Aetna Better Health® of Ohio Provider Responsibilities

OhioRISE | aetna®

Provider Relations

June 2022

Aetna Better Health of Ohio Provider Responsibilities Outline:

- Aetna Better Health of Ohio Plan Overview
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- Participating Provider Disputes
- Care Management
- Critical Incidents
- Quality Improvement and Population Health
- Contacts and Resources

Plan Overview

Background

- Over **40%** of kids over the age 15 in the child welfare system are in congregate care
- **140 kids per day** are receiving care out-of-state. A **200% increase** in kids per year compared to 2016
- **38% of Youth** with multi-system needs have individuals in their families with a history of OUD, SUD, and/or SED primary diagnosis

Kids with multi-system needs require very different kind of care coordination. This is reason OhioRISE exist.

Program Overview

- Specialized managed care program for youth with complex behavioral health and multisystem needs.
- Aims to expand access to in-home and community-based services.
- State-wide, with regional “catchment areas.”

Eligibility

- Enrolled in Ohio Medicaid
  - Managed care or fee-for-service
  - Including kids enrolled in I/DD or OHCW 1915 (c) waivers
  - Including kids enrolled in the new 1915 (c) OhioRISE waiver
- Under the age of 21
- Demonstrated need of significant behavioral health services
- Meets a functional needs threshold for behavioral healthcare, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment tool, or use of an inpatient behavioral health service

OhioRISE Services Overview

- Care Coordination at 3 different levels
- Intensive Home-Based Treatment (IHBT)
- Psychiatric Residential Treatment (effective January 2023)
- Mobile Response and Stabilization (MRSS)
- Behavioral Health Respite
- Wraparound Supports/Flex Funds
- Additional services available through 1915C Medicaid Waiver

Provider Responsibilities

Provider Responsibilities Overview

Providers are contractually obligated to adhere to and comply with all terms of the:

- OhioRISE program
- Provider contract obligations ***and***
- All responsibilities outlined in the Provider Manual

Providers are required to have:

- Have an active Medicaid ID number with the state of Ohio
- Unique Identifier or National Provider Identifier (NPI)
- Act lawfully in their scope of practice of treatment, management, and discussion of the medically necessary care
- Make certain to use the most current diagnosis and treatment protocols and standards

Providers cannot:

- Refuse treatment to qualified individuals with disabilities
- Become a part of the network if they have been excluded from participation in any federally or state funded healthcare program

Provider Responsibility

Providers (including Waiver providers) are REQUIRED to have an active…

- Medicaid ID number with the State of Ohio to bill Aetna Better Health of Ohio.
- Unique Identifier or National Provider Identifier (NPI)

Ohio Medicaid ID Number:

In order to obtain a Medicaid ID number, providers must register online with Ohio Department of Medicaid (ODM) at:

- https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/provider-enrollment/support/

NPI Number Registration:

In order to obtain a NPI number, providers must register online at:

- NPPES (hhs.gov)

In addition to the above it is expected that all providers update ODM MITS system with any changes to their organization. This information is shared with all managed care plans by ODM via a provider master file. Below are examples of changes but the list is not all-inclusive:

- Demographic changes (i.e.. address/phone number changes)
- Add/removal of providers
- Changes to specialty
- Add/removal of tax ID number and/or NPI number
- And more

If information is not updated OhioRISE will not have the most accurate information and it may cause delay in payment.

Fraud, Waste, and Abuse

Fraud, Waste and Abuse

Aetna Better Health of Ohio has an aggressive, proactive Fraud, Waste, and Abuse (FWA) Program that complies with state and federal regulations

- **Special Investigations Unit (SIU)**
  - Conducts proactive monitoring to detect potential fraud, waste, and abuse, and is responsible to investigate cases of alleged fraud, waste, and abuse
  - Experienced, Full-Time Investigators, Field Fraud (claims) Analysts, Full-Time Dedicated Information Technology Organization
  - National toll-free hotline for providers **1-800-338-6361**

Definitions

- **Fraud, Waste and Abuse** is defined as 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** is defined as an 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 or Medicare 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 and or Medicare program.

Fraud, Waste and Abuse Examples

Examples of Fraud, Waste, and Abuse include:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by the OhioRISE plan
- Billing for services that were never rendered
- Billing for services at a higher rate than is justified
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health of Ohio due to improper payments to providers or overpayments.
- Physical or sexual abuse of members

In addition, member fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit.
- Attempting to use a member's ID card to obtain prescriptions when the member is no longer covered under the drug benefit.
- Looping (i.e., arranging for a continuation of services under another member's ID).
- Forging and altering prescriptions.
- Doctor shopping (i.e., when a member consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Combat Fraud, Waste and Abuse

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

- Develop a compliance program
- Monitor claims for accuracy – make certain coding reflects services provided
- Monitor medical records – make certain documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem
- Understand that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim

Reporting Suspected Fraud and Abuse

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

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; or
- By phone to our confidential Special Investigation Unit (SIU) at 1-833-865-0278. Note: If you provide your contact information, your identity will be kept confidential.

You can also report fraud to the State of Ohio Office of the Inspector General at 1-800-686- 1525, or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services (HHS) at 1-800-HHS-TIPS (1-800-447-8477).

CMS requires us to have a compliance plan that guards against potential fraud, waste, and abuse under 42 C.F.R. §422.503 (b) (4) (vi), and 42 C.F.R §423.504(b) (4) (vi).

Appointments and Availability Standards

Appointments and Availability Standards

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.

- **Providers are required to notify Aetna Better Health of Ohio within 3 calendars if they are not able to comply with appointment wait times.**

- Our Provider Experience 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.

Appointments and Availability Standards

Event	Expectation
Emergency Service	24-hours; 7 days a week
Urgent Care For Behavioral Health Condition	Seen within 48-hours of request
Behavioral Health Non-Life Threatening Emergency	Within 6 - hours
Behavioral Health Routine Care	Within 10 business days or 14 calendar days whichever is earlier.
CANS Ongoing Assessment	Every 90 days or when a change in the Member's condition warrants a re-assessment
ASAM Residential/Inpatient Services – 3:3.1, 3.5, 3.7	Within 48 hours of Request
ASAM Medically Managed Intensive Inpatient Services - 4	24 hours, 7 days/week
Psychiatric Residential Treatment Facilities	Within 48 Hours

Telephone Accessibility Requirements

After hours coverage is defined as being available or having on-call arrangements in place for medical advice, determining the need for emergency and other after-hours services including authorizing care and verifying member enrollment.

- It is our policy that network providers cannot use an answering service as a replacement for on-call coverage
- 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.**

We will routinely measure the provider's compliance with these standards.

Please notify Provider Services Department if a covering provider is not contracted or affiliated with OhioRISE.

- 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.

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

Cultural Competency

Cultural Competency Training

To effectively communicate and serve diverse populations it is important for providers to have training in:

- Understanding the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.
- Understanding the reluctance of certain cultures to discuss mental health issues
- The impact that a member's religious and/or cultural beliefs can have on health outcomes
- The problem of health illiteracy and the need to provide patients with understandable health information
- The history of the disability rights movement and the progression of civil rights for people with disabilities
- The physical and programmatic barriers that impact people with disabilities accessing meaningful care

To assist providers in best understanding the diverse cultures, languages, and communities they serve please access the online cultural competency course at:

https://www.hrsa.gov/culturalcompetence/index.html

Member Rights and Eligibility Verification

Member Rights and Responsibilities

Member Rights

Aetna Better Health of Ohio members have the following rights:

- To receive all services that our plan must provide.
- To be treated with respect and with regard for their dignity and privacy.
- To be sure that the members medical record information will be kept private.
- To be given information about the members health. This information may also be available to someone whom the member has legally approved to have the information. Or whom the member said should be reached in an emergency when it is not in the best interest of the members health to give it to them.
- To be able to take part in decisions about the members health care unless it is not in their best interest.
- To get information on any medical care treatment, given in a way that the member can follow.
- To be sure others cannot hear or see the member when they are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask, and get, a copy of medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about the member given out unless we have to by law.
- To be able to say no to treatment or therapy. If the member says no, the doctor or our plan must talk to the member about what could happen and must put a note in the members medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing.
- To be able to get all our written member information from our plan:
    - At no cost to the member.
    - In the prevalent non-English language of members on our service area.
    - In other ways, to help with the special needs of member who may have trouble reading the information for any reason.

Member Rights and Responsibilities

Member Rights (cont'd)

- To be able to get help free of charge from our plan and its providers if the member does not speak English or need help in understanding information.
- To be able to get help with sign language if the member is hearing impaired.
- To be told if the health care provider is a student and to be able to refuse their care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will).
- To file any complaint about not following the members advance directive with the Ohio Department of Health.
- To be free to carry out the members rights and know that Aetna Better Health of Ohio, our providers, or the Ohio Department of Medicaid (ODM) will not hold this against the member.
- To know that we must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives the member care whenever possible and appropriate.
- To be able to get a second opinion from a qualified provider in our network. If a qualified provider is not able to see the member, we must set up a visit with a provider not in our network.
- To get information about Aetna Better Health of Ohio from us.
- To make recommendations regarding Aetna Better Health of Ohio's member rights and responsibilities policy.
- To contact the Ohio Department of Medicaid and/or the United States Department of Health and Human Services Office of Civil Rights at the phone numbers and addresses provided in the provider manual with any complaint of discrimination based on race, ethnicity, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

Aetna Better Health of Ohio is committed to always treating members with respect and dignity. Member rights and responsibilities are shared with staff, providers, and members each year.

Member Eligibility Verification

Enrollee eligibility can be verified through one of the following ways:

Telephone Verification

- Call our Member Services Department to verify eligibility at 1-855-364-0974
- To protect the member's confidentiality, providers are asked for at least three pieces of identifying information before any eligibility information can be released.

Secure Portal Verification:

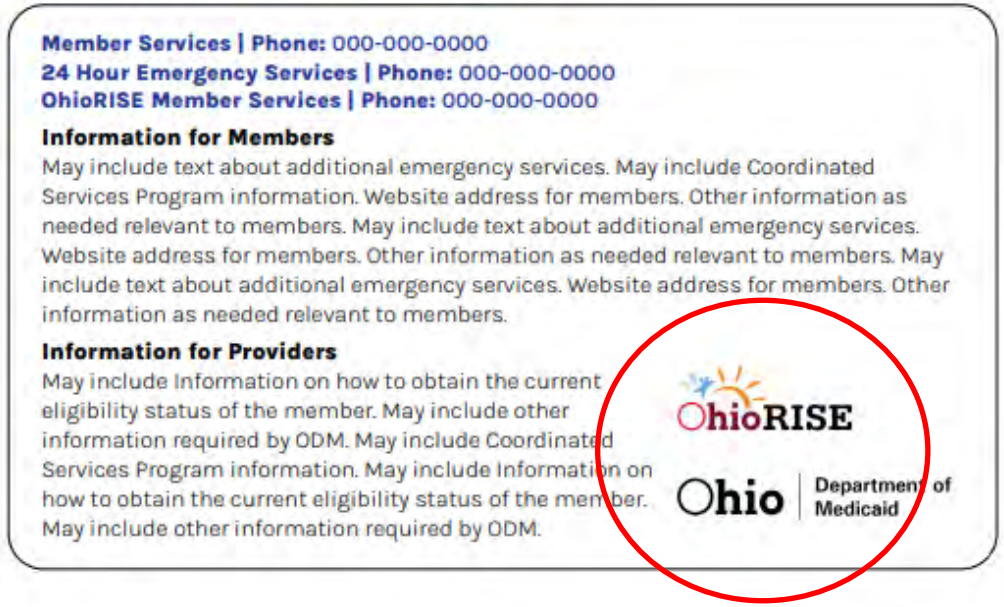
- Member eligibility search & panel rosters are found on our Secure Provider Portal
- Contact our Provider Services Department for additional information about access to the Secure Provider Portal.

Member ID Card

Members should present their ID card at the time of service. Providers should always confirm eligibility prior to rendering services.

front

back



Aetna Better Health® of Ohio Secure Provider Portal

Secure Provider Portal

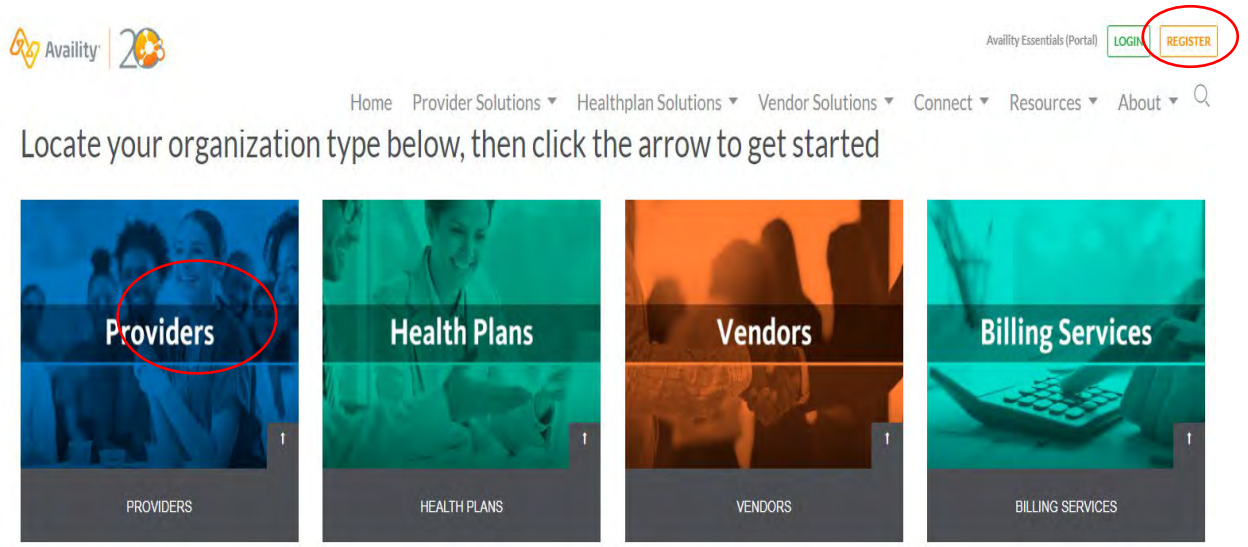
Availity is Aetna's Secure Provider Portal used for prior authorization, claim status, electronic remittance advices, and added features with the health plan.

- If you already have an account with Availity, you will not have to do anything else. You will see **OhioRISE** as an option when you click on the Aetna payer **effective 7/6/2022**.

- If you **DO NOT** already have an account set up with Availity, each office will need an administrator to begin the registration process.

- The first step to create an account is to access the Availity website at www.availity.com and click register, next:

1. Enter your Information
2. Choose three security questions and answers
3. Verify your information and create your account
4. Confirm your email address within 24 hours
5. Log in to Availity Portal
6. Once this step is complete, you will register your organization and create accounts for other users



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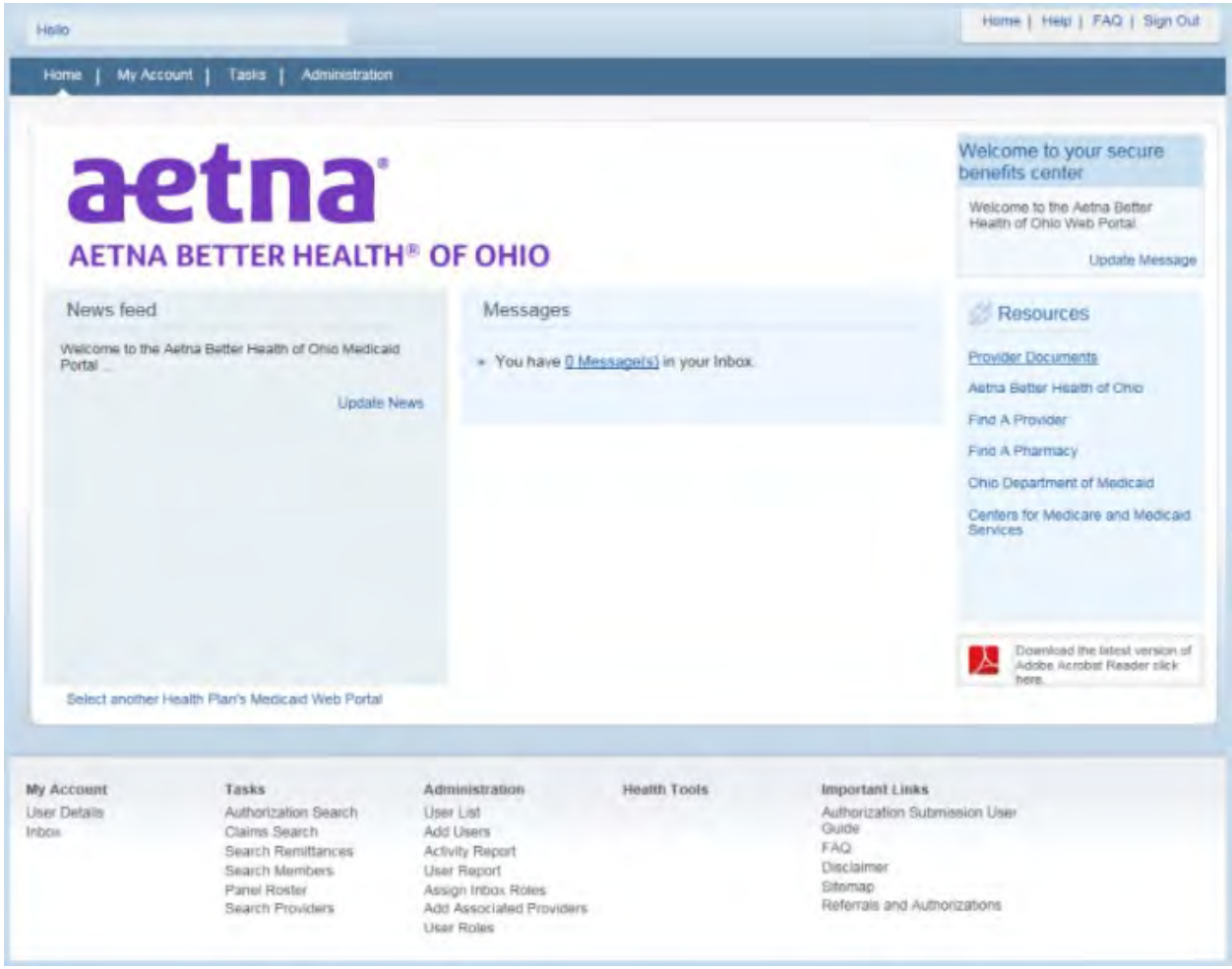
Secure Provider Portal

- This is an example of our Secure Provider Portal Availity.
- Contracted providers can sign up for this self-service site online or using a paper registration form.
- Different levels of access can be assigned to designated staff using different roles.
- Next slide for additional task availability



Secure Provider Portal

The following tasks can be performed in the Secure Provider Portal:

- Member Eligibility Search
- Panel Roster
- Provider List
- Claims Submission/Claim Status
- Remittance Advice Search
- Submit Authorizations Request- Types of authorization types are available:
  - Inpatient
  - Outpatient
- Healthcare Effectiveness Data and Information Set (**HEDIS®**)
  - Check the status of the member's compliance with any of the HEDIS measures.
    - A **"Yes"** means the member has measures that they are not compliant with
    - A **"No"** means that the member has met the requirements.
- Search/Review/Export CPT and HCPCS codes
- Provider Prior Authorization Look Up Tool
- Search/Review prior authorization requirements
- Claim Disputes/Resubmission/Correction

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website or call our Provider Experience Department at:

1-833-711-0773

Prior Authorization Requirements

Prior Authorization Requirements

Provider Prior Authorization Requirements

- Providers are responsible for complying with Aetna's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to be reported on their claims.
- A list of services that require prior authorization, along with a list of exceptions, can be found on our website at:
  - https://www.aetnabetterhealth.com/ohiorise/index.html

Aetna will not prohibit, or otherwise restrict, practitioners and providers from:

- Acting within the lawful scope of practice
- From advocating on behalf of an OhioRISE member
- From advising members of all treatment options and potential risks, benefits, and consequences of treatment or non-treatment
- The ability for the individual to refuse treatment
- To express preferences about future treatment decisions

How to Request Prior Authorization

A prior authorization request may be submitted by:

- Submitting the request through the 24-hours-a-day, 7-days-aweek Secure Provider Web Portal located on our website (only available to contracted providers)

How to Request Prior Authorizations

- Service authorizations may be requested through Aetna's Secure Web Portal, Availity at https://apps.availity.com/availity/Demos/Registration/index.htm or
- visit the OhioRISE webpage at www.aetnabetterhealth.com/ohiorise/providers/index.html (contracted providers only)

Exceptions to Prior Authorizations:

- Emergency services including behavioral health care
- Urgent care
- Crisis stabilization, including mental health; or
- Post-stabilization services whether provided by an in-network or out-of-network practitioner/provider
- OhioRISE 1915(c) Waiver Services which includes Out-of-Home Respite, Transitional Services and Supports, and Secondary Flex Funds (including Emergency Funds).

Timeliness of Prior Authorization Decisions:

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Forty-eight (48) hours from receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent pre-service denial	Forty-eight (48) hours from receipt of request	Practitioner/Provider Member	Oral or Electronic/Written
Non-urgent pre- service approval	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider	Oral or Electronic/Written
Non-urgent pre- service denial	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider Member	Electronic/Written
Urgent concurrent approval	Forty-eight (48) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent concurrent denial	Forty-eight (48) hours of receipt of request	Practitioner/Provider	Oral or 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 Member	Electronic/Written
Termination, Suspension, Reduction of prior authorization	At least fifteen (15) Calendar Days before the date of the action.	Practitioner/Provider Member	Electronic/Written

Prior Authorization – Transition of Care

The Transition of Care Period is from **July 1, 2022 to September 30, 2022**

Purpose: The OhioRISE plan will honor services that were prior authorized by a managed care organization (MCO) or fee-for-service Medicaid upon a youth's transition onto the OhioRISE plan in July 2022

For the first 3 months of the OhioRISE program, beginning July 1, 2022 and ending September 30, 2022 only the following services will require authorization or approval by the OhioRISE plan:

- Services that will require prior authorization (PA) using the traditional provider-initiated PA process will include:
  - Inpatient psychiatric services (including hospital and PRTF services), and
  - Electroconvulsive Therapy (ECT)

Prior-Approval

Services requiring prior approval through the child and family-centered care plan (CFCP) that need to be approved **before** they can be provided and reimbursed:

- Primary Flex Funds – budget authority
- OhioRISE 1915(c) Waiver Services
  - Secondary Flex Funds – budget authority
  - Transitional Services and Supports
  - Out-of-home respite

Following the OhioRISE transition of care period ending September 30, 2022, additional authorization will be required for certain OhioRISE services.

Services Requiring Prior Authorization

OhioRISE services requiring prior authorization through a traditional provider-initiated prior authorization request
Inpatient treatment for psychiatric and/or substance use disorder primary diagnoses
Psychiatric Residential Treatment Facility (PRTF) services
Electroconvulsive Therapy (covered by OhioRISE as part of the outpatient hospital BH benefit)
SUD Partial Hospitalization (H0015 TG)

Soft Billing Limitations

OhioRISE services with soft billing limitations Prior authorization through traditional provider-initiated request will be required for continued coverage beyond these limitations Service Code Benefit Period Continued Coverage Authorization Requirement	
Intensive Home-Based Treatment (IHBT) H2015 Multi-Systemic Therapy (MST)* H2033 NEW Functional Family Therapy (FFT) H2015 TF *	Enrollment span Up to 180 days per person. Prior Authorization is required for additional service.
Assertive Community Treatment H0040	Enrollment span Up to 180 days per person. Prior Authorization is required for additional service.
Behavioral Health Respite S5150, S5151	Calendar year Up to 50 days per person. Prior Authorization is required for additional service.
Mobile Response and Stabilization Service (MRSS) - Stabilization Service S9482 MRSS	Prior authorization is needed for stabilization services rendered more than six weeks from the completion of mobile response.
Psychiatric Diagnostic Evaluations 90791, 90792 FFS	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization is required for additional service.
Psychological Testing 96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137	Up to 20 hours/encounters per patient per calendar year for all psychological testing codes. Prior authorization is required for additional service.
Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization is required for additional service.
Alcohol or Drug Assessment H0001	2 assessments per patient per calendar year per billing agency. Prior authorization is required for additional service

Soft Billing Limitations

OhioRISE services with soft billing limitations Prior authorization through traditional provider-initiated request will be required for continued coverage beyond these limitations Service Code Benefit Period Continued Coverage Authorization Requirement	
TBS Group Per Diem H2020	Prior authorization is required for an additional per diem service to the same client on the same day.
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. This applies to first two stays. Third and subsequent stays in the same year require prior authorization from the first day of admission.
SUD Peer Recovery H0038	Calendar Year Up to 4 hours per day without prior authorization. Prior authorization would be needed to cover more than 4 hours in a day once limit is reached.
**Services should be on care plan but claims will pay even if not on the care plan as long as prior authorization is in place. Aetna will flag cases in which the care plan does not include services submitted for reimbursement by treatment/support providers and will work with CMEs and care coordinators to ensure these services are included on future CFCPs*	

Claims Submission

How to Bill Aetna Better Health® of Ohio

To best ensure timely and accurate payment of your claim, submit a "clean claim".

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

Clean claims are processed according to the following timeframes:

- 90% of clean EDI claims adjudicated within **30 days** of receipt

Timely Filing of Claim Submissions

- In accordance with contractual obligations, claims for services provided to an enrollee must be received in a timely manner. Our timely filing limitations are as follows:
  - ***New Claim Submissions*** –Please consult your contract for your contractual timely filing limit for new claims.
  - ***Claim Disputes & Resubmissions*** – Please consult your contract for your contractual timely filing limit for disputes and corrected claims.

Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial.

Aetna Better Health® of Ohio Claim Submission

Claim Submission Methods:

All claims should be submitted electronically to Change Healthcare or Office Ally. We **do not** accept direct EDI submissions from our providers. There are **two** methods for claim submission. Paper claims **will not** be accepted.

1. Electronic Claims through Provider's Own Clearinghouse:

- Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare and Office Ally, using ANSI 837 5010 EDI file format.
- Use Payer ID **#45221** when submitting electronic claims.

2. Electronic Claims through ABHO Provider Portal (Emdeon/Change Healthcare):

- Aetna Better Health of Ohio encourages participating providers to electronically submit claims through our portal at www.aetnabetterhealth.com/ohio
  - Select 'For Providers', ***then***
  - ''Claims' tab ***then***
  - "How to File a Claim", then link to WebConnect on the page**.**
  - Be sure to complete the sign-up process before getting started.

Aetna Better Health® of Ohio Claim Submission

Access the custom URL assigned to Aetna Better Health of Ohio:
https://physician.connectcenter.changehealthcare.com/#/site/home?vendor=214555

- Create your ConnectCenter user account
- Create a submitter account through which you and your co-workers can share information in ConnectCenter.
- Create a provider record for use in claims and status inquiries

***NOTE:** Please DO NOT use Sign-Up more than once. Additional users and additional providers should be added after your initial use of Sign-Up and after you log-in to Connect Center.

Testing Your Connection

Change Healthcare as a clearinghouse vendor tests all direct connections with their payor partners, practice management vendors, other vendor partners and provider submitters.

- Many providers send claims through a vendor system that has already been tested with Change Healthcare.

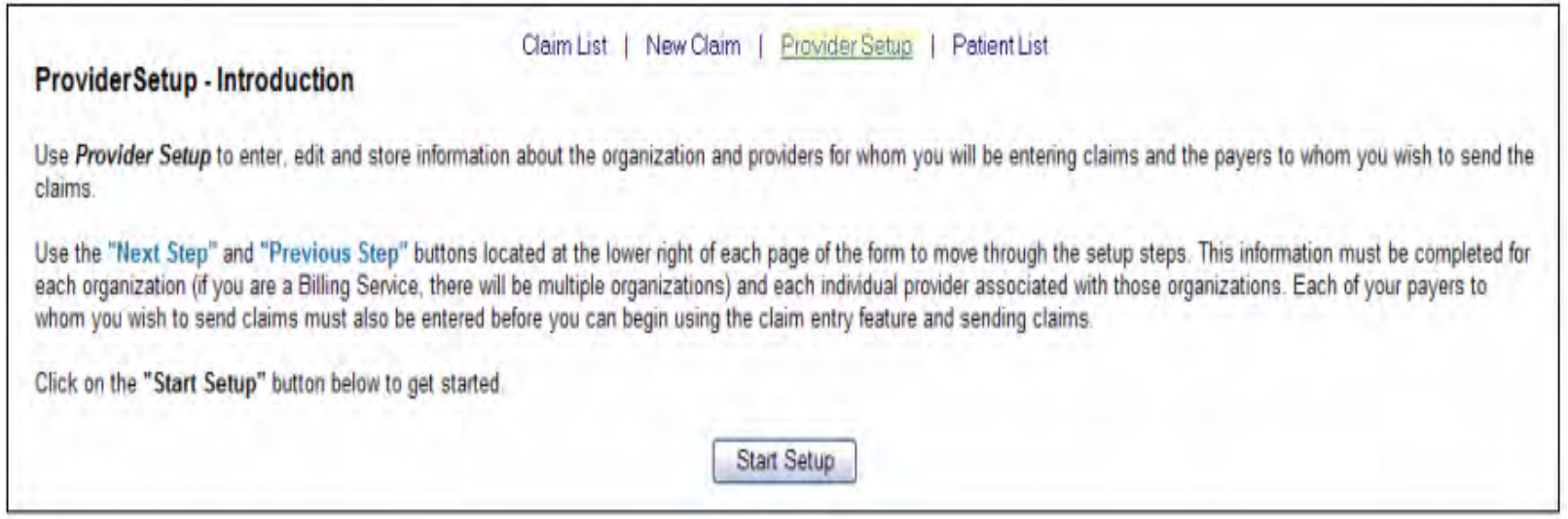
Aetna Better Health® of Ohio Claim Submission

WebConnect is Aetna's portal for electronic claim submission. To access the portal to submit claims, you must first complete the **Provider Setup**.

Once completed, you can automatically populate saved information such as Provider NPI, TIN and Patient List, etc.

Complete the on-screen steps to set up your organization, this will automatically populate fields on your claim form:

- Provider Organization/Facility
- Tax IDs/NPIs
- Addresses
- Providers
- Payers
- Submitter



Aetna Better Health® of Ohio Claim Submission

To submit a **New Claim** Select:

- Claims
- Create
- Click **"New Claim"** link

Continue following the on-screen instructions to continue entering claim data and save once complete.

Aetna Better Health® of Ohio Claim Tips

- Claim numbers are assigned using the year and then the Julian date.
- For example, 17001 at the beginning of a claim would indicate that claim was received on the First day of 2017.
- A claim beginning with 16365 would indicate that claim was received on the last day of 2016.
- Claim Indicators:
- A claim with an “S” indicates it’s the secondary processing (Medicaid) but only if we also processed the Medicare claim within ABHO.
- “A” indicates an adjusted claim, while “R” indicates a reversal. Example: 17001E999999A1.

Aetna Better Health® of Ohio Balance Billing

Balance billing a member is **prohibited** under the OhioRISE plan.

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health of Ohio. This includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part.

- A provider must agree **not** to bill a member for medically necessary services covered under the plan and always notify members prior to rendering services.

- A member **CAN** be billed only when the member **knowingly** agrees to receive non-covered services under the OhioRISE plan.
  Provider **MUST** notify the member in advance that the charges will not be covered under the program.

- Provider **MUST** have the member sign a statement agreeing to pay for the services and place the document in the member's medical record.

- When referring a member to another provider for non-covered services, a provider **must** make certain the member is aware of the obligation to pay in full for the non-covered services.

Participating Provider Disputes

Dispute Process

Providers can dispute a claim decision. If you disagree with a claim decision OhioRise has made it so you can submit a dispute online:

- **Use the Secure Web Portal** to dispute the claim electronically after locating the claims on the right

Non-participating providers can appeal via the website at:

https://www.aetnabetterhealth.com/ohio/providers/forms.

Aetna Better Health® of Ohio Claim Disputes

Provider Claim Disputes:

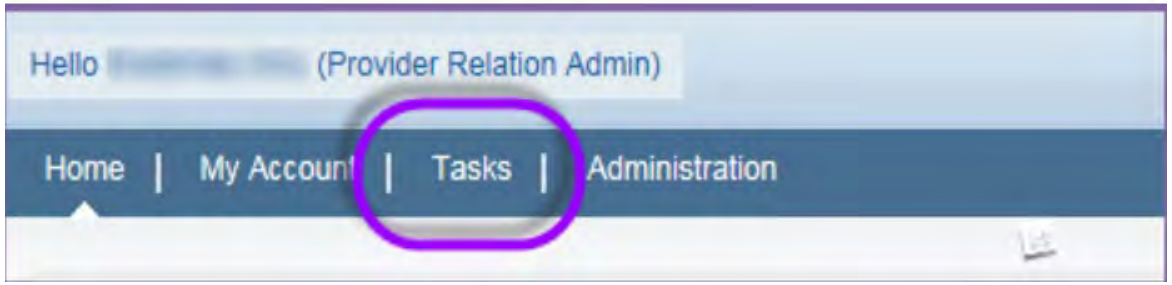
Claim disputes for participating providers are delegated to the **Claim Investigation/Claims Research Department** for review. Once the review is complete, the provider will be notified of the decision on the remit if reprocessed or by letter if more information is needed.

To have claims reconsidered through our Claim Disputes process for participating providers, the contracted provider may submit the dispute using one of the two methods:

Calling the **Claims Inquiry Claims Research Department** at **1-833-711-0773**

Claims can also be disputed by logging into our Secure Provider Web Portal at www.aetnabetterhealth.com/ohio/providers/portal

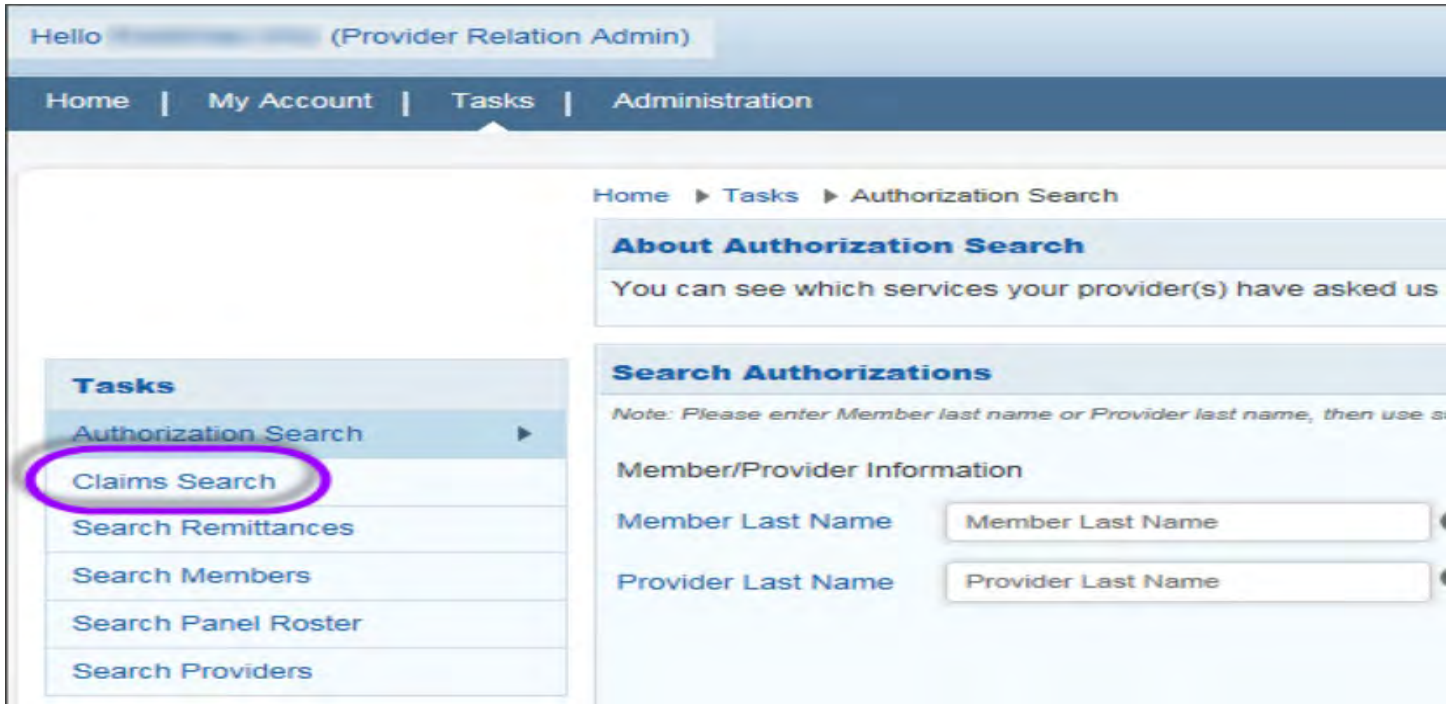
Next, click on **TASKS:**



Aetna Better Health® of Ohio Claim Disputes

Providers Claim Disputes:

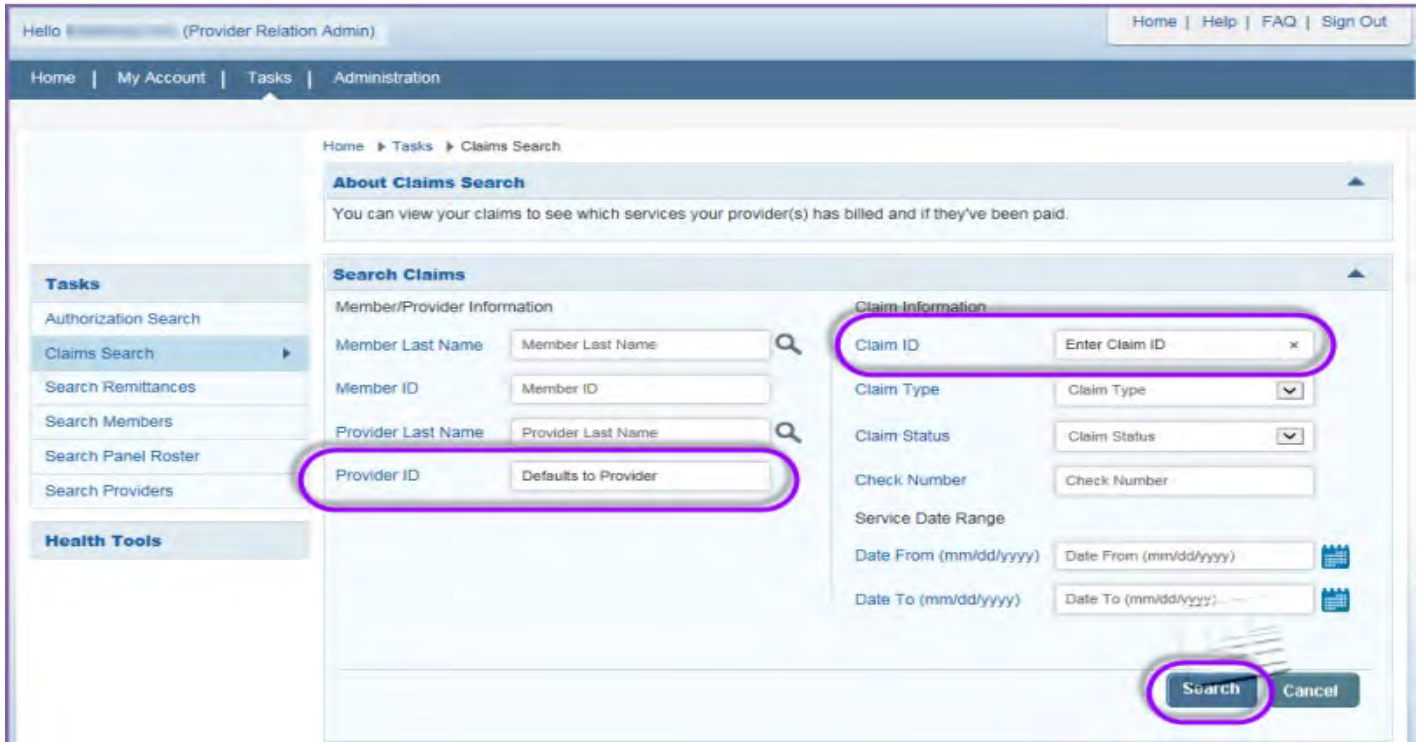
From the **TASKS** menu select **"Claim Search"**



Aetna Better Health® of Ohio Claim Disputes

Provider Claim Disputes:

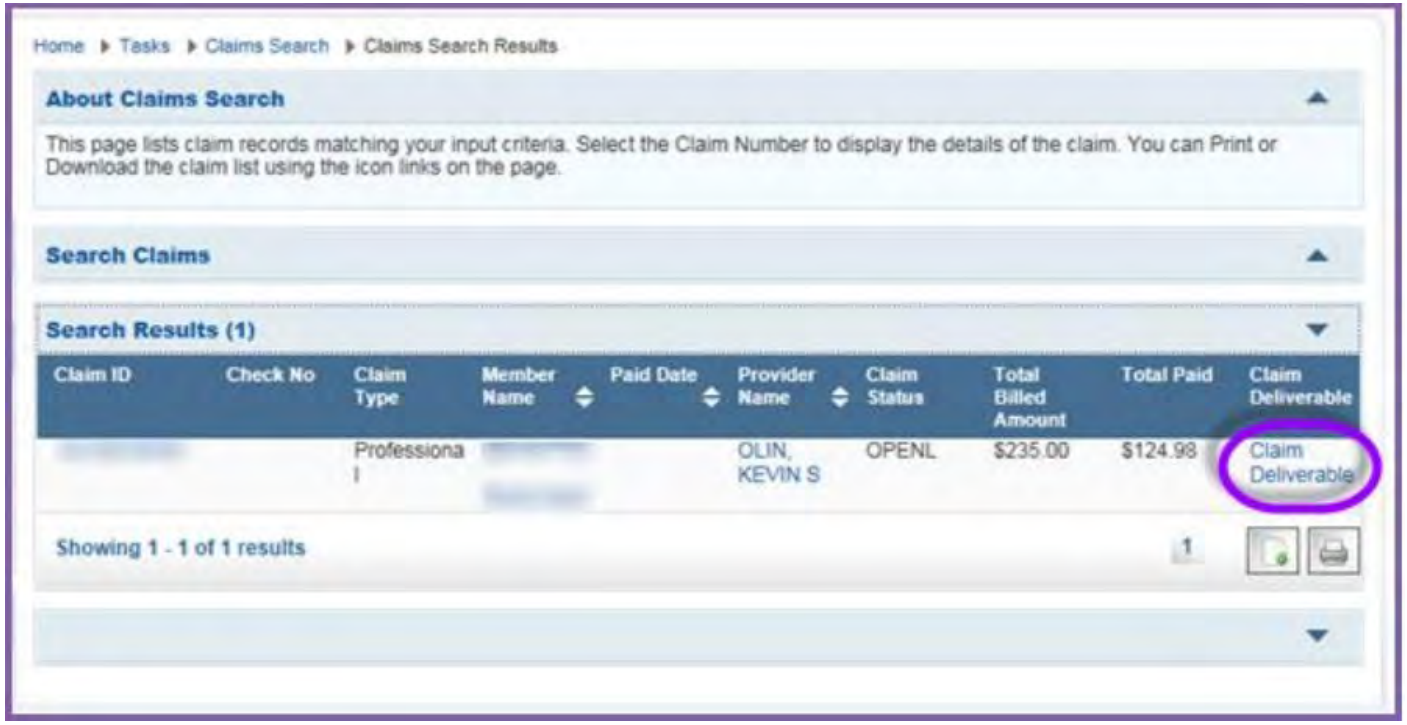
The logged in provider's name will default in the **Provider ID** field. Enter the **Claim id#** that is being disputed and hit the search button:



Aetna Better Health® of Ohio Claim Disputes

Provider Claim Disputes:

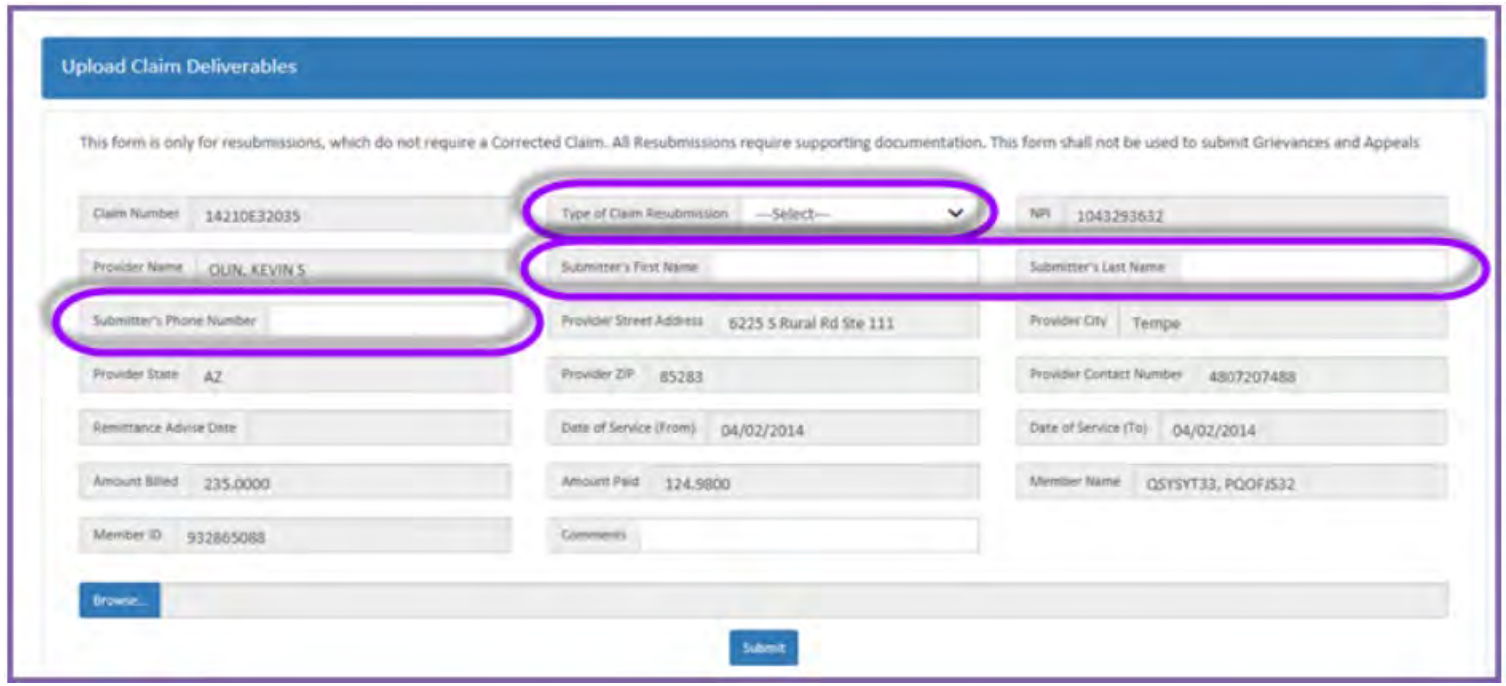
Once loaded, select the **“Claim Deliverable”** link to begin the dispute process:



Aetna Better Health® of Ohio Claim Disputes

Provider Claim Disputes:

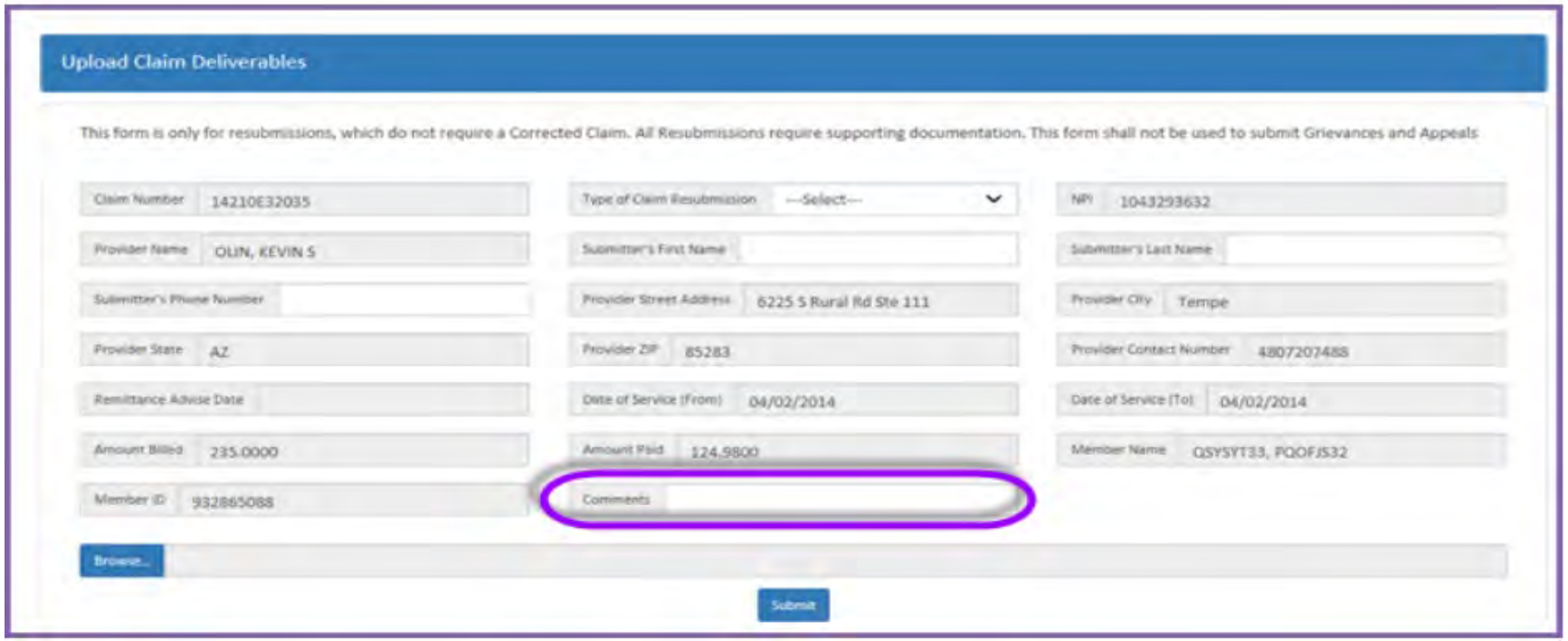
- Select **Upload Claim Deliverables** screen and then
- Select the ***"Type of Claim Resubmission"*** and fill in the **Submitters Name and Phone Number**:



Aetna Better Health® of Ohio Claim Disputes

Providers Claim Disputes:

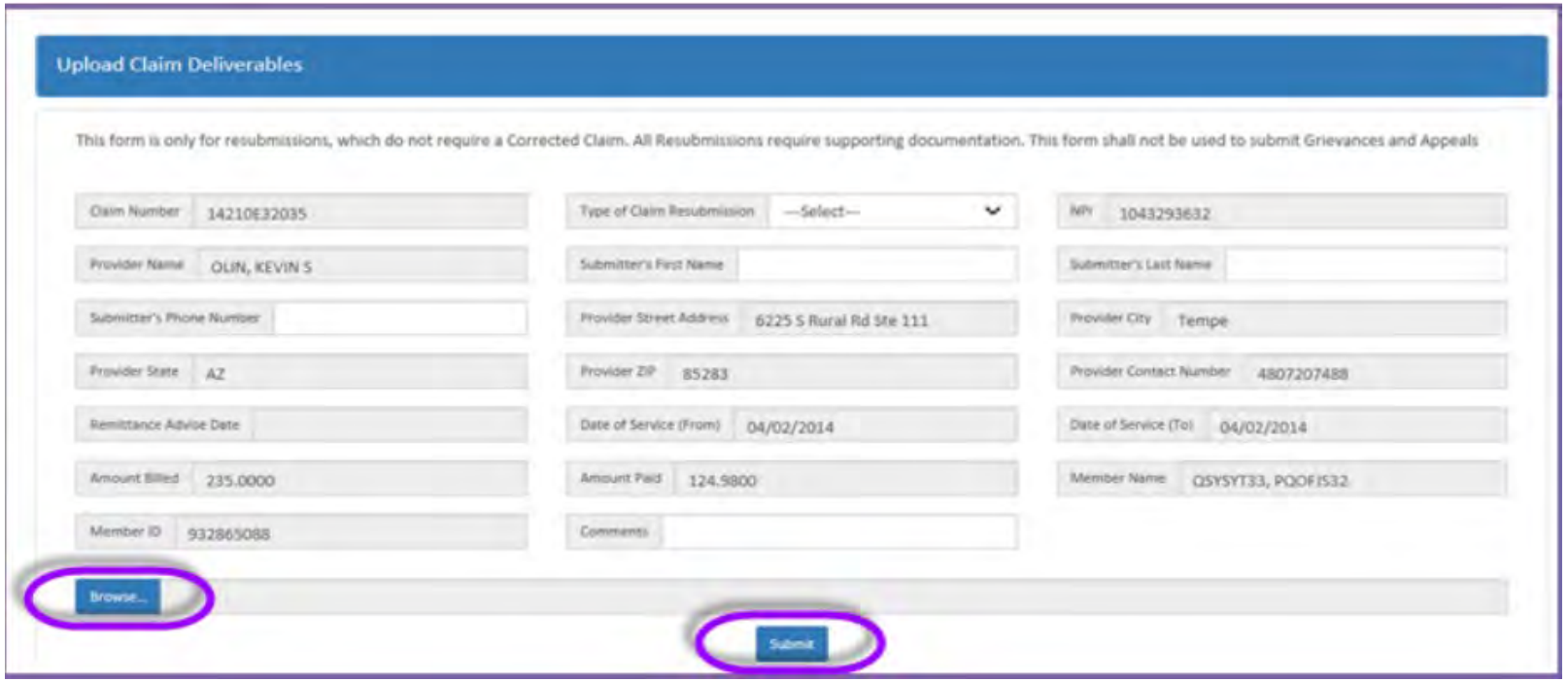
When **other** is selected as the *"**Type of Claim Resubmission**"*, the **Comment** field is mandatory:



Aetna Better Health® of Ohio Claim Disputes

Provider Claim Disputes:

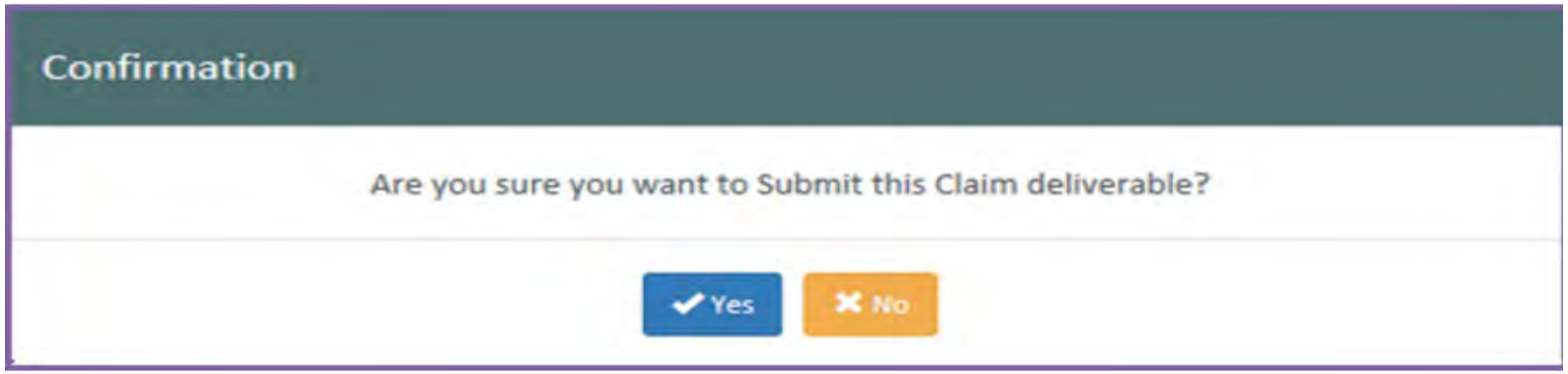
Supporting documentation can be submitted be selecting the **“Browse”** button:



Aetna Better Health® of Ohio Claim Disputes

Provider Claim Disputes:

Once the supporting documentation has been submitted and you select yes to submit, you will receive the below confirmation:



Aetna Better Health® of Ohio Claim Disputes

Provider Claim Disputes:

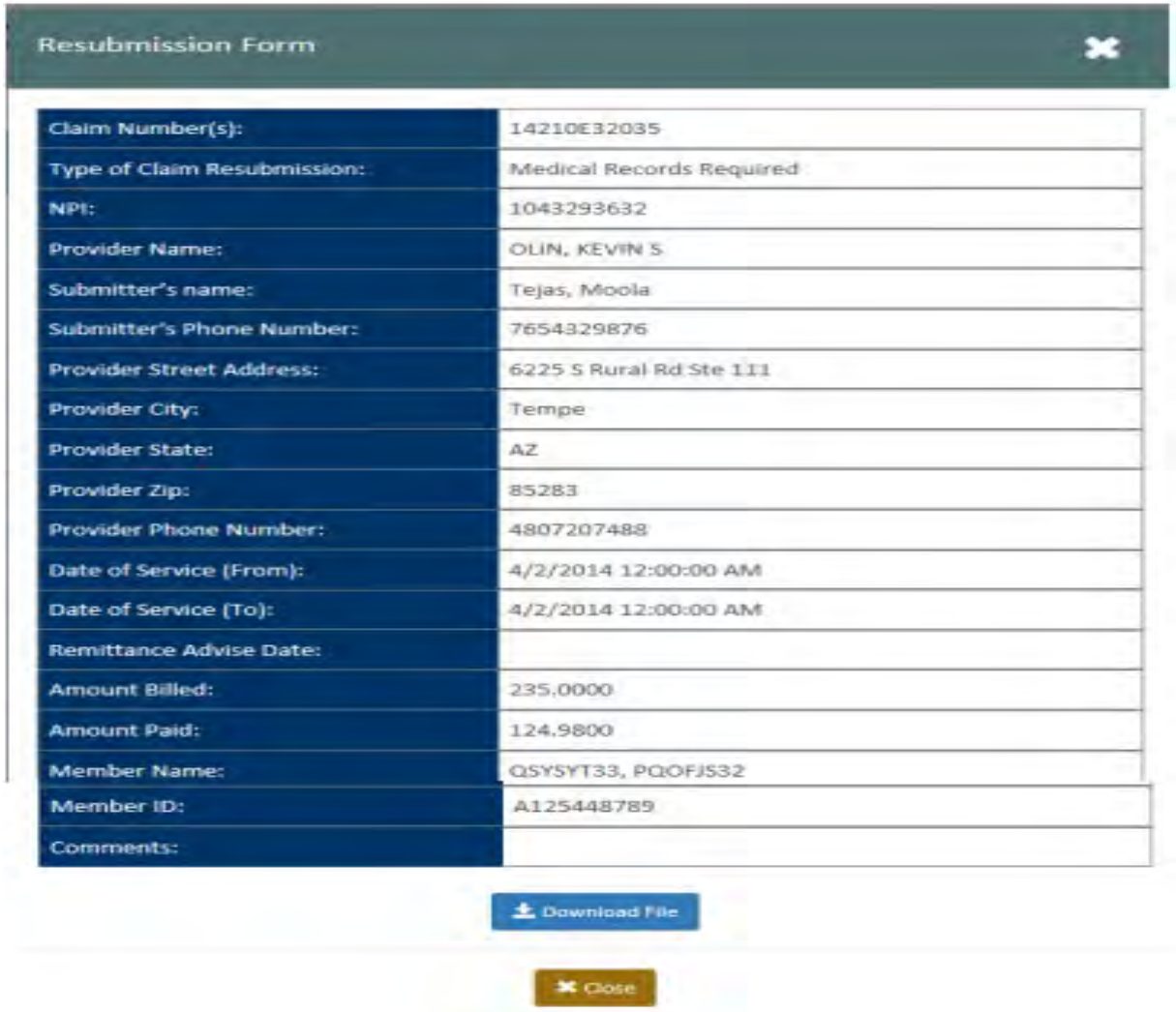
Previously submitted documents can be viewed by selecting the **“View Deliverable”** button:

Claim ID	Submitter Name	File Name	Submission Date	View Deliverable
15147C000417	Kevin Olin	SubmitGrievance-LA(4).pdf	3/6/2017 7:26:56 PM	
15147C000417	Kevin Olin	SubmitGrievance-LA(2).pdf	3/6/2017 6:24:16 PM	
15147C000417	Kevin Olin	adverseIncidentReportingInstructionsDefinitions-LA(3).pdf	3/6/2017 6:22:55 PM	
15147C000417	Kevin Olin		3/6/2017 6:21:50 PM	
15147C000417	Kevin Olin	Testing worddoc for Upload(2).docx	3/6/2017 3:51:30 PM	

1 2 3 4 5 6

Aetna Better Health® of Ohio Claim Disputes

Provider Claim Disputes:



Claims Payment Systemic Errors (CPSE)

Claims that were adjudicated incorrectly (overpayment, underpayment, denied) due to a systemic issue and it affected more than **5** providers will be documented and tracked for resolution.

A report outlining CPSE(s) will be posted on Aetna's website and updated monthly. The report will explain the following:

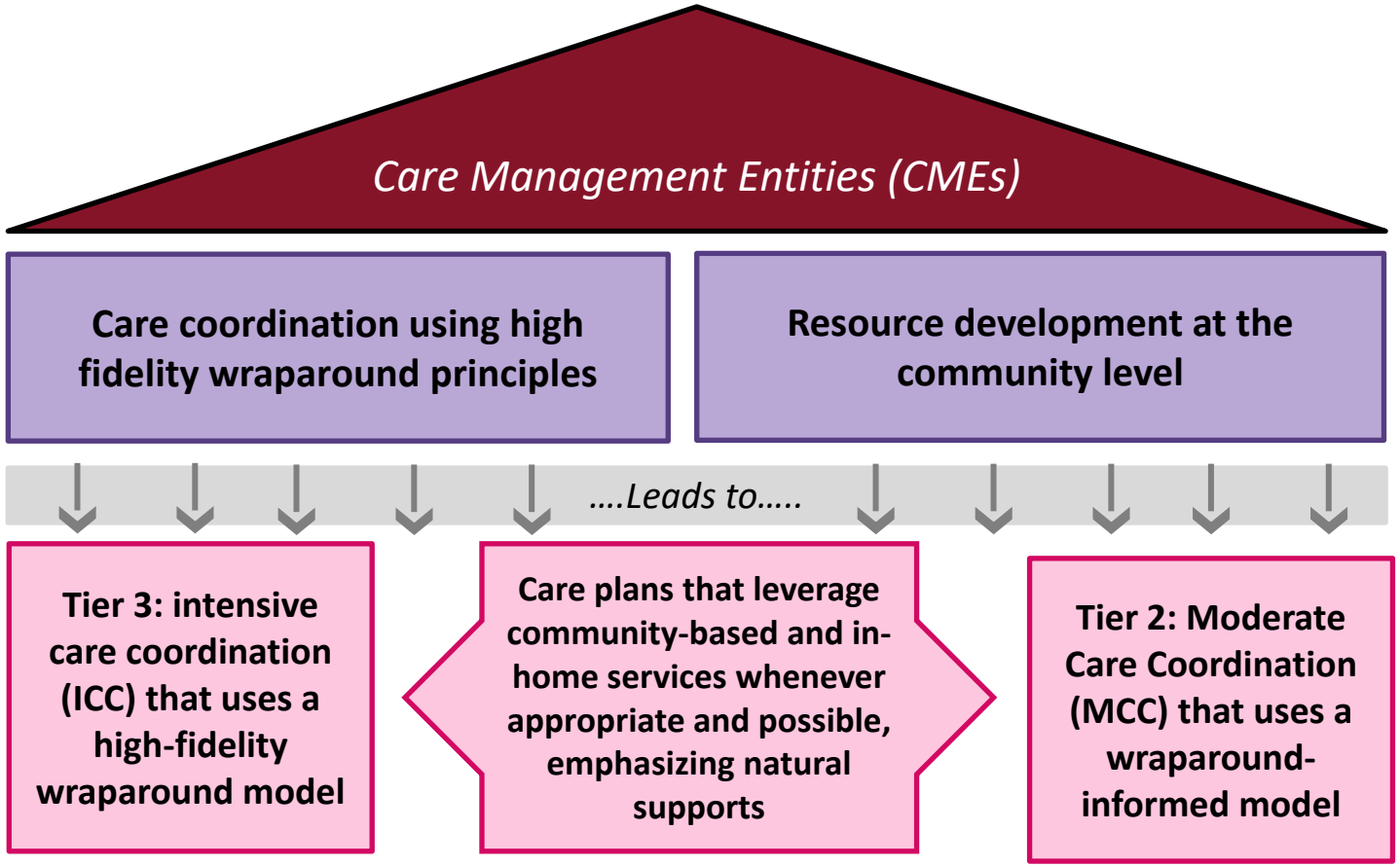
- A detailed description and scope of all active CPSEs
- The date the CPSE was first identified
- The type of all providers impacted
- The timeline for fixing CPSE
- The date(s) or date span(s) of corrected claims adjustment
- Status of CPSE issue
- Number of claims impacted

In addition to provider updates, communication will occur promptly to Ohio Department of Medicaid (ODM).

Care Management

Care Management Entities (CME)

- CMEs will be the OhioRISE plan's collaborative partner, **a "go-to" place** to help families/caregivers, providers, and other community partners **navigate a complex and often confusing multi-system environment.**
- In addition to individual work with youth and caregivers, **the CMEs will work with community partners** (service providers, public child serving agencies and other stakeholders) **to develop the local system of care.**
- **CMEs will be culturally and linguistically competent**, with agencies, programs, and care coordination services that reflect **the cultural, racial, ethnic, and linguistic differences of the populations they serve** to facilitate access to and utilization of appropriate services and supports and **to eliminate disparities in care**.



Care Management Entities (CME)

CME Provider	Counties	Area
Unison Health	Defiance, Fulton, Henry, Lucas, Mercer, Paulding, Putnam, Van Wert, Williams	A
Harbor	Crawford, Erie, Hancock, Huron, Marion, Ottawa, Sandusky, Seneca, Union, Wood, Wyandot	B
National Youth Advocate Program*	Allen, Auglaize, Champaign, Clark, Darke, Hardin, Green, Logan, Madison, Miami, Shelby	C
Choices Coordinated Care Solutions	Montgomery, Preble	D
CareStar	Butler, Clinton, Warren	E
Lighthouse Youth and Family Services*	Hamilton (West)	F
Cincinnati Children's Healthvine	Adams, Brown, Clermont, Hamilton (East), Lawrence, Scioto	G
Integrated Services for Behavioral Health	Athens, Fayette, Gallia, Jackson, Highland, Hocking, Meigs, Pickaway, Pike, Ross, Vinton	H
Integrated Services for Behavioral Health	Coshocton, Fairfield, Guernsey, Morgan, Muskingum, Noble, Perry, Washington	I
Jefferson Co. Educational Service Center	Belmont, Carroll, Columbiana, Harrison, Jefferson, Monroe, Stark, Tuscarawas,	J
The Village Network*	Franklin (West)	K
The Buckeye Ranch	Franklin (East)	L
I Am Boundless, Inc.	Delaware, Knox, Licking, Morrow	M
Wingspan Care Group	Lorain, Medina	N
Coleman Health Services	Ashland, Holmes, Richland, Wayne	O
OhioGuidestone	Cuyahoga (West)	P
Positive Education Program	Cuyahoga (Central)	Q
Ravenwood Health	Ashtabula, Cuyahoga (East), Geauga, Lake	R
Coleman Health Services	Portage, Summit	S
Cadence Care Network*	Mahoning, Trumbull	T

CME Relationship Managers

CME Relationship Managers	Assigned Catchment Area
Halli Andrews	Regions: D, H, I, M
Jeanie Kleiber	Regions: C, E, F, G
Jill Tayfel	Regions: A, B, J, N
Shawanda Lockridge	Regions: P, Q, R, T
Stephen Fomba	Regions: K, L, O, S

CME Relationship Managers work to support CME(s) and assist the provider community. They work in conjunction with the Provider Servicing Team.

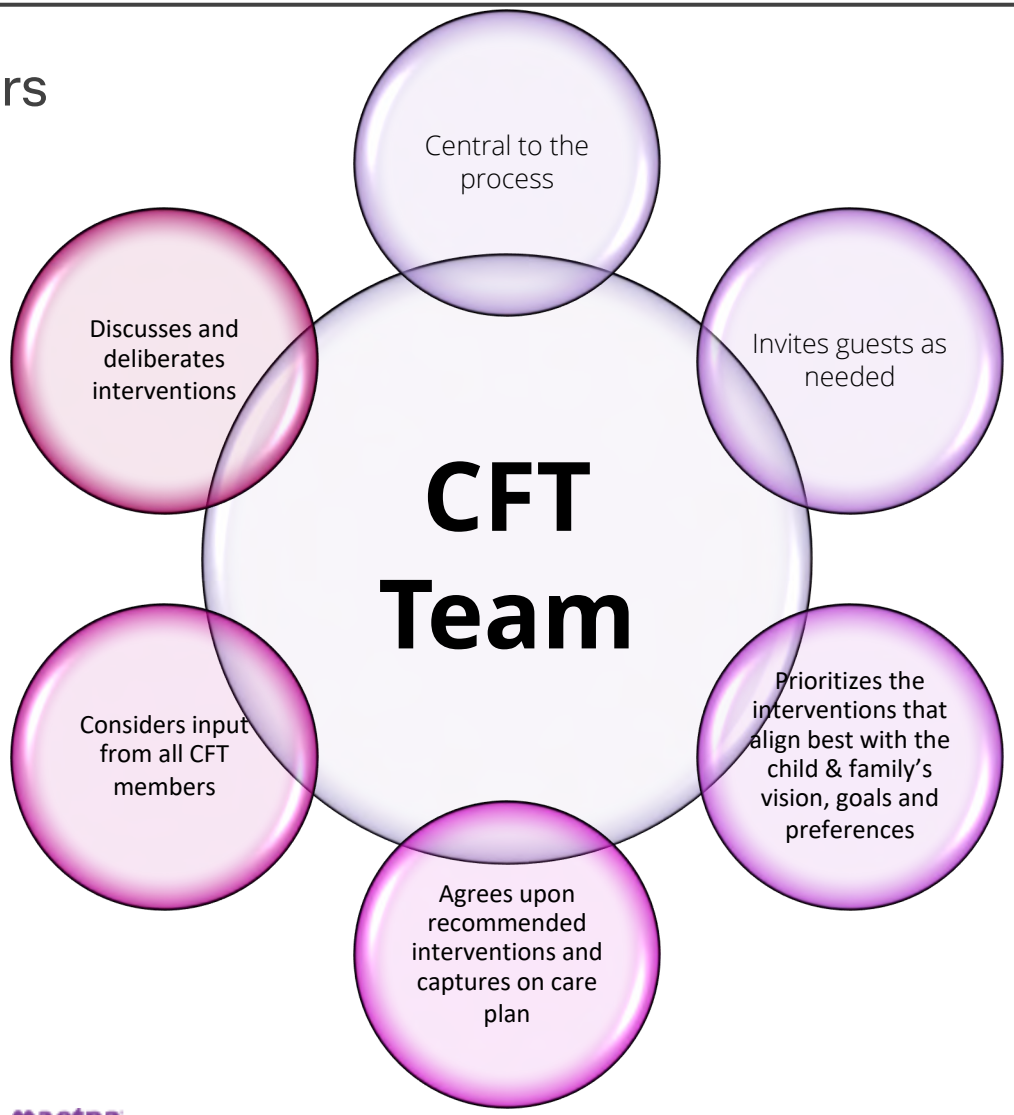
Care Coordination Activities

- Face-To-Face Visits
- Child and Family Team Meeting
- Complete Child and Family Care Plan
- Safety and Crisis Plan Development
- Facilitate Referrals and Linkage
- Discharge Planning and Transition Planning
- Information Sharing with CFT partners/providers for care coordination
- Telephone outreach

Child and Family Team

The team can consist of many different members such as:

- CME
- BH providers
- Physical health providers
- Schools
- County BDs
- Courts
- MCOs
- Natural supports
- And more



Waiver Eligibility

In order to be eligible for OhioRISE 1915(c) Waiver. The member must:

- Have an Inpatient Psychiatric Level of Care demonstrated by
  - Comprehensive CANS assessment completed by CME (only CME's can complete the IP LOC CANS)
  - Diagnosis of Serious Emotional Disturbance
  - Documented functional limitations

- Be age 20 or younger = will allow continued enrollment in program through age 22
- Determined to need at least one of the OhioRISE waiver services, and agree to receive at least one waiver on a regular basis
- Have waiver needs which are less than or equal to the waiver service cost limit ($15,000)
- Meets all other Medicaid and OhioRISE program eligibility criteria

Additional Care Coordination Activities under the 1915(c) Waiver

Complete Home & Community Based Services Checklist

Complete back up waiver service plan with the CFCP

Track out of home respite utilization

Educate member and family on participant directed budget of secondary and emergency flex funds

Ensure member does not exceed waiver cost limit

Include identified waiver services on the CFCP for review and approval PRIOR to starting

Ensure member has a need for, and participates in at least one waiver service monthly

Waiver Services

OhioRISE 1915(c) waiver covered services include:

Out-of-Home Respite: A service provided outside of the youth's home that will provide a short-term temporary relief to those persons who normally provide care for the youth.

- This supports and preserves the primary caregiving relationship

Transitional Services and Supports: Designed to provide support for youth and their families who are experiencing a change in circumstance as listed in 5160:0-59-05.1

Secondary Flex Funds: Services, equipment, or supplies, not otherwise provided through the waiver or through the Medicaid state plan, that are designed to meet a need of the youth in order to address identified needs.

- Similar to Primary Flex Funds covered under the 1915(b)(3) services
- $2000 Emergency Flex Funds
- Must exhaust Primary Flex Funds first before using this service

Home-Community Based Services (HCBS)

At initial enrollment and annual redetermination for OhioRISE 1915(c) waiver, care coordinators must:

- Conduct an assessment of waiver settings where the OhioRISE 1915(c) waiver enrolled member reside and waiver services are provided (with the exception of Out-of-Home Respite and Secondary Flex Funds) to verify those settings meet the CMS criteria to provide home and community-based services in accordance with OAC rule 5160-44-01.

Waiver enrolled members must reside in a private residence or another setting that meets the home and community-based setting requirements set forth in this rule.

A private residence is:

- A home and community-based setting provided it meets the requirements. For the purposes of this rule, provider owned or controlled settings are **not** private residences.

Home-Community Based Services (HCBS)

Home and community-based settings that do **not** meet private residence definition:

- An institution for mental diseases (IMD)
- An intermediate care facility for individuals with intellectual disabilities
- A hospital OR
- Any other locations as determined by the ODM or its designee

HCBS must have all of the appropriate characteristics outlined by U.S. Department of Health and Human Services.

Examples of characteristics (but not all inclusive) are:

(1) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as individuals not receiving services through the ODM or ODA-administered waiver programs

Home-Community Based Services (HCBS)

(2) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting.

(a) The setting options are identified and documented in the person-centered services plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board.

(b) For the purposes of this rule, non-disability specific setting means a home and community-based setting that is not limited to same or similar types of disabilities, or any disabilities at all.

(3) The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(4) The setting optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

(5) The setting facilitates individual choice regarding services and supports, and who provides them.

To obtain a **full** list of characteristics, refer to: Ohio Administrative Code (OAC) 5160-44-01

Flex Funds

Flex funds are intended to enhance and supplement the array of services available to a youth enrolled in the OhioRISE program.

These funds must be used to:

- Decrease the need for other Medicaid services
- Promote the youth's inclusion in the community
- Increase the individual's safety in the home environment

Primary Funds:

- Available to **all** OhioRISE members
- Total amount available in a 365-day period: **$1,500**

Secondary Funds

- Only available to OhioRISE 1915(c) waiver members
- Total amount available in 365-day period: **$3,000**
- Secondary Flex Funds also allows for an Emergency Fund allotment of an additional $2,000 (Only available after Primary and Secondary Flex Funds are exhausted)

Flex Funds

The OhioRISE 1915(c) Waiver allows members the ability for ***participant-direction*** through budget authority as applicable for the service. Care Coordination will provide information and education to members on how to exercise participant-directed budget authority.

For the process of self-direction, the Care Coordinator is key to providing guidance and support.

Care Coordinator will:

- Support the individual in developing the Child and Family-Centered Care Plan and assist them exercising budget authority
  - ***Budget authority*** is a member's budget which they may use for the purchase of goods and services.
- Work with the individual and other members of their child and family team to ensure understanding of responsibility
  - Documentation in the care plan will occur and note if self-direction is being used
  - Provide services and support to the individual to meet their identified goals
  - Be available to answer questions and give guidance along the way

Flex Funds

In addition to the role of Care Coordinator, it is important to note that the CME will work directly with the OhioRISE Plan, the **Financial Management Service** (FMS) vendor and ODM.

They will be responsible to determine:

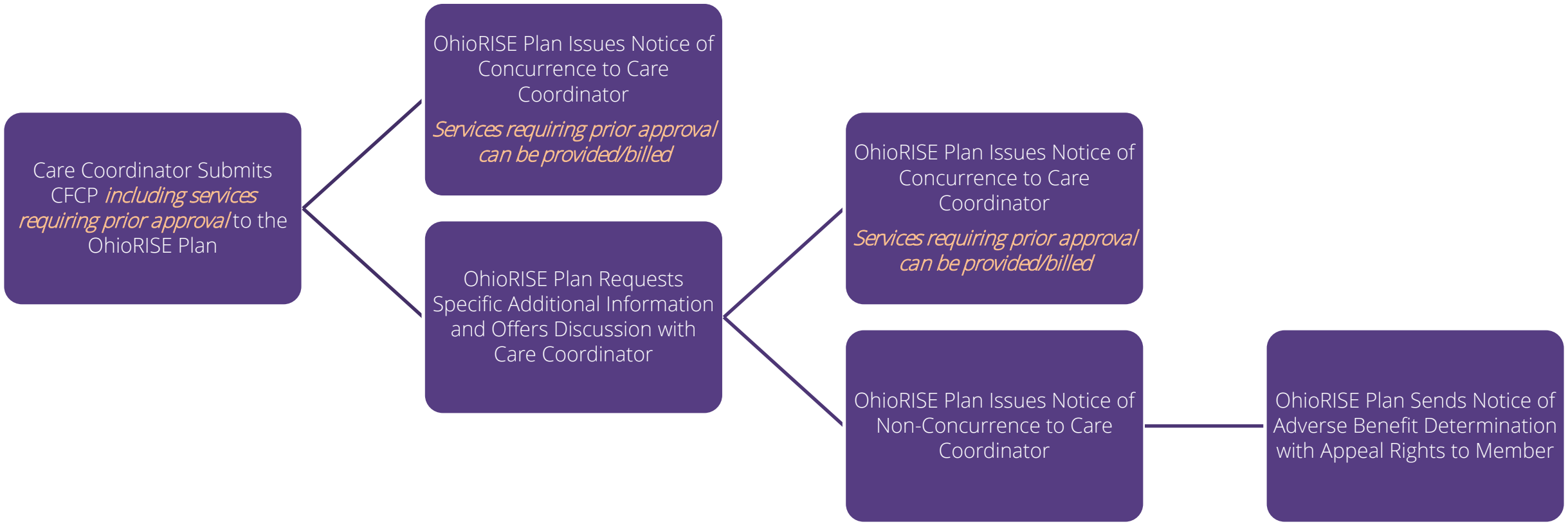
- If and when involuntary termination of individual's rights to exercise budget authority

Situations when budget authority are terminated involuntarily for an individual and/or authorized representative include but are not limited to:

- Using Flex Funds for prohibited purchase of items
- Purchasing items not identified on the care plan and/or purchasing items coverable under the Flex Funds/Customized Goods and Service without detailing an expected outcome
- Using the budget for Flex Funds/Customized Goods and Service in a manner which contradicts the State of Ohio policies and procedures

The Care Coordinator will work with the individual and child and family team to ensure continuity of coverage, including needed services are in place prior to terminating Flex Funds/Customized Goods and Services in the care plan

Child and Family Care Plan (CFCP) Process



Prior Approval

The following services will require “prior approval” before services can be rendered.

❖ **Primary Flex Funds**

❖ **OhioRISE 1915(c) Waiver Services**:

- Secondary Flex Funds, including Emergency Funds
- Transitional Services and Supports
  - Initial service approval on care plan is for up to 72 hours. Additional hours of service may be approved on care plan updates.
- Out-of-Home Respite – up to 90 days per 365 days

Prior Approval Process

A service that requires prior approval uses the Child and Family Care Plan (CFCP) process

- Service must be documented in detail on the child and family-centered care plan (CFCP), and the CFCP must be approved by the OhioRISE plan prior to the child/youth receiving the service and the provider billing for the service.

- Care coordinators will understand services requiring prior approval, work to ensure these services are considered by the child and family team (CFT), and when appropriate work to include providers of these services in the CFT .

- After developing CFCP with CFT, care coordinator submits the CFCP to the OhioRISE plan.
  - **For services that require prior approval before they can be provided/reimbursed, the OhioRISE plan must concur with the CFCP – this concurrence serves an approval to provide and bill for the services that must be approved using the CFCP process**.
  - The OhioRISE plan may concur with the CFCP, or they may request more information and/or follow-up discussion(s) with the care coordinator to improve the quality of the CFCP prior to issuing a concurrence.
  - If CFCP questions remain, the OhioRISE plan may issue a notice of non-concurrence, and the care coordinator will need to amend the CFCP and resubmit.

- Once a CFCP including these services is reviewed and concurrence (approval) is issued by the OhioRISE plan, the services may be used by the member and billed by the provider.

Additional Training

We want to ensure all providers have the necessary resources and information to service OhioRISE members.

Therefore additional training will be created and offered to the provider community. Covered topics will include:

- Education about self-directing secondary flex funds goods and services
- Explanation about setting types that may not meet HCBS setting requirement and require further review
- Information about provider selection for waiver services during CFCP development
- And more…

Information about the training opportunity will be posted on our website at:
https://www.aetnabetterhealth.com/ohiorise/index.html

Critical Incidents

Critical Incidents

The Critical Incident Event is used to document critical incidents, reportable incidents, incident resolution and collaboration with CCE/CME, if member is so assigned, to support a prevention plan and/or intervention following the incident. The following list of critical incidents are required to be documented in the Critical Incident Event:

- **Abuse**-- The injury, confinement, control, intimidation, or punishment of an individual that has resulted in physical harm, pain, fear, or mental anguish. Abuse includes, but is not limited to physical, emotional, verbal, or sexual abuse, or the use of restraint, seclusion, or the use of restrictive intervention implemented without authorization from the waiver case management agency, or the OhioRISE plan or its designee.
- **Self-Harm or Suicide Attempt--** Self-harm or suicide attempt that includes a physical attempt by an individual to harm themselves that results in emergency room treatment, in-patient observation, or hospital admission.
- **Neglect**-- When there is a duty to do so, failing to provide an individual with any treatment, care, goods, or services necessary to maintain the health or welfare of the individual.
- **Exploitation**-- The unlawful or improper act of using an individual or an individual's resources through the use of manipulation, intimidation, threats, deceptions, or coercion for monetary or personal benefit, profit, or gain.
- **Misappropriation over five hundred dollars** -- The act of depriving, defrauding, or otherwise obtaining the money, real or personal property (including prescribed medication) of an individual by any means prohibited by law that could potentially impact the health and welfare of the individual.
- **Death**-- Any death of an OhioRISE member
- **The health and welfare of the individual is at risk due to the individual being lost or missing.**
- **Any of the following prescribed medication issues:**
  - Provider error
  - Prescribed medication issue resulting in EMS response, emergency room visit, or hospitalization

Critical Incidents

The following reportable incidents are required to be documented in the Critical Incident Event:

- Natural deaths that are not due to events such as accidents, injuries, homicide, suicide, and overdoses.
- Individual or family behavior, action, or inaction resulting in the creation of, or adjustment to, a health and safety action plan
- The health and welfare of the individual is at risk due any of the following:
- Loss of the individual's paid or unpaid caregiver;
- Prescribed medication issue not resulting in EMS response, emergency room visit, or hospitalizations; or
- Eviction or housing crisis
- Suicide attempt that does not result in emergency room treatment, in-patient observation, or hospital admission.

NOTE: All Critical and Reportable Incidents must be entered into the state's Incident Management System.

QUALITY IMPROVEMENT AND POPULATION HEALTH

Quality Improvement

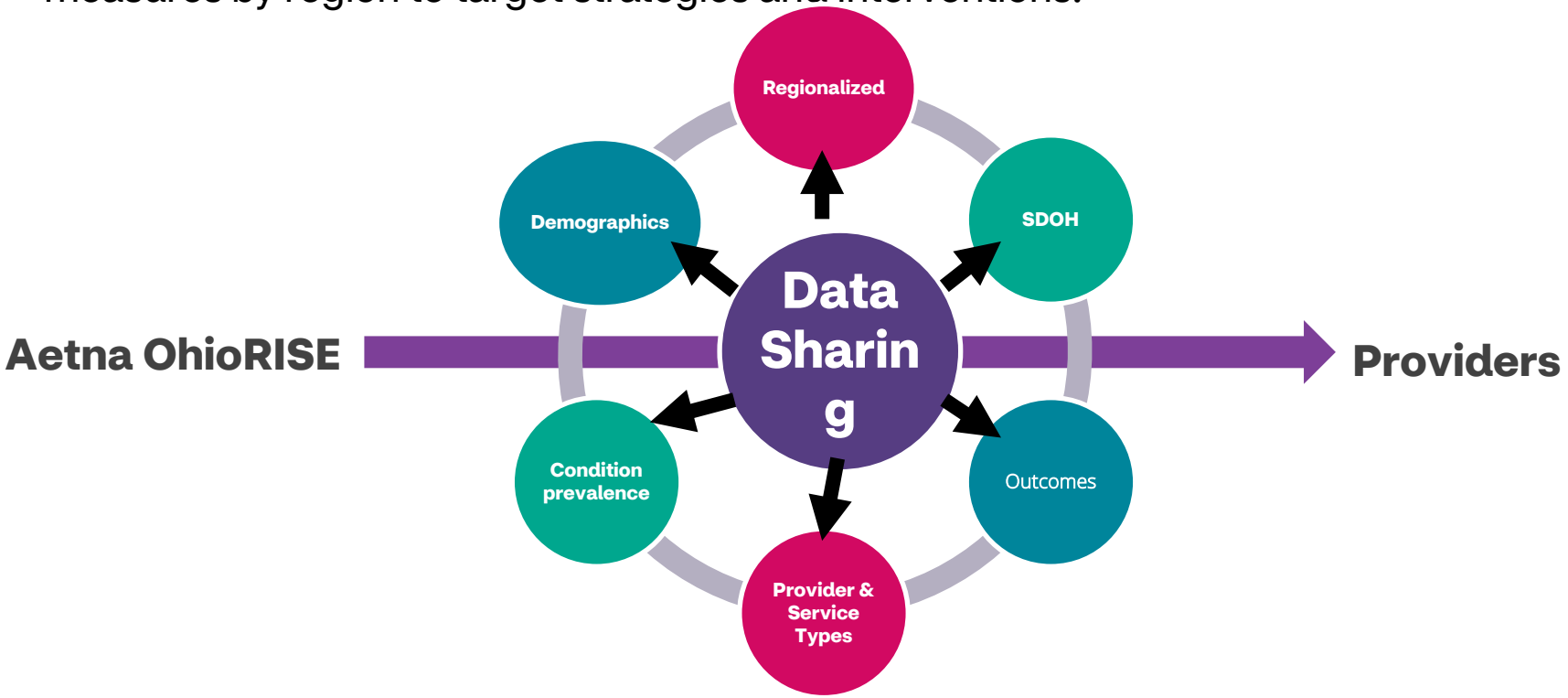
The primary purpose of the Quality Improvement Department is to provide the structure and processes necessary to:

- Identify and improve clinical quality
- Maximize safe clinical practices
- Enhance member and provider satisfaction
- Improve the care delivery system

The OhioRISE QI Team also conducts Performance Improvement Projects (PIP) to improve the performance in the quality or appropriateness of service provision. Each PIP relates to Population Health initiatives as well as to other MCO and ODM quality improvement strategies.

Population Health

OhioRISE will analyze and share data to with you to guide the design and assess improvement strategies for measures related to the OhioRISE Population. This begins by stratifying and reporting measures at the regional level and across provider types and member populations, including race, ethnicity, and gender to identify poor health outcomes. We will analyze SDOH factors and root causes of health disparities impacting measures by region to target strategies and interventions.



Aetna Better Health® of Ohio

Contacts and Resources

Network Relations Contact Information

NETWORK RELATIONS TEAM

- **Chanin Hensley**, Network Relationship Manager
  Regions N, P, Q, R, S, Phone: 740-507-9010
- **Jamie Taylor**, Network Relationship Consultant
  Regions H, I , Phone: 380-222-4078
- **Lanita Haskins**, Network Relationship Consultant
  Regions J, O, T , Phone: 614-204-8915
- **Nea Lindsey**, Network Relationship Consultant
  Regions B, M, Phone: 380-205-6371
- **Stephanie Humphrey**, Network Relationship Manager
  Regions A, C, K, L, Phone: 937-657-8334
- **Venita Benford**, Network Relationship Manager
  Regions D, E, F, G, Phone: 380-205-6374

CME RELATIONSHIP MANAGERS

- **Halli Andrews**, CME Relationship Manager
  Regions D, H, I, M. Phone: 380-222-0836
- **Jeanie Kleiber**, CME Relationship Manager
  Regions C, E, F, G. Phone: 513-630-6213
- **Jill Tayfel**, CME Relationship Manager
  Regions A, B, J, N. Phone: 380-205-6572
- **Shawnda Lockridge**, CME Relationship Manager
  Regions P, Q, R, T. Phone: 216-645-5869
- **Stephen Fomba**, CME Relationship Manager
  Regions K, L, O, S. Phone: 380-209-6766

Color	CME	Projected Annual Assignment (estimate for 12 months)	Count of Counties in CME Region	Counties in CME
	A	2920	9	Williams, Defiance, Fulton, Henry, Putnam, Paulding, Van Wert, Mercer, Lucas
	B	1650	11	Wood, Ottawa, Erie, Sandusky, Seneca, Wyandot, Hancock, Huron, Crawford, Marion, Union
	C	2100	11	Allen, Auglaize, Hardin, Darke, Shelby, Miami, Logan, Champaign, Clark, Green, Madison
	D	2350	2	Preble, Montgomery
	E	2180	3	Butler, Warren, Clinton
	F	2430	1	**Hamilton**
	G	2750	6	**Hamilton**, Clermont, Brown, Adams, Scioto, Lawrence
	H	2070	11	Fayette, Pickaway, Highland, Ross, Pike, Hackson, Gallia, Meigs, Hocking, Vinton, Athens
	I	1750	8	Fairfield, Perry, Muskingum, Morgan, Noble, Guernsey, Coshocton, Washington
	J	2920	8	Monroe, Belmont, Harrison, Tuscawaras, Carroll, Jefferson, Columbiana, Stark
	K, L	2600, 2500	1, 1	**Franklin**
	M	1350	4	Licking, Knox, Morrow, Delaware
	N	1430	2	Lorain, Medina
	O	1310	4	Ashland, Richland, Wayne, Holmes
	P, Q	2400, 2400	1, 1	**Cuyahoga**
	R	1660	4	**Cuyahoga**, Lake, Geauga, Ashtabula
	S	2300	2	Summit, Portage
	T	2450	2	Trumbull, Mahoning

Aetna Better Health® of Ohio OhioRISE Contacts and Resources

Providers can best utilize their contacts and resources by:

- Knowing your Regional Care Management Entity (CME)
- Knowing your member's Care Coordinator (Aetna for Tier One and the regional CME for Tier 2 and 3).
- Knowing your Aetna Network Relations Professional for ongoing support, claims projects, and provider updates.
- Utilize the provider services mailbox for general questions and contracting requests OHRise-Network@aetna.com
- Utilizing the Aetna Network Provider Call system, **833-711-0773**
- Accessing the Aetna Better Health and Ohio Department of Medicaid web-pages for:
  - Provider News & Notices and additional resources, www.aetnabetterhealth.com/ohiorise/index.html ***and***
  - Managedcare.medicaid.ohio.gov/managed-care/ohiorise/ohiorise

Aetna Better Health® of Ohio OhioRISE Contacts and Resources

Important Contacts	Phone Number	Hours and Days of Operation (excluding State of Ohio holidays)
Aetna Better Health of Ohio	1-833-711-0773 (follow the prompts to reach the appropriate departments)	7 a.m.-8 p.m. EST Monday-Friday
Aetna Better Health of Ohio Compliance Hotline (Reporting Fraud, Waste or Abuse)	1-833-865-0278	24-hours-a-day, 7-days-a- week through Voice Mail inbox
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	Facsimile
Population Health/Equity	OhioRISEhealthequity@aetna.com
Member Services	833-711-0773
Provider Services & Provider Claim Disputes	833-711-0773
Care Management (includes behavioral health services)	833-711-0773
Medical Prior Authorization	833-711-0773
Pharmacy Prior Authorization	Providers to use managed care plan assigned to member

Contacts and Resources Continued:

Important Addresses	
Aetna Better Health of Ohio Participating Provider Disputes	https://apps.availity.com/availity/Demos/Registration/index.htm Disputes are filed online through Availity
Aetna Better Health of Ohio Appeals (Non- participating providers)	Aetna Better Health of Ohio Provider A&G Mail Aetna Better Health of Ohio PO Box 81040 5801 Postal Road Cleveland, OH 44181
Claim Submission	Claims submission to occur through Change Healthcare Payer ID: 45221 https://www.aetnabetterhealth.com/ohio/assets/pdf/OH_WebConnect_user_guide_Claims.pdf

Contacts and Resources Continued:

Community Resource	Contact Information
Ohio Statewide Crisis Line	1-800-720-9616
State of Ohio Quit Line	1-800-QUIT-NOW (1-800-784-8669) Website: https://ohio.quitlogix.org/en-US/

Contractors	Phone Number	Hours and Days of Operation
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 1-833-865-0278 (for more information on how to schedule these services in advance of an appointment)	24-hours-a- day, 7-days- a-week

Thank You

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