	
Provider Tax Identification Number (TIN)	
National Provider Identifier (NPI)	
Method of Retrieval	

DEG8	ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION
Clearinghouse Name	
Clearinghouse Contact Name	
Telephone Number	
Email Address	

DEG10	SUBMISSION INFORMATION
Reasons For Submission – Select from below	

☐ **New Enrollment**

☐ **Change Enrollment**

☐ **Cancel Enrollment**

Electronic Remittance Advice (ERA) Authorization Agreement Page 4 – Definitions for DEG group data elements contained in Appendix.	
Authorized Signature	
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	
Printed Title of Person Submitting Enrollment	

Authorization Agreement – By signing above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below.

Authorization Agreement

Electronic Remittance Advice (ERA)

An ERA is an electronic version of a payment explanation of benefits (EOB) explaining claims payment or denial.

This authorization is to remain in effect until Aetna Better Health of Ohio has received an ERA cancellation notification from me that affords Aetna Better Health of Ohio a reasonable opportunity to act on it. Please allow 10-15 business days for processing once enrollment is received. Processing times may vary depending on number of enrollments received, accuracy of the information provided and how legible the form is.

Additional Required Information For Enrollment – MUST BE COMPLETED

ERA Receiver Information**		
Receiver ID		
Distribution Method** (must indicate one method)	❑ FTP Internet Log ID (8 characters) ❑ TSO ID ❑ NDMs Node Name (unique vendor ID) lower case ❑ Emdeon Office (email address)*** ❑ Emdeon Payment Manager	**Distribution**

ERA Receiver Information and Distribution Method Choices(Receiver ID must accompany the Distribution Method):**

1. FTP Internet- this may be an FTP log on or it may be used to list the payment manager connection. MEDICOM is the distribution method when using payment manager.
2. TSO Mailbox- this is a dial up connection.
3. NDM S Node- this is typically used for 837 claim submissions.
4. Emdeon Office*** is a suite of Emdeon practice management products, which includes a multitude of provider products. Emdeon Office should only be selected if you as the provider use the suite of Emdeon Office practice management products.
5. Emdeon Payment Manager – Enter Payment Manager as the Receiver ID even if enrolling for Payment Manager as part of this ERA enrollment.

Additional Information Required If Enrolling in Emdeon Payment Manager – Offered at no additional cost		
Check the correct box to indicate a Payment Manager request	Yes ❑ No ❑	Both ERA and Payment Manager ❑
If Payment Manager, does a User ID already exist?	Yes ❑ No ❑	Payment Manager User ID:

Additional National Provider Identification (NPI) to be enrolled		
NPI	**NPI**	**NPI**
NPI	**NPI**	**NPI**
NPI	**NPI**	**NPI**
NPI	**NPI**	**NPI**
NPI	**NPI**	**NPI**

General Reference Information

Payer Information

Payer ID: **Aetna Better Health of Ohio 50023**	**Tax ID:** **45-2764938**

Emdeon Confirmations – Internal Use Only

Send Emdeon 835 enrollment confirmations to: OH_ProviderServices@aetna.com

Appendix - Data Element Names and Descriptions – To be used for completing the Electronic Remittance Advice (ERA) Authorization Agreement Page 6

DEG1	PROVIDER INFORMATION
Data Element Name	**Description**
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person(s) who actually own it and are responsible for it
Provider Address - Street	The number and street name where a person or organization can be found
Provider Address - City	City associated with provider address field
Provider Address – State/Province	ISO 3166-2 two character code associated with the State/Province/Region of the applicable Country
Zip Code/Postal Code	System of postal-zone codes (zip stands for “zone improvement plan”) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities

DEG2	PROVIDER IDENTIFIERS INFORMATION
Data Element Name	**Description**
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identifier Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digits number). This means that the numbers do not carry other information about the healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

DEG3	PROVIDER CONTACT INFORMATION
Data Element Name	**Description**
Provider Contact Name	Name of a contact in provider office for handling ERA issues
Telephone Number	Associated with contact person
Email Address	An electronic mail address at which the health plan might contact the provider
Fax Number	A number at which the provider can be sent facsimiles

DEG7	ELECTRONIC REMITTANCE ADVICE INFORMATION
Data Element Name	**Description**
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) - Select from below	Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment
Provider Tax Identification Number (TIN)	
National Provider Identifier (NPI)	
Method of Retrieval	The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)

DEG8	ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION
Data Element Name	**Description**
Clearinghouse Name	Official name of the provider's clearinghouse
Clearinghouse Contact Name	Name of a contact in clearinghouse office for handling ERA issues
Telephone Number	Telephone number of contact
Email Address	An electronic mail address at which the health plan might contact the provider's clearinghouse

DEG10	SUBMISSION INFORMATION
Data Element Name	**Description**
Reason for Submission - Select from below	
New Enrollment	
Change Enrollment	
Cancel Enrollment	
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment.
Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment

Aetna, A CVS Health Company
Medicare Compliance Program Guidelines
First Tier Attestation

This attestation confirms your organization received Aetna's *First Tier, Downstream and Related Entity ("FDR") Medicare Compliance Program Guide*. It also confirms your commitment to comply with the Centers for Medicare & Medicaid Services (CMS) requirements[1]. These requirements are listed below and apply to all services your organization, as Aetna's First Tier Entity[2], provides for Aetna Medicare business[3]. The requirements also apply to any of the Downstream Entities[4] you use for Aetna Medicare business.

1. **Standards of Conduct and/or Compliance Policies**
   My organization has Standards of Conduct and/or Compliance Program policies that explain its commitment to comply with federal and state laws, ethical behavior and compliance program operations. They are distributed to employees within 90 days of hire, upon revision, and annually thereafter.
2. **US Department of Health & Human Services Office of Inspector General (OIG) and General Services Administration's System for Award Management (SAM) exclusion screening**
   My organization screens the OIG and the SAM exclusion lists prior to hire or contracting, and monthly thereafter, for our employees and Downstream Entities. My organization immediately removes any person/entity from working on Aetna Medicare business if found on either of these lists, and we will notify Aetna right away.
3. **Reporting Mechanisms**
   My organization communicates to employees how to report suspected or detected non-compliance or potential Fraud, Waste, or Abuse, and that it is their obligation to report without fear of retaliation or intimidation against anyone who reports in good faith. My organization either requests employees report concerns directly to Aetna or maintains confidential and anonymous mechanisms for employees to report internally. In turn, we report these concerns to Aetna, when applicable.
4. **Offshore Operations**
   If my organization and/ or our Downstream Entities perform work that involves the receipt, processing, transferring, handling, storing or accessing of Protected Health Information (PHI) offshore, we have submitted Aetna's *Offshore Services Attestation: Required Information* form and have received approval from an authorized Aetna representative.
5. **Downstream Entity Oversight**
   My organization either doesn't use Downstream Entities, or uses Downstream Entities for Aetna Medicare business and conducts oversight to ensure that they abide by all laws, rules and regulations that apply to me as a First Tier Entity. This includes ensuring that my organization's:
   - Contractual agreements with Downstream Entities contain all CMS-required provisions
   - Downstream Entities comply with the Medicare compliance program requirements described in this attestation
   - Downstream Entities comply with any applicable Medicare operational requirements
6. **Operational Oversight**
   My organization conducts internal oversight of the services that we perform for Aetna Medicare business to ensure that compliance is maintained with applicable laws, rules, and regulations including CMS regulatory/sub-regulatory guidance.

I certify, as an authorized representative of my organization, that the statements made above are true and correct to the best of my knowledge. Also, my organization agrees to maintain documentation supporting the statements made above. We'll maintain this documentation in accordance with federal regulations and our contract with Aetna, for a period of no less than ten (10) years. My organization will produce this evidence, upon request. My organization understands that the inability to produce this evidence may result in a request by Aetna for a Corrective Action Plan (CAP) or other contractual remedies such as contract termination.

Revised April 2019

Proprietary

Aetna, A CVS Health Company
Medicare Compliance Program Guidelines
First Tier Attestation

____
First Tier Organization's Authorized Representative Printed Name and Title

____ _____________
Signature of First Tier Organization's Authorized Representative Date

____
First Tier Organization Name Printed

____
First Tier Organization Mailing Address

____
Tax ID# (TIN)/Employer ID# (EIN)

____

[1] CMS's guidance for Medicare Advantage organizations and Part D sponsors are published in both, Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 9 and in Pub.100-16, Medicare Managed Care Manual, Chapter 21, and are identical in each. Other applicable CMS regulatory/sub-regulatory guidance includes, but is not limited to: CY2019 Final Rule CMS-4182-F published April 16, 2018; 42C.F.R.§§422 & 423; and associated CMS Manuals and HPMS memos.

[2] First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or healthcare services to a Medicare eligible individual under the Medicare Advantage program or Part D program. (See, 42 C.F.R. §§ 422.500 & 423.501)

[3] For purposes of this attestation, "Aetna Medicare Business" means Medicare Advantage, Medicare-Medicaid Plans (MMPs), Dual Special Needs Plans (DSNPS), and/or Medicare prescription drug plans (PDP), offered or administered by a subsidiary company of CVS Health, including but not limited to Aetna Health companies, Aetna Better Health companies, Aetna Life Insurance Company, Coventry Health and Life Insurance Company, Coventry Health Care companies, First Health Life & Health Insurance Company, SilverScript Insurance Company, and those joint venture entities in which a CVS Health subsidiary company has ownership interests (any of whom individually or collectively here are referred to as "Aetna"),

[4] Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §§ 422.500 & 423.501)

Revised April 2019

Proprietary