Aetna Better Health ® of
Ohio, a MyCare Ohio plan
MyCare Ohio plan
Provider Training
RESEARCHE

Aetna Better Health of Ohio Overview

- Aetna has more than 150 years of experience in meeting enrollees' health care needs with 25 years of experience in Medicare and Medicaid managed care.
- Aetna Inc. – Commercial and Medicare Products
- Aetna Better Health – Medicaid Products
- Aetna Better Health of Ohio – MyCare Ohio plan

Aetna Better Health of Ohio Overview

Aetna Better Health business unit operates in the following areas:

AETNA MEDICAID PROGRAMS

MISSOURI
HealthCare USA
Owner & Administrator
Pop. TANF/CHIP/
Foster Children

Coventry Health Care of Missouri
Owner & Administrator
Pop. Duals SNP

NEBRASKA
CoventryCares of Nebraska
Owner & Administrator
Pop. TANF/ABD/SSI/CHIP/
Foster Children

MICHIGAN
CoventryCares of Michigan
Owner & Administrator
Pop. TANF/ABD/SSI/CHIP
Dual Eligibles
COMING 2014

ILLINOIS
Aetna Better Health
Owner & Administrator
Integrated Care Program
Pop. ABD/LTSS
Dual Eligibles
COMING 2014

PENNSYLVANIA
Aetna Better Health Kids
Owner & Administrator
Pop. CHIP

Aetna Better Heath
Owner & Administrator
Pop. TANF/ABD/
Dual Eligibles/
Working Uninsured

CoventryCares
Owner & Administrator
Pop. TANF/ABD/SSI/
Medically & Clinically Needy

Coventry Health Care
of Pennsylvania
Owner & Administrator
Pop. Duals SNP

NEW YORK
Aetna Better Health
Owner & Administrator
Pop. MLTC
Fully Integrated Duals Advantage
COMING 2014

DELAWARE
Delaware Physicians Care
Owner & Administrator
Pop. TANF/CHIP/ABD/LTC

MARYLAND
Maryland Physicians Care
Administrator
Pop. TANF/CHIP/DD/ABD/PAC

OHIO
Aetna Better Health
Owner & Administrator
Pop. Dual Eligibles
COMING 2014

VIRGINIA
MajestaCare
Administrator
Pop. TANF/CHIP/ABD

CoventryCares of Virginia
Owner & Administrator
Pop. TANF/ABD/SSI/CHIP

WEST VIRGINIA
CoventryCares of West Virginia
Owner & Administrator
Pop. TANF

KENTUCKY
CoventryCares of Kentucky
Owner & Administrator
Pop. TANF/Dual Eligibles/ABD/SSI/CHIP/
Foster Children

ARIZONA
Mercy Care Plan
Administrator
Pop. TANF/CHIP/ABD/LTC/DD/Dual
Eligibles/Medicare SNP

Mercy Maricopa Integrated Care
Administrator
Maricopa RBHA
Pop. GMH/SMI/SA/Medicare SNP
COMING 2014

TEXAS
Aetna Better Health
Owner & Administrator
Bexar Service Area
Pop. TANF/CHIP

TEXAS
Aetna Better Health
Owner & Administrator
Tarrant Service Area
Pop. TANF/CHIP

Parkland Community
Health Plan
Administrator
Dallas Service Area
Pop. TANF/CHIP

TEXAS
CHRISTUS
Health Plan
Administrator
Nueces
Service Area
Pop. TANF/CHIP

FLORIDA
Vista
Owner & Administrator
Pop. TANF/ABD/SSI/
Florida Healthy Kids (CHIP)/
Long Term Care Duals

Buena Vista
Owner & Administrator
TANF/ABD/SSI

Vista Independence Plan
Owner & Administrator
Nursing Home Diversion
(sunsets 2013; will be
replaced by Coventry Health
Care of Florida Managed
Long Term Care)

Coventry Health Care of Florida
Owner & Administrator
Pop. Duals SNP

*

The names listed above do not, in all instances, reflect the licensed legal entity or full name of the health plan or line of business in each state.

SA-13-10-02

Aetna Better Health of Ohio Counties

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

Eligibility

Individuals who meet the following plan eligibility requirements may enroll:

- Entitled to benefits under Medicare Part A and enrolled in Medicare Parts Part B and D, and receiving full Medicaid benefits
- Reside in a MyCare Ohio plan county
- Age 18 or older at the time of enrollment

Non-Eligible Populations

The following populations are not eligible for the MyCare Ohio plan:

- Individuals under the age of 18
- Individuals who are Medicare and Medicaid eligible and are on delayed Medicaid spend down
- Individuals enrolled in both Medicare and Medicaid who have other third party creditable health care coverage
- Individuals with Intellectual Disabilities (ID) and other Developmental Disabilities (DD) who are otherwise serviced through an Intellectual and Developmental Disabilities (IDD) 1915(c) HCBS waiver or an Intermediate Care Facility- Intellectual and Developmental Disabilities (ICF-IDD)
- Individuals enrolled in a Program of All-inclusive Care for the Elderly (PACE)
- Individuals participating in the Centers of Medicare and Medicaid (CMS) Independence at Home (IAH) demonstration

Integrated Care Management

- Our Integrated Care Management (ICM) approach uses a bio-psycho-social model (BPS) to identify and reach our most vulnerable enrollees.
- The approach matches enrollees with the resources they need to improve their health status and to sustain those improvements over time.
- We use evidence-based practices to identify enrollees at high risk of not doing well over the next 12 months, and offer them intensive care management services built upon a collaborative relationship with a single clinical care manager, their caregivers and their primary provider. This relationship continues throughout the care management engagement.
- We offer enrollees who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support.

Please note that our clinical guidelines are located on our website.

Care Coordination

We will provide care planning and care coordination by a Trans-disciplinary Care Management Teams (TCMTs) that will be centered around each enrollee in the MyCare Ohio plan The TCMT is a team of individuals that will provide person-centered care coordination and care management to enrollees.

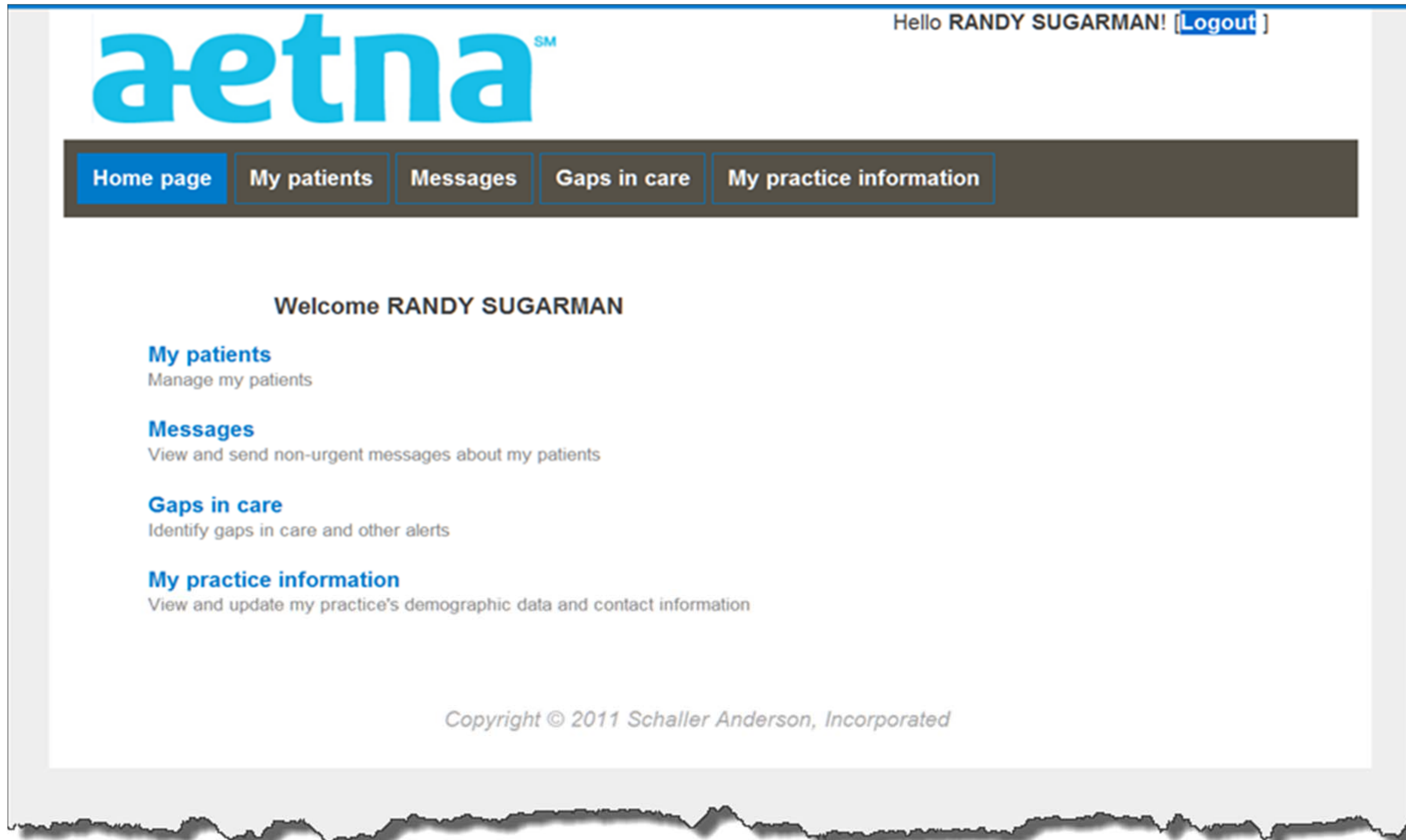
Primary Care Provider (PCPs) in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to enrollees assigned to them, and attempt to ensure coordinated quality care that is efficient and cost effective.

Coordination responsibilities include, but are not limited to:

- Referring enrollees to providers (i.e., MH/SA providers, hospitals)
- Coordinating prior authorization procedures & medical care (including ER services, inpatient care, drug oversight, and care rendered by a specialist)
- Conducting follow-up with enrollee
- Care setting transitioning and coordinating with clinical services and community-based LTSS

Member Care Secure Web Portal

Provider View



Mental Health/Substance Abuse (MH/SA)

In order to meet the behavioral health needs of our enrollees, we will provide a continuum of services to enrollees at risk of or suffering from mental, addictive, or other behavioral disorders.

We endorse early identification of mental health issues so that timely intervention, including treatment and patient education, can occur. To that end, providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem/disorder
- Treat mental health and/or substance abuse disorders within the primary care providers' scope of practice
- Inform enrollees how and where to obtain behavioral health services
- Understand that enrollees may self-refer to an in-network behavioral health care provider without a referral from the enrollee's PCP.

Whenever a PCP is concerned about an enrollee who may have a MH/SA problem, it can be very helpful to have designated screening tools to help the PCP decide whether to take further action. Please refer to the Provider Manual about the tools we use to screen enrollees with possible MH/SA concerns.

Covered Services

Under the MyCare Ohio plan, Aetna Better Health of Ohio are responsible for administering medically necessary Medicare Parts A, B, and D and Medicaid State Plan and 1115(a) and 1915(c) waiver items and services to covered enrollees. For a complete list of covered services, please review the MyCare Ohio Provider Manual.

Healthchek - Early & Periodic Screening, Diagnostic, and Treatment (EPSDT)

- As mandated by Ohio Administrative Code Chapter 5160-14, screening components of the healthchek (EPSDT) visit shall be provided to individuals at ages and at frequencies in accordance with American academy of pediatrics recommendations for preventative pediatric health care (March, 2000), www.aap.org.

- Healthcheks include a range of medically necessary screening, diagnosis and treatment services

- Recommendations for Preventive Pediatric Health Care:

http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

- A list of commonly used billing codes are listed below:

Billing Codes	Descriptions
90704	MUMPS VIRUS VACCINE LIVE SUBCUTANEOUS
90705	MEASLES VIRUS VACCINE LIVE SUBCUTANEOUS
90712	POLIOVIRUS VACCINE ANY LIVE ORAL

Required components are located: http://codes.ohio.gov/oac/5160-14-03

Pharmacy Coverage

CVS Caremark administers the prescription drug benefit for our enrollees.

- Some enrollees may have a copay for Part D drugs

- Pharmacies are required to follow federal and state guidelines surrounding dispensing emergency medications.

- The following document are available online:
  - Preferred Drug List (PDL)
  - Over-the-Counter Drug List
  - Prior Authorization Form
  - Mail Order Form

Medical Prior Authorization

You may submit prior authorization requests to us 24-hours-a-day, 7-days-a-week through one of the options below:

- Secure Web Portal (Only for In-Network Providers)
- Fax
- Phone

Please submit the following with each authorization request:

- Enrollee Information, e.g., correct and legible spelling of name, ID number, date of birth, etc.
- Diagnosis Code(s)
- Treatment or Procedure Codes
- Anticipated start and end dates of service(s) if known
- All supporting relevant clinical documentation to support the medical necessity
- Include an office/department contact name, telephone and fax number

Prior Authorization Decision Timeframes

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Seventy-two (72) hours from receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent pre-service denial	Seventy-two (72) hours from receipt of request	Practitioner/Provider Enrollee	Oral and Electronic/Written
Non-urgent pre-service approval	Fourteen (14) Calendar Days from receipt of the request	Practitioner/Provider	Oral or Electronic/Written
Non-urgent pre-service denial	Fourteen (14) Calendar Days from receipt of the request	Practitioner/Provider Enrollee	Electronic/Written
Urgent concurrent approval	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent concurrent denial	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral and Electronic/Written
Post-service approval	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider	Oral or Electronic/Written
Post-service denial	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider Enrollee	Electronic/Written
Termination, Suspension Reduction of Prior Authorization	At least fifteen (15) Calendar Days before the date of the action.	Practitioner/Provider Enrollee	Electronic/Written

Provider Secure Web Portal

Provider View

-Prior Authorization Requirements Search Tool

Hello Shepherd,Dirk (Provider - Admin)

Home | Help | FAQ | Sign Out

Home | My Account | Tasks | Administration

aetna

AETNA BETTER HEALTH® OF OHIO

Welcome Note Message

Welcome to the Aetna Better Health of Ohio provider and member web portal

Health News

Welcome to Medicaid Portal ... Health Plan User

Highlights

- You have 0 Message(s) in your Inbox.
- You have 0 Post(s) through Posts and Notifications.

Health Plan Contacts

For any questions, please contact
Member/Provider Services Department at (855) 364-0974 ,
Hearing Impaired (TTY/TDD): 711
or email them at OH_ProviderServices@aetna.com

OR

Contact us through e-mail by click the following link
Contact Health Plan

Useful Links

Aetna Better Health of Ohio

Ohio Provider Directory

Pharmacies

Ohio Department of Medicaid

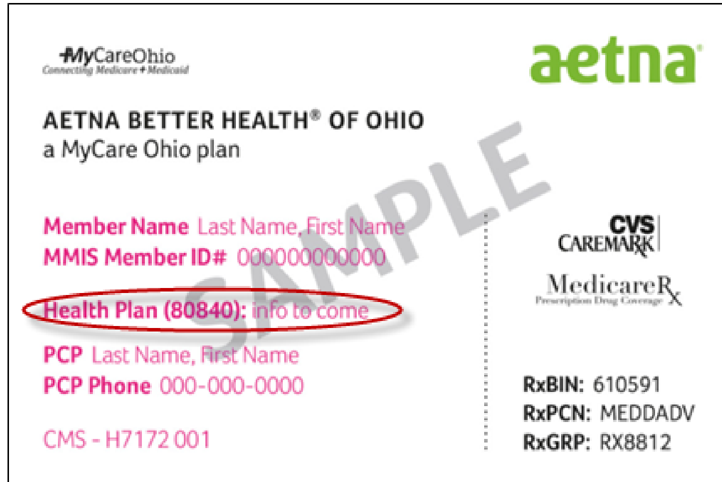
Centers for Medicare and Medicaid Services

Download the latest version of Adobe Acrobat Reader here

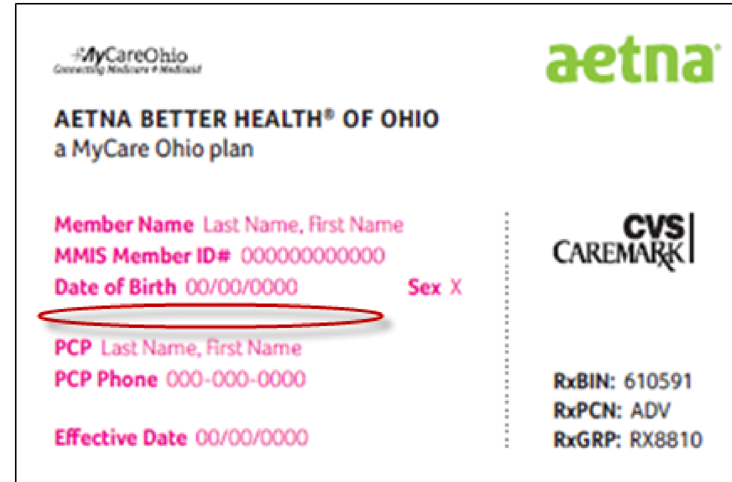
Sample ID Cards

Front

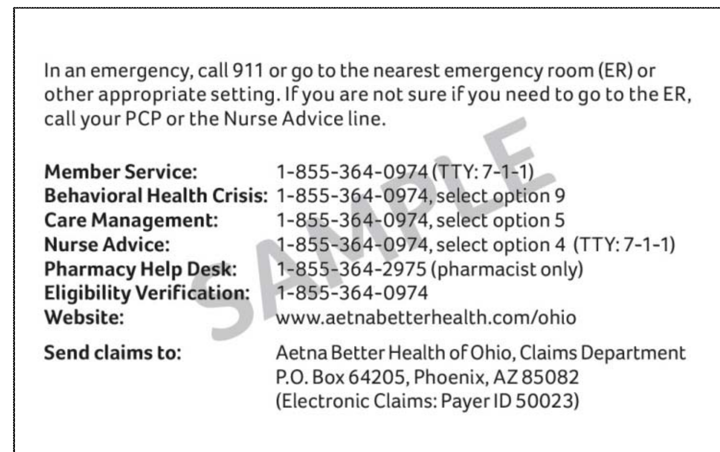
Duals



Medicaid



Back



Clearinghouse & Clean Claims

Important- Providers are prohibited from balance billing MyCare Ohio enrollees for costs of any covered service, which includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part. Please note that payments that providers receive are, in whole or in part, from federal funds. (Except Part D Pharmacy Copay's)

- We accept both paper and electronic claims

- Emdeon is preferred clearinghouse for electronic claims
  - EDI claims received directly from Emdeon
  - Processed through pre-import edits to:
    - Evaluate data validity
    - Ensure HIPAA compliance
    - Validate enrollee enrollment
    - Facilitate daily upload to Aetna Better Health system
- We process clean claims according to state and federal timeframes

- A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

Claim Submission

Aetna Better Health encourages participating providers to electronically submit claims through Emdeon. You can submit claims by visiting Emdeon at http://www.emdeon.com/. Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Emdeon.

Please use the following Submitter (Payer) ID when submitting claims to Aetna Better Health:

- Submitter (Payer) ID# 50023
- Provider ID# 0082400 (for FQHCs/RHCs when billing ODM)

Paper Claims:
Aetna Better Health of Ohio
P.O. Box 64205
Phoenix, AZ 85082

Claim Submission

Please note that we follow Ohio's billing practices, (i.e., required diagnosis codes, CPT, HCPCs and associated modifiers), and Ohio's fee schedule methodologies. We also follow Ohio's timely filing requirements along with the claim dispute processes and timeframes.

Common Barriers

- 5010 Requirements (Rendering NPI and pay-to NPI; Both are required)
- NDC Codes Missing or Incomplete
- Lack of Prior Authorization

Resubmissions

- Electronic and paper resubmitted claims are accepted, however, we prefer electronic claims. Resubmitted claims must be labeled appropriately.
- Our Provider Services staff, Manager or the COO are available for any escalated issue and/or concerns.

Claim Submission

Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.

- How to fill out a CMS 1500 Form:
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
- Sample CMS 1500 Form:
  - http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf
- How to fill out a CMS UB-04/1450 Form:
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

Example 1

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 133445567 – Enter Member Plan ID here

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): John Doe

3. PATIENT'S BIRTH DATE MM DD YY: 09 01 43 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Main St.

CITY: Chicago STATE: IL

ZIP CODE: 60001 TELEPHONE (Include Area Code): (312) 123-4567

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES NO
b. AUTO ACCIDENT? YES NO PLACE (State)
c. OTHER ACCIDENT? YES NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 250.00 (ALL FIVE DIGITS MUST ENTERED ICD-9 Dx)
2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10 01 13	10 07 13	12		S5170	1	$ 343.20	80		NPI	12345678901 0987654321
									NPI	
									NPI	
									NPI	

Enter Medicaid ID Here

Enter NPI Here

Enter Dates of Service Here

Enter Place of Service Here

VISIT WWW.CMS.GOV

Enter CPT Code Here

Enter Cost for All Units Here

Enter Units Here

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123456789 – Enter TIN Here

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 343.20

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Provider Sign and Date Here

SIGNED DATE 2/1/12

32. SERVICE FACILITY LOCATION INFORMATION: Service Location Here — ABC Facility, 987 Main St., Nowhere, IL 99999

a. 0987654321 b. 12345678901

33. BILLING PROVIDER INFO & PH #: Provider Billing Info Here — ABC Facility, 123 Stop Here Road, Anywhere, IL 99999

a. 0987654321 b. 12345678901

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Enter NPI Here

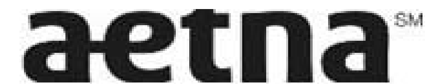
Enter Medicaid ID Here

Enter NPI Here

Enter Medicaid ID Here

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Sample Authorization



September 28, 2012

Member ID:	976545290
Member Name:	Amanda Jackson17
Address:	88 North St Anytown, IL 60606
Phone:	123-123-1234
Date of Birth:	05/03/1969
Servicing Provider	AGE WITH GRACE
Address:	555 MAIN STREET SUITE 5 ANYTOWN, NY 98789
Phone:	(555) 111-2233
Home Delivered Meal Site:	88 North St Anytown, IL 60606
Phone:	123-123-1234
PCP Name	Walter Wolf
PCP Phone:	(555) 111-2365
Case Manager:	Mary Smith
Phone:	(555) 555-5555
Diagnosis:	344.9 - UNSPECIFIED PARALYSIS
Service Code:	S5170 Home Delivered Meals
Billing Modifier:	None
Units:	5
Frequency:	Weekly
Service Start Date:	12/01/2012
Service End Date:	02/28/2013
Member Service Preference Level:	4-Can wait until next scheduled visit
Authorization Number:	123456789098

Notice to Community Agencies

Community Agencies should not bill for any days that fall between the admission date and the discharge date of a member's hospitalization, and should never bill on any day during which services were not provided.
If any hours are submitted when a member has been hospitalized for the full 24 hours, or it is discovered through audit that services were not provided, the agency will be required to pay back any monies paid by the Plan.

Claims Submission Tips

Important Documentation Requirements

Personal Emergency Response System

- Documents do not need to be sent in with your claim
- Continue to send documentation to the Care Manager at the Plan
- The Care Managers name will be on the Service Authorization Letter

Home Health Agencies

- Documents do not need to be sent in with your claim
- Continue to send documentation to the Care Manager at the Plan
- The Care Managers name will be on the Service Authorization Letter

National Drug Code (NDC)

- An NDC is a unique 11-digit, three-segment number assigned to drugs by the Food and Drug Administration (FDA). The Deficit Reduction Act of 2005 (DRA) requires Medicaid agencies to collect NDC numbers on pharmaceuticals.

- Primary Care Providers, Specialty Care Providers, Outpatient Hospital Departments, Federally Qualified Health Centers, Rural Health Centers, and all other outpatient providers administering drugs to patients are required to submit NDC codes.

- NDC codes have an assigned HCPCS code. It is important that claims be submitted with the most accurate information when billing for injectable medications that are administered in the office during an enrollee's visit.

Please refer to the Quick Reference guide located in your Provider Orientation Kit for further information regarding NDC.

Provider Services Department

- Contact (Phone/Email) : 1-855-364-0974 or OH_ProviderServices@aetna.com
- Provider Services Manager:
  - Responsible for Provider Services Representatives and Liaisons
  - Responsible for training Provider Staff in all areas (i.e., provider questions, provider complaints, provider responsibilities, claim submission, prior authorization requirements and enrollee eligibility).
- Provider Services Staff:
  - Educate network providers on our policy and procedures & claim submission.
  - Inform providers of changes through face-to-face visits, provider forums, webinars
  - Provide written or electronic communication including the Provider Manual, Periodic Provider Newsletters, and fax/email blasts.
- If you're interested in participating in our EFT program and/or would like electronic 835 remits, please email us at the above email address for additional information.

Provider Communications

Provider Newsletters

We publish Periodic Provider Newsletters to all participating network provider. The purpose of periodic newsletters is to provide a consistent and reliable method of communication with participating network providers. The Network Newsletter will also be posted on our web page.

Special Provider Communications

Special provider communications are used to distribute information updates to our provider practices, when the distribution and implementation timeline for the information (e.g., new evidence-based practice guidelines) precedes the next regularly scheduled provider communication.

Enrollee Rights & Responsibilities

It is our policy not to discriminate against enrollees based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of enrollee rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating enrollees with respect and dignity.

In the event that we are made aware of an issue with an enrollee not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.

For a complete list of enrollee's right and responsibilities, please review the Provider Manual.

Americans with Disabilities Act (ADA)

The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.

- Our providers are obligated to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities ((e.g., physical locations, waiting areas, examination space, furniture, bathroom facilities, and diagnostic equipment must be accessible)
- Offer waiting room and exam room furniture must meet needs the needs of all enrollees, including those with physical and non-physical disabilities.
- Be accessible along public transportation routes and/or provides enough parking.
- Have clear signage and "way" finding (e.g., color and symbol signage) throughout doctors offices/facilities.

Resources:

- http://www.ada.gov/reg3a.html

Olmstead Decision

On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified institutional segregation of persons with disabilities is discrimination and a violation of Title II of the Americans with Disabilities Act.[1]

The U.S. Supreme Court held that public entities must provide community-based services to persons with disabilities when: [2]

- Community-based services are appropriate;
- Affected persons do not oppose community-based treatment; and
- Community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

Resources:

- http://www.worksupport.com/resources/printView.cfm/376

[1]Source: U.S. Dept. of Justice, Civil Rights Division Web site
[2]Source: U.S. Dept. of Justice, Civil Rights Division

Cultural Competency

Full Document in Packet

CULTURAL COMPTENCY

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

Aetna Better Health of Ohio promotes cultural competency and offers sensitivity education and training in an effort to help eliminate health care inequalities. We offer free online cultural competency courses that health care providers and their staff can take advantage of to help with daily interactions with patients.

need for health care systems to accommodate increasingly diverse patient populations, cultural competence has increasingly become a matter of national concern.

Fraud, Waste, & Abuse

Full Document in Packet

PROVIDER FRAUD, WASTE, AND ABUSE TRAINING

Welcome!
We designed this training to assist you in helping Aetna Better Health 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.

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

What are my responsibilities as provider?

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

First you are require to comply with all applicable statutory, regulatory, and other CMS requirements, including adopting and implementing an effective compliance pro-

Abuse, Neglect, Exploitation & Misappropriation of an Enrollee's Property

Please pull out your hand-out.

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 them-
...lves.

Neglect

Types of Neglect

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

Signs of Neglect

- Malnutrition or dehydration
- Unkempt appearance; dirty or inadequate
- ...ntreated medical condition

Critical Incident Reporting

Monitoring, tracking and investigating critical incidents are essential to ensuring the health and welfare of our enrollees.

Critical Incident Reporting

Aetna Better Health of Ohio is contractually obligated to immediately report critical incidents to the Department.

Critical incidents include, but are not limited to the following:

- Unexpected death of an enrollee or Severe injury sustained by an enrollee
- Suspected physical, mental or sexual abuse and/or neglect of an enrollee
- Seclusion, Neglect, Deprivation, Restraint of an enrollee
- Theft or financial exploitation of an enrollee
- Medication error involving an enrollee
- Inappropriate/unprofessional conduct by a provider involving an enrollee
- Illegal Activity by the Enrollee - Fraudulent activities on the part of the enrollee
- Enrollee arrested, charged, or convicted of a crime
- Illegal Activity by the Provider - Enrollee is the Victim - Fraudulent activities on the part of the Provider
- Provider arrested, charged, or convicted of a crime.
- Staff Falsification of Credentials or Records

National Provider Identification (NPI)

Please pull out your hand-out.

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?

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 [illegible]

Provider Appointment Standards

Provider Type	Emergency Appointment	Urgent Care Appointment	Routine Care
Primary Care	Same Day	Within two (2) calendar days	Within six (6) weeks of enrollee request
Specialty Care	Immediate	Within two (2) calendar days	Within six (6) weeks of enrollee request

Provider Type	Screening Visit	Initial Visit for Newborns	Preventive Pediatric Visit
EPSDT	Available no more than two (2) weeks after the initial request	During newborn physical exam	According to the American Academy of Pediatricians periodicity schedule up to age twenty-one (21)

Provider Appointment Standards Cont.

Provider Type	Emergency	Initial Prenatal Care- First Trimester	Initial Prenatal Care- Second Trimester	Initial Prenatal Care- Third- Trimester
OB/GYN	Immediate	Within three (3) weeks of first request	Within seven (7) calendar days of first request	Within three (3) calendar days of first request

Provider Type	Initial Prenatal Care- High Risk	Routine Care	Urgent Care	Postpartum Care
OB/GYN Cont.	Within three (3) calendar days of identification of high risk	Within six (6) weeks of enrollee requests	Within two (2) calendar days	Within six (6) weeks of enrollee request

Provider Appointment Standards Cont.

Provider Type	Emergency	Urgent	Routine	Non-Life Threatening Emergency
Behavioral Health	Immediate treatment for potentially suicidal individual	Within two (2) calendar days	Within seven (7) calendar days of first request	Within six (6) hours

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.

Medical Records - Standards

Medicare laws, rules, and regulations require that network providers to retain and make available all records pertaining to any aspect of services furnished to an enrollees or their contract with Aetna Better Health of Ohio for inspection, evaluation, and audit for the longer of:

- A period of ten (10) years from the end of the contract with Aetna Better Health of Ohio;
- The date ODM or their designees complete an audit; or
- The period required under applicable laws, rules, and regulations.

Additional Information:

- Providers must maintain enrollee records in either a paper or electronic format.
- Providers must also comply with HIPAA security and confidentiality of records standards.

Our standards for medical records have been adopted from NCQA and the Medicaid Managed Care Quality Assurance Reform Initiative (QARI). For a complete list of minimum acceptable standards, please review the Provider Manual.

Marketing Guidelines

Per Medicare regulations, “marketing materials” include, but are not limited to, promoting the MyCare Ohio plan, informing enrollees that they may enroll or remain enrolled in the MyCare Ohio plan, explaining the benefits of enrollment in the MyCare Ohio plan or rules that apply to enrollees, or explaining how services are covered under the MyCare Ohio plan.

Please note that providers may engage in discussions with potential enrollee should a potential enrollee seek advice. However, providers must remain neutral when assisting with enrollment decisions and may not: (this is not a complete list)

- Offer scope of appointment forms and accept MyCare Ohio plan enrollment applications.
- Make phone calls or direct, urge or attempt to persuade potential enrollees to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Aetna Better Health of Ohio.
- Offer anything of value to induce plan enrollees to select them as their provider.
- Offer inducements to persuade potential enrollees to enroll in a particular plan or organization.

For a complete list, please refer to the Provider Manual.

Provider Grievance

Both network and out-of-network providers may file a complaint verbally or in writing directly with Aetna Better Health of Ohio in regard to our policies, procedures or any aspect of our administrative functions.

All written complaints must be submitted to the health plan at the following mailing address or faxed to the following fax number:

Aetna Better Health of Ohio
Grievance System Manager
7400 West Campus Road
Mail Code: F494
New Albany, OH 43054

An acknowledgement letter will be sent within three (3) business days summarizing the grievance and will include instruction on how to:

- Revise the grievance within the timeframe specified in the acknowledgement letter
- Withdraw a grievance at any time until Grievance Committee review

Additional information is located in the Provider Manual.

Provider Appeals

A provider may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with us verbally or in writing, within sixty (60) calendar days from the postmark on the Aetna Better Health Notice of Action. Providers can file a verbal appeal with us by calling 1-855-364-0974. All verbal appeals must be followed up in writing. All written appeals should be sent to the following:

Aetna Better Health of Ohio
Grievance System Manager
7400 West Campus Road
Mail Code: F494
New Albany, OH 43054

An acknowledgement letter will be sent within three (3) business days summarizing the appeal and will include instruction on how to:

- Revise the appeal within the timeframe specified in the acknowledgement letter
- Withdraw an appeal at any time until Appeal Committee review

Additional information is located in the Provider Manual.

Additional Information & Important Requirements

- Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with the Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

- Accommodating enrollees with special needs, which includes but is not limited to: offering extend office hours to include night and weekend appointments, promoting practices offering extended hours, and offering flexible appointment scheduling systems

- Ensuring that hours of operation are convenient to, and do not discriminate against, enrollees. This includes offering hours of operation that are no less than those for non-enrollees, commercially insured or public fee-for-service individuals (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals) All services are available 24 hours a day, 7 days a week when medically necessary

Thank you!

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