Below is a description of the documents included in the Provider Orientation Kit.

<table>
<thead>
<tr>
<th>Document</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Welcome Letter</td>
<td>The Welcome Letter welcomes providers to our network.</td>
</tr>
<tr>
<td>Provider Dispute Form</td>
<td>The Provider Dispute Form is used in the event a provider is dissatisfied with us.</td>
</tr>
<tr>
<td>Contact List</td>
<td>The Contact List is a document comprised of our contact information as well as our vendors.</td>
</tr>
<tr>
<td>Identifying &amp; Reporting Abuse, Neglect, and</td>
<td>The Abuse, Neglect, and Exploitation training document provides important resources and information pertaining to identifying and reporting abuse.</td>
</tr>
<tr>
<td>Exploitation of an Enrollee Training</td>
<td></td>
</tr>
<tr>
<td>Fraud, Waste &amp; Abuse Training</td>
<td>The Fraud, Waste, and Abuse (FWA) training document was created to help us detect, report, and prevent fraud, waste, and abuse. Our training includes CMS requirements surrounding provider FWA.</td>
</tr>
<tr>
<td>Cultural Competency Training</td>
<td>The Cultural Competency training document assists the provider in understanding the social, linguistic, moral, intellectual, and behavioral characteristics of our enrollee.</td>
</tr>
<tr>
<td>National Provider Identification (NPI)</td>
<td>The National Provider Identification (NPI) Requirements training document is used to assist the provider with understanding how to use their NPI and HIPAA standard electronic transactions.</td>
</tr>
<tr>
<td>Requirements Training</td>
<td></td>
</tr>
<tr>
<td>Access &amp; Availability Standards</td>
<td>The Access &amp; Availability Standards document outlines the requirements a provider must follow when scheduling appointments with enrollees.</td>
</tr>
<tr>
<td>Medical Authorization Form</td>
<td>The Medical Authorization Form is used by providers when asking for medical service authorization.</td>
</tr>
<tr>
<td>Additional forms are available on our site at</td>
<td><a href="http://www.aetnabetterhealth.com/Michigan/">http://www.aetnabetterhealth.com/Michigan/</a></td>
</tr>
</tbody>
</table>
Dear Contracted Provider:

**Aetna Better Health® of Michigan, a Premier Plan** is proud to have been chosen by the Michigan Department of Community Health (MDCH) to participate in the State of Michigan’s new Health Link program. Michigan Health Link is a new managed care program that will coordinate physical, behavioral and long-term care services for individuals age 18 and older who are eligible for both Medicare and Medicaid.

The goals of Aetna Better Health of Michigan’s Premier Plan are to:

- Create a person-centered care management approach to improve the quality of care members receive.
- Comprehensively manage benefits across the continuum of care, including social and community services.
- Integrate services for all physical, behavioral, long-term care, and social needs.
- Utilize a payment structure that blends Medicare and Medicaid funding.

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

<table>
<thead>
<tr>
<th>Region 1</th>
<th>Region 4</th>
<th>Region 7</th>
<th>Region 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alger, Baraga</td>
<td>Iron, Keweenaw</td>
<td>Barry, Berrien</td>
<td>Wayne</td>
</tr>
<tr>
<td>Chippewa</td>
<td>Luce, Mackinac</td>
<td>Branch</td>
<td>Macomb</td>
</tr>
<tr>
<td>Delta</td>
<td>Marquette</td>
<td>Calhoun</td>
<td></td>
</tr>
<tr>
<td>Dickinson</td>
<td>Menominee</td>
<td>Cass</td>
<td></td>
</tr>
<tr>
<td>Gogebic</td>
<td>Ontonagon</td>
<td>Kalamazoo</td>
<td></td>
</tr>
<tr>
<td>Houghton</td>
<td>Schoolcraft</td>
<td>St. Joseph</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Van Buren</td>
<td></td>
</tr>
</tbody>
</table>

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

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

We have assembled the enclosed Provider Orientation Kit to help acquaint you and your staff with the Aetna Better Health of Michigan’s Premier Plan. We hope you find this information to be useful. Should you have any questions or concerns, please contact us directly at: 1-855-676-5772 or via email at AetnaBetterHealth-MI-ProviderServices@AETNA.com

Sincerely,

Donna West
Provider Services Manager
Aetna Better Health of Michigan

Enclosure
Participating Provider Quick Reference Guide

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

Eligibility Verification

Please contact us at 1-855-676-5772 or log into our Care Bridge Web Portal to verify eligibility.

Tools & Resources

Website

- Provider Handbook
- Evidence of Coverage / Member Handbook
- 24/7 Secure Web Portal (See below for full details)
- Clinical Guidelines
- Forms
- Provider Education

Care Bridge Web Portal (24/7)
The Care Bridge Web Portal allows participating providers to perform a variety of tasks such as:
- Verifying eligibility
- Download various forms used to submit authorization requests
- Submission and verification of prior authorization requests
- Review prior authorization requirement search tool
- Checking claims status
- Pull PCP roster of assigned enrollees

Participating providers must complete our user agreement in order to access the Care Bridge Web Portal.

Claims

Claim Inquires
Participating providers may review the status of a claim by checking the Care Bridge Web Portal located on our website at www.aetnabetterhealth.com/Michigan or by calling our Claims Investigation and Research Department (CICR) at 1-855-676-5772.

Claims & Resubmissions
Aetna Better Health of Michigan requires clean claims submissions for processing.

To submit a clean claim, the participating provider must submit:
- Enrollee’s name
- Enrollee’s date of birth
- Enrollee’s identification number
- Service/admission date
- Location of treatment
- Service or procedure

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

Electronic Claims Submission
Aetna Better Health encourages participating provider to electronically submit claims through Emdeon. Emdeon offers two ways to submit claims. Either through the normal process of Emdeon, or through Web-Connect.

Emdeon
http://www.emdeon.com/
or
Emdeon “WebConnect”
https://office.emdeon.com/secure/scripts/inq.dll?
MfcISAPICommand=LogIn

Please use the following Provider ID and Submitter ID when submitting claims to Aetna Better Health of Michigan:
- Payer ID#: 128MI

For electronic resubmissions, participating providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.

Paper Claims Submissions and or Resubmissions
Please use the following Provider ID and Submitter ID when submitting claims to Aetna Better Health of Michigan:
- Payer ID#: 128MI

Aetna Better Health of Michigan
P.O. Box 66215
Phoenix, AZ 85082

For resubmissions, please stamp or write one of the following on the paper claims:
- Resubmission, Rebill, Corrected Bill, Corrected or Rebilling

About WebConnect
Aetna Better Health of Michigan uses Emdeon WebConnect. WebConnect is a web based solution that simplifies the everyday tasks the provider practices by integrating eligibility and benefits verification, claims and payment management as well as clinical tools all into one easy to use application. There are no provider costs for specialized software or per-transaction fees, even providers who previously only interfaced by submitting claims manually may utilize WebConnect for automated payer interaction.

Features

- Secure personalized web portal for submitting providers
- Automated electronic batch claim submission & real-time patient eligibility, benefit verification, referrals, pre-certs, authorizations, claim inquiry and more
- Fast implementation
- Real-time provider enrollment offers immediate electronic capability

Benefits

- Improves auto-adjudication rates
- Increases automation and improves efficiency
- Reduces call center volumes and associated expenses
- Eliminates requirement for capital investments in IT and staffing related to internal portal development and maintenance
- Drives providers directly to payers’ websites
- Improves provider satisfaction
Prior Authorization

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

- To request a prior authorization, please refer to the Prior Authorization Requirement Search Tool located on our 24/7 Care Bridge Web Portal, or call the Aetna Better Health of Michigan Prior Authorization Department at 1-855-676-5772, or fax the request form to 1-844-241-2495.

- When requesting prior authorization, please provide the following:
  * Enrollee’s identification number
  * Demographic information
  * Requesting provider contact information
  * Clinical notes/explanation of medical necessity
  * Other treatments that have been tried
  * Diagnosis and procedure codes
  * Date(s) of service (DOS).

- Important Note:
  * Emergency services do not require prior authorization; however, notification is required the same day.
  * For post stabilization services, hospitals may request prior authorization by calling 1-855-676-5772.
  * All out of network services must be authorized.
  * Unauthorized services will not be reimbursed and authorizations is not a guarantee of payment.

Services that require prior authorization:
(Not a complete list. For additional details, please contact us.)

- All Inpatient Services
- All LTSS Services
- Surgical Services
- Therapy
- Imaging
- DME
- Dental
- Injectables
- Orthotics/Prosthetics
- Transportation

Decision/Notification Requirements

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

<table>
<thead>
<tr>
<th>Decision</th>
<th>Decision/notification timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent pre-service approval</td>
<td>72 hours from receipt of request</td>
</tr>
<tr>
<td>Urgent pre-service denial</td>
<td>72 hours from receipt of request</td>
</tr>
<tr>
<td>Non-urgent pre-service approval</td>
<td>14 Calendar Days from receipt of the request</td>
</tr>
<tr>
<td>Non-urgent pre-service denial</td>
<td>14 Calendar Days from receipt of the request</td>
</tr>
<tr>
<td>Urgent concurrent approval</td>
<td>24 hours of receipt of request</td>
</tr>
<tr>
<td>Urgent concurrent denial</td>
<td>24 hours of receipt of request</td>
</tr>
<tr>
<td>Post-service approval</td>
<td>30 calendar days from receipt of the request</td>
</tr>
<tr>
<td>Post-service denial</td>
<td>30 calendar days from receipt of the request</td>
</tr>
<tr>
<td>Termination, Suspension</td>
<td>At least 10 Calendar Days before the date of the action.</td>
</tr>
<tr>
<td>Reduction of Prior Authorization</td>
<td></td>
</tr>
</tbody>
</table>

Online Provider & Pharmacy Search Tool

For a list of participating providers, including behavioral health, please access our online search tool located on our website at: [www.aetnabetterhealth.com/Michigan](http://www.aetnabetterhealth.com/Michigan).

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

For information on how to access behavioral services, please contact us at 1-855-676-5772.

Contact Information

- **Health Plan Administration:** 1-855-676-5772
- **For Vision, Dental, Transportation, and Behavioral questions, please call the Health Plan directly and select the corresponding option.**
- **CVS (Pharmacy) Help Desk:** 1-855-319-6287
- **Emdeon:** 1-800-845-6592
- **Michigan Relay:** 7-1-1

For HCBS providers, please refer to the HCBS Quick Reference Guide.
# Participating Provider Dispute Form

## Premier Plan

### Mail and/or fax dispute to:

<table>
<thead>
<tr>
<th>Mail:</th>
<th>Toll Free Fax:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health of Michigan, a Premier Plan Provider Relations Department <strong>Attention: Provider Dispute</strong> 1333 Gratiot Ave. Detroit, MI 48207</td>
<td>1-860-975-3615</td>
</tr>
</tbody>
</table>

---

### Provider Information (required)

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitter’s name:</td>
<td></td>
</tr>
<tr>
<td>Provider Street Address:</td>
<td></td>
</tr>
<tr>
<td>Provider City, State &amp; ZIP</td>
<td></td>
</tr>
<tr>
<td>Provider Phone Number:</td>
<td></td>
</tr>
</tbody>
</table>

### Member Information (required)

| Member Name |  |
| Member ID # |  |

### Claim dispute - provide the following information:

<table>
<thead>
<tr>
<th>Type of claim dispute (circle one)</th>
<th>Corrected Claim or Resubmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date(s) of Service</td>
<td></td>
</tr>
<tr>
<td>Remittance Advice Date</td>
<td></td>
</tr>
<tr>
<td>Amount Billed</td>
<td></td>
</tr>
<tr>
<td>Amount Paid</td>
<td></td>
</tr>
<tr>
<td>Claim Number(s)</td>
<td></td>
</tr>
</tbody>
</table>

Providers have a total of 365 days from the date of service to submit, resubmit, and/or dispute a claim.

Please use the space below to document a contractual dispute involving something other than a claim determination; and to supply any other necessary information, along with your attachments, to enable a thorough reconsideration of all disputes.

---

Signature of Sender: ___________________________  Date: ___________________________
Providers who have additional questions can refer to the following Aetna Better Health of Michigan, Premier Plan phone numbers:

<table>
<thead>
<tr>
<th>Important Contacts</th>
<th>Phone Number</th>
<th>Hours and Days of Operation (excluding State of Michigan holidays)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health of Michigan</td>
<td>1-855-676-5772 (follow the prompts in order to reach the appropriate departments)</td>
<td>8 a.m.-6 p.m. EST Monday-Friday</td>
</tr>
<tr>
<td>Provider Services Department</td>
<td></td>
<td>8 a.m.-6 p.m. EST Monday-Friday</td>
</tr>
<tr>
<td>Member Services Department</td>
<td></td>
<td>24-hours-a-day, 7-days-a-week</td>
</tr>
<tr>
<td>(Eligibility Verifications)</td>
<td><a href="http://www.aetnabetterhealth.com/Michigan/">http://www.aetnabetterhealth.com/Michigan/</a></td>
<td></td>
</tr>
<tr>
<td>Aetna Better Health of Michigan Prior Authorization Department &amp; Nurse Advice Line</td>
<td>See Program Numbers Above and Follow the Prompts</td>
<td>6 a.m.-8 p.m. EST Monday-Friday</td>
</tr>
<tr>
<td>Aetna Better Health of Michigan Compliance Hotline (Reporting Fraud, Waste or Abuse)</td>
<td>1-866-676-5280</td>
<td>24-hours-a-day, 7-days-a-week through Voice Mail inbox</td>
</tr>
<tr>
<td>Aetna Better Health of Michigan Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse)</td>
<td>1-800-338-6361</td>
<td>24-hours-a-day, 7-days-a-week</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aetna Better Health of Ohio Department Fax Numbers</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
<td>1-855-854-3245</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>1-844-300-7473</td>
</tr>
<tr>
<td>Care Management (includes behavioral health services)</td>
<td>1-844-466-7914</td>
</tr>
<tr>
<td>Medical Prior Authorization</td>
<td>1-844-241-2495</td>
</tr>
<tr>
<td>Pharmacy Prior Authorization</td>
<td>1-844-242-0914</td>
</tr>
<tr>
<td>Grievances &amp; Appeals for Providers</td>
<td>1-860-975-3615</td>
</tr>
<tr>
<td>Grievances &amp; Appeals for Members</td>
<td>1-844-321-9567</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Resource</th>
<th>Contact Information</th>
<th>Website:</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Michigan Quit Line</td>
<td>1-800-784-8869</td>
<td><a href="https://michigan.quitlogix.org/">https://michigan.quitlogix.org/</a></td>
</tr>
</tbody>
</table>
Providers who have additional questions can refer to the following Aetna Better Health of Michigan, Premier Plan phone numbers:

<table>
<thead>
<tr>
<th>Contractors</th>
<th>Phone Number</th>
<th>Facsimile</th>
<th>Hours and Days of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scion Dental (Dental Vendor) <a href="http://www.sciondental.com">www.sciondental.com</a></td>
<td>Enrollee Line: 1-866-416-6774 (TTY 1-800-502-6975)</td>
<td>N/A</td>
<td>Monday – Friday 7 a.m.-4 p.m. CST</td>
</tr>
<tr>
<td></td>
<td>Provider Line: 1-888-249-8841</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>Please contact our Member Services Department at 1-1-855-676-5772 (for more information on how to schedule these services in advance of an appointment)</td>
<td>N/A</td>
<td>24-hours-a-day, 7-days-a-week</td>
</tr>
<tr>
<td></td>
<td>Provider Line: 1-800-615-1883</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Transportation Management (MTM) (Non-Emergent Transportation Vendor) <a href="http://www.mtm-inc.net/">http://www.mtm-inc.net/</a></td>
<td>Enrollee Line: Contact Aetna Better Health of Michigan directly</td>
<td>N/A</td>
<td>7 a.m.-7 p.m. CST 8 a.m.-8 p.m. EST</td>
</tr>
<tr>
<td></td>
<td>Provider Line: 1-844-549-8347 (providers call to make standing order reservations for patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>Pharmacy Help Desk 1-855-319-6287 Or 1-888-624-1135</td>
<td>1-844-242-0914</td>
<td>8 a.m.-6 p.m. EST Monday-Friday</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pharmacist available after hours for prior authorizations, 24-hours-a-day, 7-days-a-week.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Important Contacts</th>
<th>Phone Number</th>
<th>Facsimile</th>
<th>Hours and Days of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emdeon Customer Service Email Support: <a href="mailto:hdsupport@webmd.com">hdsupport@webmd.com</a></td>
<td>1-800-845-6592</td>
<td>N/A</td>
<td>24-hours-a-day, 7-days-a-week</td>
</tr>
</tbody>
</table>
Providers who have additional questions can refer to the following Aetna Better Health of Michigan, Premier Plan phone numbers:

<table>
<thead>
<tr>
<th>Important Contacts</th>
<th>Phone Number</th>
<th>Facsimile</th>
<th>Hours and Days of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan Relay</td>
<td>Dial 711</td>
<td>N/A</td>
<td>24-hours-a-day, 7-days-a-week</td>
</tr>
</tbody>
</table>

**Reporting Suspected Neglect or Fraud**

<table>
<thead>
<tr>
<th></th>
<th>Phone Number</th>
<th>Facsimile</th>
<th>Hours and Days of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office of Services to the Aging</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Long-Term Care Ombudsman Program (LTC Ombudsman)</td>
<td>1-866-485-9393</td>
<td>24-hours-a-day, 7-days-a-week</td>
<td>8 a.m.-7 p.m. EST Monday-Friday (Excluding holidays and weekends. Voice mail service will be available whenever the Hotline is closed)</td>
</tr>
<tr>
<td><strong>Michigan Department of Human Services</strong></td>
<td>Centralized Intake for Abuse and Neglect Hotline: 1-855-444-3911</td>
<td>24-hours-a-day, 7-days-a-week</td>
<td>See link for hours of operation in each county.</td>
</tr>
<tr>
<td><strong>Michigan Attorney General’s Office</strong></td>
<td>Report abuse either online at <a href="http://www.michigan.gov/ag">www.michigan.gov/ag</a> or call the “HOTLINE” at 1-800-24-ABUSE (22873)</td>
<td>24-hours-a-day, 7-days-a-week</td>
<td>24-hours-a-day, 7-days-a-week</td>
</tr>
<tr>
<td><strong>The National Domestic Violence Hotline</strong></td>
<td>1-800-799-SAFE (7233)</td>
<td>24-hours-a-day, 7-days-a-week</td>
<td>24-hours-a-day, 7-days-a-week</td>
</tr>
<tr>
<td><strong>The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)</strong></td>
<td>1-800-HHS-TIPS (1-800-447-8477)</td>
<td>24-hours-a-day, 7-days-a-week</td>
<td>24-hours-a-day, 7-days-a-week</td>
</tr>
</tbody>
</table>
Identifying & Reporting Abuse, Neglect & Exploitation of a Member

Aetna Better Health of Michigan’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

- **Reasonable Cause** means that, based on your observations, training and experience, you have a suspicion that a vulnerable person has been subject to abuse or neglect as described below. Significant incidents that may place a vulnerable person at risk of harm must also be reported. Reasonable cause can be as simple as doubting the explanation given for an injury.

- **Immediately** means “right-away”; however reporting may be delayed to prevent harm (e.g., for as long as it takes to call emergency responders and/or address the need to maintain supervision.)

- **Discovery** comes from witnessing the situation, or when the vulnerable person or another individual comes to you and the available information indicates reasonable cause.

The Social Welfare Act, MCL 400.11, provides the following definitions:

- **Abuse** means harm or threatened harm to an adult’s health or welfare caused by another person. Abuse includes, but is not limited to, non-accidental physical or mental injury, sexual abuse, or maltreatment.

- **Adult in need of protective services or “adult”** means a vulnerable adult not less than 18 years of age who is suspected of being or believed to be abused, neglected or exploited.

- **Exploitation** means an action that involves the misuse of an adult’s funds, property, or personal dignity by another person.

- **Neglect** means harm to an adult’s health or welfare caused by the inability of the adult to respond to a harmful situation or by the conduct of a person who assumes responsibility for a significant aspect of the adult’s health or welfare. Neglect includes the failure to provide adequate food, clothing, shelter, or medical care. A person shall not be considered to be abused, neglected or in need of emergency or protective services for the sole reason that the person is receiving or relying upon treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, and this act shall not require any medical care or treatment in contravention of the stated or implied objection of that person.

- **Protective Services** includes, but is not limited to, remedial, social, legal, health, mental health, and referral services provided in response to a report of alleged harm or threatened harm because of abuse, neglect or exploitation.

- **Vulnerable** means a condition in which the adult is unable to protect himself or herself from abuse, neglect or exploitation because of a mental or physical impairment or because of advanced age.

Neglect

**Types of Neglect**

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

**Signs of Neglect**

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

**Examples of Neglect**

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

Abuse

**Examples of Abuse**

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

**Behaviors of Abusers (Caregiver and/or Family Member)**

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

Financial Exploitation

**Examples of Financial Exploitation**

- Caregiver, family member, or professional expresses excessive interest in the amount of money being spent on the member
- Forcing member to give away property or possessions
- Forcing member to change a will or sign over control of assets
IDENTIFYING & REPORTING ABUSE, NEGLECT & EXPLOITATION OF A MEMBER

Timeframes For Reporting
See the below grid for details.

CMS Guidance—Nursing Home/Long-Term Care Facilities
The Centers for Medicare and Medicaid Services (CMS) issued guidance on the reporting requirements for nursing homes when there are alleged violations related to mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property. Federal regulations (42 C.F.R. § 483.13 & 42 U.S.C. § 1320b–25) and state regulations (Mich. Comp. Laws § 400.11a(1) and (4) – (5)) require the reporting of alleged violations of abuse, mistreatment and neglect, including injuries of unknown origin, immediately to the facility administrator and in accordance with state law, to the Department of Health. Additionally, Federal regulations require that alleged violations of misappropriation of resident property be reported immediately.

Reporting timeframes are as follows:

- **Serious Bodily Injury** – two (2) Hour Limit: If the incident and/or events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual must report the suspicion immediately, but not later than two (2) hours after forming the suspicion.
- **All Others** – Within twenty-four (24) Hours: If the incident and/or events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual must report the suspicion not later than twenty-four (24) hours after forming the suspicion.

Aetna Better Health of Michigan’s Compliance Hotline
After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health of Michigan.
- 1-855-676-5280

**What Should be Reported?**

Information the reporter should have ready to provide:

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

**Additional Resources**


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<td>N/A</td>
<td>Report abuse either online at <a href="http://www.michigan.gov/ag">www.michigan.gov/ag</a> or call the “HOTLINE” at 1-800-24-ABUSE (22873)</td>
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<td>Michigan Department of Human Services</td>
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<tr>
<td>Centralized Intake for Abuse and Neglect Hotline: 1-855-444-3911</td>
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<tr>
<td>Nursing Home / Long-Term Care Facilities</td>
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<td>Serious Bodily Injury – immediately, but not later than two (2) hours after forming the suspicion All Others –twenty-four (24) hours after forming the suspicion</td>
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<td>Office of Services to the Aging</td>
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<td>The Long-Term Care Ombudsman Program (LTC Ombudsman): 1-866-485-9393</td>
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</table>
Welcome!
We designed this training to assist you in helping Aetna Better Health of Michigan detect, report, and prevent fraud, waste, and abuse.

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

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

Definitions

Fraud: An intentional act of deception, misrepresentation, or concealment in order to gain something of value.

Abuse: Excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice.

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

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

What Does That Mean?
Intentionally submitted false information to the government or a government contractor in order to get money or a benefit.

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

Differences Between Fraud, Waste, and Abuse

There are differences between fraud, waste and abuse. One of the primary differences is intent and knowledge. Fraud requires the person to have an intent and obtain payment and knowledge that their actions are wrong.

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

What are my responsibilities as 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 program.

Second you have a duty to the Medicare-Medicaid Program to report any violations of laws that you may be aware of.

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

How Can I Prevent Fraud, Waste, and Abuse?

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

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

Resources
Examples of Fraud, Waste, and Abuse
Billing for services and/or supplies that were never performed or provided.
- Billing for a higher-level treatment than was actually provided.
- Billing separately for services that are already included in the primary procedure.
- Health care provider not providing enough care or delaying needed care. This is done in order to maximize the health care provider's service funds.
- Billing for services or procedures that are not needed.
- Utilizing false or inflated diagnosis codes for encounter information to increase premiums.
- Writing scripts from brand name pharmaceuticals even though generic is stated in the plan formulary.
- Use of medical benefits by an unauthorized individual.

Reporting Fraud, Waste, and Abuse
Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to the compliance department or Aetna Better Health of Michigan's Compliance Department. Aetna Better Health of Michigan will investigate and make the proper determination.

Aetna Better Health of Michigan Compliance Hotline:
- 1-855-676-5280
Aetna Better Health of Michigan Special Investigations Unit:
- aetnasiu@aetna.com
- 1-800-338-6361

Laws You Need to Know About

Civil Fraud Civil False Claim Act
Prohibits:
- Presenting a false claim for payment or approval.
- Making or using a false record or statement in support of a false claim.
- Conspiring to violate the False Claim Act.
- Falsely certifying the type/amount of property to be used by the Government.
- Certifying receipt of property without knowing if it’s true.
- Buying property from an unauthorized Government officer.
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.
(31 United States Code § 3729-3733)

Damages and Penalties
The damages may be tripled. Civil Money Penalty between $5,000 and $10,000 for each claim.

Criminal Fraud Penalties
If convicted, the individuals shall be fined, imprisoned, or both. If violations resulted in death, the individual may be imprisoned for any term of years or for life, or both. (18 United States Code § 1347)

Anti-Kickback Statue
Prohibits:
- Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare-Medicaid program). (42 United States Code § 1320a-7b(b))

Penalties
Fine of up to $25,000, imprisonment up to five (5) years, or both fine and imprisonment.

Stark Statute
Physician Self-Referral Law
Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply). (42 United States Code § 1395nn)

Damages and Penalties
Medicare claims tainted by an arrangement that does comply with Stark are not payable. Up to a $15,000 fine for each service provided. Up to a $100,000 fine for entering into an arrangement or scheme.

Exclusions
No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General. (42 U.S.C. § 1395(e0(1), 42 U/F/R/ §1001/1901)

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

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

Consequences of Committing Fraud, Waste, or Abuse
The following are potential penalties. The actual consequences depends on the violation.
- Civil Money Penalties
- Criminal Convictions/Fines
- Imprisonment
- Loss of Provider License
- Exclusion from Federal health Care Program
CULTURAL COMPETENCY

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 Michigan 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.

To access Aetna Better Health of Michigan’s “physician” online cultural competency courses, please visit: http://www.aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html

Our Quality Interactions® course series is designed to help our providers to:
- Bridge cultures
- Build stronger patient relationships
- Provide more effective care to ethnic and minority patients
- Work with your patients to help obtain better health outcomes

Additional provider-focused cultural competency resources can be found on the U.S. Department of Health and Human Services (HRSA) website at: http://www.hrsa.gov/culturalcompetence/index.html

Furthermore, the Physician’s Practical Guide to Culturally Competent Care offered by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) at: https://cccm.thinkculturalhealth.hhs.gov/GUIs/GUI_AboutthisSite.asp is a self-directed training course for health care providers with a specific interest in cultural competency in the provision of care. With growing concerns about racial and ethnic disparities in health and about the need for health care systems to accommodate increasingly diverse patient populations, cultural competence has increasingly become a matter of national concern. To train health care providers to care for diverse populations, the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) has commissioned the Cultural Competency Curriculum Modules (CCCMs). The modules, encompassed in “A Physician’s Practical Guide to Culturally Competent Care,” will equip health care providers with competencies that will enable them to better treat the increasingly diverse U.S. population.

Things to remember:

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

Health Care providers should ensure that patients are effectively receiving understandable, respectful and timely care compatible with their cultural health beliefs, practices and preferred languages from all staff members.

When treating a person with a disability remember to:
- talk to the patient, not someone who accompanies them.
- avoid making assumptions.
- ask, “How can I help you?” and respect the answer.
- ensure that educational materials are easily accessible.
- allow time for history taking & exam.

When treating a person who is blind or visually impaired, provide written material
- in an auditory format.
- on computer disc.
- in Braille or large print.

When treating a person who is deaf or hard of hearing:
- ask how to best communicate.
- provide written educational material.
- look at the person while speaking.
- avoid shouting.
- minimize background noise.
- provide interpreter, if necessary for effective communication.
- patients cannot be charged for interpretation
- family members should not be pressured to interpret to save time or expense.

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

Pertinent Articles on Disability Issues and Research
Welcome!
We designed this training to assist you with understanding how to use your NPI in HIPAA standard electronic transactions.

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

General

Which HIPAA standard electronic transactions have to include the NPI?

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

How do I use my NPI?

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

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

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

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

Is Aetna Better Health of Health of Michigan’s maintaining old and generating new Aetna Better Health of Michigan provider identification numbers?

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

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

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

- An entity or individual "as a taxpayer" using the TIN (for example, Social Security number or employer identification number (EIN)). This exception only applies to billing providers in claims and payees in remittance advices. An NPI must also be used to identify covered health care providers "as providers" in these situations.
- Providers acting in a way that is not considered to be a "provider" role, such as information submitter or receiver or utilization management organization.
- Non-covered health care providers. For example, a referring provider who does not conduct any electronic transactions is a non-covered provider who may have chosen not to obtain an NPI.
- Individuals and entities who are not considered health care providers (also known as atypical providers). Atypical providers are persons or groups whose services may be paid for by health benefits plans but who do not directly provide health care. Some common examples include:
  - Personal care workers (for example, aides providing assistance with daily living)
  - Non-medical living arrangements (for example, assisted living, certified family homes, boarding homes, supervised independent living and community residential facilities)
  - Non-emergency transportation providers (for example, taxi services)
  - Entities that administer health benefits but do not directly provide health care, such as:
    - Other health plans
    - Individual practice associations (IPAs)

For more information, see CMS' answer to question ID 5816 at http://questions.cms.hhs.gov.

I submit electronic transactions but am not eligible for an NPI. How do I notify Aetna Better Health of Michigan's?

Notify us by using calling our Provider Services Department at 1-855-676-5772.

For more information, see CMS' answer to question ID 5816 at http://questions.cms.hhs.gov.
My organization has multiple NPIs. Which should I use in transactions?
View our help document for guidance on submitting transactions with NPIs for organizations below (Appendix A).

Claims & encounters

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

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

Does Aetna Better Health of Michigan require the NPI on paper claims?
Regulations only require the use of NPIs on electronic transactions. However, the professional and institutional paper claims forms (CMS [previously HCFA] 1500 version 12/90 and UB-92) were revised to allow NPIs to be included. We recommend you send, but do not require, NPIs on the revised forms (CMS 1500 version 08/2005 and UB-04). Additional information on the new CMS 1500 form is available at www.nucc.org. Select “1500 Claim Form,” then “1500 Instructions.” You may also subscribe to the UB-04 manual; visit www.nubc.org.

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

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

How is Aetna Better Health of Michigan processing claims that were previously submitted with Medicare OSCAR numbers?
Note: OSCAR numbers, commonly referred to as UPIN or MPN, are six-digit Medicare provider numbers issued to facilities.

To comply with the regulations, use of a Medicare provider number is not permitted on electronic claims. Because of this, we require an NPI, or an NPI and taxonomy code, on institutional claims where the submission of a Medicare provider number was required by Aetna Better Health of Michigan.

Depending on your current setup, you may or may not be required to submit a taxonomy code to Aetna Better Health of Michigan.

Institutional providers that currently bill Medicare for subparts are required to use taxonomy codes on their claims to Aetna Better Health of Michigan. All other providers are encouraged to use taxonomy codes to help ensure accurate identification, but submission of taxonomy codes is not required.

For situations where a provider is unable to send his or her claims electronically, the billing facility taxonomy code should be formatted on the UB-04 paper claim form in field 81cc, preceded with the qualifier B3.

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

If you want to change your tax ID number for Aetna Better Health of Michigan you can communicate this change as you do any other demographic update by doing one of the following:

- Contacting our Provider Services Department
- Utilizing the Secure Web Portal

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

What error codes will I see if my claim submissions reject for no NPI?
Depending on the format of your vendor’s claim status report, you may see codes as listed below and/or text similar to that below:

Code Text
A3 -- Acknowledgement/Returned as unprocessable claim. The claim/encounter has been rejected and has not been entered into the adjudication system.
562 -- National Provider Identifier (NPI)
85 -- Billing Provider

Remittance advice

Does Aetna Better Health of Michigan include NPIs on Explanation of Benefits (EOB) formats other than the electronic remittance advice (ERA)?
Only electronic remittance advices include NPIs at this time.
If an electronic remittance advice (ERA) can have a different NPI than submitted on the claim, how can I tell which claim the ERA is responding to?
The submitter’s claim number (from CLM01 in an 837 EDI claim) is returned in the CLP01 element in the 835 ERA, and this is not affected by the NPI regulations or related changes. The 835 ERA implementation guide states the following about the CLP01: "This data element is the primary key for posting the remittance information into the provider’s database. We also recommend that it be used for that purpose rather than matching by provider IDs."

Matching remittances to claims using the provider ID is normally not necessary.

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

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

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

What should I do if I get an error message when I try to transmit my NPI in an eligibility, claim status inquiry, referral or precertification transaction?
In these instances, you should confirm that we have received and loaded your NPI into our database. You can confirm that your NPI is in our system by calling our Provider Services Department at 1-855-676-5772.

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

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

Contact
For additional information, please contact the Provider Services Department at 1-855-676-5772.

Note:
Providers who provide services to our enrollees must obtain identifiers. Aetna Better Health of Michigan requires each provider to have a unique identifier, and qualified providers must have a National Provider Identifier (NPI) on or after the compliance date established by the Centers of Medicare and Medicaid (CMS). We understand that some provider types (i.e., assisted living, certified family homes, boarding homes, supervised independent living, and community residential facilities) may not have an NPI numbers. If a provider does not have an NPI number due to their provider type, we will associate the provider to a system default NPI for atypical providers (9999999995). For questions, please contact our Provider Services Department at 1-855-364-0974.
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<td>Claims</td>
<td>A health care provider has multiple Organizational (type 2) NPIs and uses one or more of them in claims.</td>
<td>Aetna Better Health of Michigan uses the tax ID number and provider name and address information to identify the billing provider. If needed, the NPI is also used to identify the billing provider.</td>
<td>Use the most appropriate Organizational NPI for the billing provider on claims.</td>
</tr>
<tr>
<td>Claim Status Inquiry</td>
<td>A health care provider has multiple Organizational (type 2) NPIs. The provider submits an Organizational NPI in a claim and later submits a claim status inquiry transaction using the same Organizational NPI and is unable to locate claims.</td>
<td>Aetna Better Health of Michigan may have selected a provider record associated with a different NPI. If no claim status inquiry requests are associated with that record, no claims will be found.</td>
<td>For professional claims, submit claim status inquiry transactions using the provider’s Individual (type 1) NPI or use the NPI associated with the entire organization.</td>
</tr>
<tr>
<td>Eligibility</td>
<td>A health care provider organization, including individual providers with differing reimbursement levels, is enumerated with a single Organizational (type 2) NPI. That Organizational NPI is used in the eligibility transaction.</td>
<td>Aetna Better Health of Michigan’s response will not contain benefit detail levels specific to particular providers within the organization.</td>
<td>Submit eligibility inquiry transactions using the provider’s Individual (type 1) NPI.</td>
</tr>
<tr>
<td>Precert Add</td>
<td>The requesting provider shares a single NPI across multiple providers or specialties. The requesting facility shares a single Organizational (type 2) NPI across multiple facilities, departments or specialties. The admitting or attending provider or facility shares a single Organizational (type 2) NPI across multiple providers, specialties, departments or facilities.</td>
<td>Aetna Better Health of Michigan must select one provider record for processing and response. The selected record may not be the intended facility, department or specialty, resulting in an unexpected provider name returned in the response.</td>
<td>The requesting provider/facility name returned in the response will not affect the validity of the precert add request. Use an Individual (type1) NPI, if available, for attending and admitting providers.</td>
</tr>
<tr>
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</tr>
<tr>
<td>Precert Inquiry</td>
<td>The inquiring entity shares a single Organizational (type 2) NPI across multiple facilities, departments or specialties.</td>
<td>Aetna Better Health of Michigan must select one provider record from among those linked to the Organizational NPI to compare with the member’s precert history. The selected record may not be the intended facility, department or specialty, resulting in no matches being returned.</td>
<td>Inquire using the Individual (type1) NPI, if available, of one of the attending, admitting or primary care providers. Or, use your Aetna Better Health of Michigan provider ID number (PIN) if your system offers this option. Precertification inquiry transaction is not a HIPAA mandated transaction. It does not require an NPI for provider identification purposes.</td>
</tr>
<tr>
<td>Referral Add</td>
<td>A referring provider shares a single NPI across multiple providers or specialties. The “referred to” organization shares a single Organizational (type 2) NPI across multiple departments or specialties.</td>
<td>Aetna Better Health of Michigan must select one provider record for processing and response. The selected record may not be the intended facility, department or specialty, resulting in an unexpected provider name returned in the response.</td>
<td>Use the Individual (type 1) NPI for the referring provider (PCP/Gyn.) Use the Individual (type 1) NPI of any provider in the appropriate specialty who is affiliated with the organization to which the member is being referred. Or, refer to a specialty/taxonomy code.</td>
</tr>
<tr>
<td>Referral Inquiry</td>
<td>The inquiring entity shares a single Organizational (type 2) NPI across multiple facilities, departments or specialties.</td>
<td>Aetna Better Health of Michigan must select one provider record from among those linked to the Organizational NPI, to compare with the member’s referral history. The selected record may not be the intended facility, department or specialty, resulting in no matches being returned.</td>
<td>Use the Individual (type 1) NPI of any provider in the appropriate specialty who is affiliated with the organization to which the patient was referred. Or, Use your Aetna Better Health of Michigan provider ID number (PIN) if your system offers this option. Referral inquiry is not a HIPAA mandated transaction. It does not require an NPI for provider identification purposes.</td>
</tr>
</tbody>
</table>
Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards, and based on the acuity and severity of the presenting condition, in conjunction with the enrollee’s past and current medical history. Our Provider Relations Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the Michigan Department of Community Health (MDCH) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services.

The tables below show appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), and high volume Participating Specialist Providers (PSPs).

<table>
<thead>
<tr>
<th>Emergency</th>
<th>Urgent</th>
<th>Routine</th>
<th>Preventive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate access, or refer to a hospital emergency room</td>
<td>Must be made same or next day or referred to an urgent care facility</td>
<td>Must be scheduled within 7 – (14) calendar days</td>
<td>Must be scheduled within 3-4 weeks (immunizations, routine physical exam, mammograms, prostate check etc.)</td>
</tr>
</tbody>
</table>

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

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 Relations Department monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.

Telephone Accessibility Standards

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

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

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

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if an enrollee may need care management intervention.
- Our compliance and provider management teams will evaluate enrollee, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all of the following situations:

- Answering the enrollee telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by an enrollee
- Identifying and rescheduling broken and no-show appointments
- Identifying special enrollee needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs)
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental staff to provide covered services within normal working hours. Protocols should be in place to provide coverage in the event of a provider’s absence.

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

In the event that a PCP fails to meet telephone accessibility standards, a Provider Relations Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.
Prior Authorization Form
Phone: 1-855-676-5772
Fax: 1-844-241-2495

Date of Request: _______________________

For urgent requests (required within 24 hours), call Aetna Better Health℠ Premier Plan at 1-855-676-5772 (TTY: 711)

MEMBER INFORMATION
Name: ______________________________________________________ ID Number ______________________
Date of Birth: ________________________ Physician Name: _______________________________________
Other Insurance: ____________________________________________ Gender (circle one): F M

REQUESTING PHYSICIAN OR PROVIDER INFORMATION
Referring Provider / Requesting Provider Place of Service or Facility Name
Name: ______________________________________________________ Name: ______________________________
Address: __________________________________________________ Address: ____________________________
Telephone #: ______________________________________________ Telephone #: __________________________
Fax #: _____________________________________________________ Fax #: ________________________________
Specialty: __________________________________________________ Specialty: __________________________
National Provider Identification (NPI): ______________ National Provider Identification (NPI): ______________
Contact Person: ____________________________________________ Contact Person: ______________________

REFERRAL / AUTHORIZATION INFORMATION
Problem / Diagnosis (ICD-9 Code(s)): _____________________________________________________________
Procedure / Test Requested (CPT Code(s)): _______________________________________________________

Date of Appointment or Service: ______________________ Number of Visits Required: ___________________
Type of Procedure (circle one): Inpatient Outpatient In Office

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

www.aetnabetterhealth.com/michigan
Welcome!
This quick reference guide was prepared to give you an overview of the Home and Community-Based Services Waiver program with Aetna Better Health of Michigan.

Aetna Better Health of Michigan coordinates supports and services for individuals who are dually eligible for both Medicare and Medicaid programs.

Services
The following Waiver services are available, as applicable to the enrollee's needs:
- Adaptive Medical Equipment and Supplies
- Adult Day Program
- Assistive Technology
- Chore Services
- Community Transition Services
- Environmental Modifications
- Expanded Community Living Supports (ECLS)
- Fiscal Intermediary (FI)
- Home Delivered Meals
- Non Medical Transportation
- Personal Emergency Response System
- Preventive Nursing Services
- Private Duty Nursing (PDN) Services
- Respite Care

Eligibility
Individuals who are aged and/or disabled, age 21 or older, eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, receiving full Medicaid benefits, and living in Region 1, 4, 7, or 9. Also included are individuals who are eligible for Medicaid through expanded financial eligibility limits associated with nursing facility placement or under a 1915(c) HCBS waiver.

Excluded population:
- Persons without full Medicaid coverage.
- Persons with Medicaid who reside in a State psychiatric hospital.
- Persons with commercial HMO coverage.
- Persons with Medicare Advantage through an employer.
- Persons dis-enrolled due to Special Disenrollment from Medicaid managed care.
- Persons incarcerated in a city, county, State, or federal correctional facility.
- Persons not living in a Demonstration region.
- Persons with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI).
- Persons enrolled in the Program of All-Inclusive Care for the Elderly (PACE) or the MI Choice waiver program.
- Individuals under age 21 who participate in the Children's Special Health Care Services (CSHCS) program operating under the authority of Title V.

Waiver Service Coordination
Enrollee’s enrolled with Aetna Better Health of Michigan and in the MI Health Link Waiver or the Habitation Waiver will receive assistance with coordinating their waiver services. Enrollees will be contacted by either their Waiver Services Coordinator or Care Manager, and receive an in-person visit to review their care needs within no more than 60 days after they are enrolled in the MI Health Link Waiver.

Waiver service coordination includes, but is not limited to, the following:
- Monitoring the enrollee’s health and welfare
- At least semi annually, assessing the enrollee needs, goals, and objectives
- Scheduling, coordinating and facilitating meetings with the enrollee and their care team
- Authorizing Waiver services in the amount, scope, and duration to meet the enrollee’s needs
- Linking and referring the enrollee to needed service providers
- Working with the enrollee and their care team to develop their Individualized Integrated Care and Service Plan
- Monitoring the delivery of all services identified in the enrollee's Individualized Integrated Care and Service Plan
- Ensuring adjustments are made as appropriate in the event the enrollee encounters significant changes, including but not limited to, hospitalization, loss of caregiver, loss of functional status
- Identifying and reporting incidents, as well as prevention planning to reduce the risk of reoccurrence
- Assisting the enrollee in developing a backup plan in the event their caregiver is unable to provide care

Individualized Integrated Care and Service Plan
The Individualized Integrated Care and Service Plan (IICSP) is a written outline of the medical and waiver services necessary to keep an enrollee safely in the community. It identifies goals, objectives, and outcomes related to their health, as well as the treatments, medical services and long term services and supports they receive.

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

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

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

Transition Plan

<table>
<thead>
<tr>
<th>Services</th>
<th>Habilitation Supports Waiver members and Members Receiving Specialty Services and Supports Program through the PIHP</th>
<th>All Other Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Services</td>
<td>N/A – current providers and level of services will remain unchanged unless changed during the person-centered planning process.</td>
<td>N/A</td>
</tr>
<tr>
<td>*MI Choice HCBS waiver members: Maintain current providers and level of services at the time of enrollment for 90 days unless changed during the person-centered planning process.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

The enrollee is admitted into the hospital on January 1, 2010 and is discharged from the hospital on January 3, 2010. There should be no billable hours for January 2, 2010, as no services were provided on that date since the enrollee was hospital confined for a full 24 hours.

Caregivers would not be able or allowed to claim time with the enrollee on the example above, since no services could be performed on January 2, 2010. This is also true for any in-home service.

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

Billing
Aetna Better Health of Michigan uses Emdeon WebConnect. WebConnect is a web based solution set that simplifies the everyday tasks the provider practices by integrating eligibility and benefits verification, claims and payment management as well as clinical tools all into one easy to use application. There are no provider costs for specialized software or per-transaction fees, even providers who previously only interfaced by submitting claims manually may utilize WebConnect for automated payer interaction.

Emdeon Features
- Secure personalized web portal for submitting providers
- Automated electronic batch claim submission & real-time patient eligibility, benefit verification, referrals, pre- certs, authorizations, claim inquiry and more
- Fast implementation
- Real-time provider enrollment offers immediate electronic capability

Benefits
- Improves auto-adjudication rates
- Increases automation and improves efficiency
- Reduces call center volumes and associated expenses
- Eliminates requirement for capital investments in IT and staffing related to internal portal development and maintenance
- Drives providers directly to payers’ websites
- Improves provider satisfaction

Please visit Emdeon to gain access: https://office.emdeon.com/secure/scripts/inq.dll?MfcISAPICommand=Login

Please use the following Payer ID when submitting claims to Aetna Better Health of Michigan:
- Payer ID# 128MI

The UB-04 CMS- 1450 Form can be located through the following website: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-LN/MLNProducts/downloads/ub04_fact_sheet.pdf

The CMS 1500 Form can be located through the following website: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500805.pdf
Adaptive Medical Equipment & Supplies

Adaptive Medical Equipment and Supplies are devices, controls, or appliances specified in the IICSP that enable enrollees to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid state plan and Medicare that are necessary to address enrollee functional limitations. All items shall meet applicable standards of manufacture, design, and installation. This will also cover the costs of maintenance and upkeep of equipment. The coverage includes training the enrollee or caregivers in the operation and/or maintenance of the equipment or the use of a supply when initially purchased.

Some examples (not an exhaustive list) of these items would be shower chairs/benches, lift chairs, raised toilet seats, reachers, jar openers, transfer seats, bath lifts/room lifts, swivel discs, bath aids such as long handle scrubbers, telephone aids, automated telephones or watches that assist with medication reminders, button hooks or zip pullers, modified eating utensils, modified oral hygiene aids, modified grooming tools, heating pads, sharps containers, exercise items and other therapy items, voice output medical supplies not available under the Medicaid state plan and durable medical equipment and supplies necessary to the proper functioning of such aids.

Other Standards:
- Each direct service provider must enroll in Medicare and Medicaid as a Durable Medical Equipment/POS provider or pharmacy, as appropriate.
- Items purchased from retail stores must meet the Adaptive Medical Equipment and Supplies service definition.

Adult Day Program

Adult Day Program services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the enrollee. Meals provided as part of these services shall not constitute a “full nutritional regimen,” i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service.

Adult Day Program should only be authorized if the enrollee meets at least one of the following criteria:
- Requires regular supervision to live in his or her own home or the home of a relative
- If he or she has a caregiver, the enrollee must require a substitute caregiver while his or her regular caregiver is unavailable
- Has difficulty or is unable to perform activities of daily living without assistance
- Capable of leaving his or her residence with assistance to receive services
- In need of intervention in the form of enrichment and opportunities for social activities to prevent and/or postpone deterioration that may lead to institutionalization

Other Standards:
- Each provider shall employ a full-time program director with a minimum of a bachelor’s degree in a health or human services field or be a qualified health professional. The provider shall continually provide support staff at a ratio of no less than one staff person for every ten enrollees. The provider may only provide health support services under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, the provider shall maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individual or organization.
- Providers shall require staff to participate in orientation training as specified in the operating standards document. Additionally, program staff shall have basic first-aid training. The provider shall require staff to attend in-service training at least twice each year. The provider shall design this training specifically to increase their knowledge and understanding of the program and enrollees, and to improve their skills at tasks performed in the provision of service. The provider shall maintain records that identify the dates of training, topics covered, and persons attending.
- If the provider operates its own vehicles for transporting enrollees to and from the program site, the provider shall meet the following transportation minimum standards:
  - All drivers must be properly licensed, and all vehicles registered, by the Michigan Secretary of State. All vehicles shall be appropriately insured.
  - All paid drivers shall be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider shall make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
  - All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
  - Each agency and transportation entity must be in compliance with Public Act 1 of 1985 regarding seat belt usage.
  - Each provider shall have first-aid supplies available at the program site. The provider shall make a staff person knowledgeable in first-aid procedures, including CPR, present at all times when enrollees are at the program site.
Adult Day Program Cont.

- Each provider shall post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers shall conduct practice drills of emergency procedures once every six months. The program shall maintain a record of all practice drills.
- Each day program center shall have the following furnishings:
  - At least one straight back or sturdy folding chair for each enrollee and staff person.
  - Lounge chairs or day beds as needed for naps and rest periods.
  - Storage space for enrollees' personal belongings.
  - Tables for both ambulatory and non-ambulatory enrollees.
  - A telephone accessible to all enrollees.
  - Special equipment as needed to assist persons with disabilities.

The provider shall maintain all equipment and furnishings used during program activities or by program enrollees in safe and functional condition.

- Each day program center shall document that it is in compliance with:
  - Barrier-free design specification of the State of Michigan and local building codes.
  - Fire safety standards.
  - Applicable State of Michigan and local public health codes.

Assistive Technology

Assistive Technology includes technology items used to increase, maintain, or improve an enrollee’s functioning and promote independence. The service may include assisting the enrollee in the selection, design, purchase, lease, acquisition, application, or use of the technology item. This service also includes vehicle modifications to the vehicle that is the enrollee’s primary method of transportation. This service includes repairs and maintenance of assistive technology devices. Vehicle modifications must be of direct medical or remedial benefit to the enrollee and specified under the IICSP.

Some examples include, but are not limited to, van lifts, hand controls, computerized voice system, communication boards, voice activated door locks, power door mechanisms, adaptive or specialized communication devices, assistive dialing device, adaptive door opener, specialized alarm or intercom.

Other Standards:
- Only properly licensed suppliers may provide pest control services. Contracted/subcontracted providers must have any appropriate state licensure or certification required to complete or provide the service or item.
- Ability to communicate effectively both verbally and in writing as well as to follow instructions.
- Previous relevant experience and training to meet MDCH operating standards.
- Must be deemed capable of performing the required tasks.

Chore Services

Chore Services are services needed to maintain the home in a clean, sanitary, and safe environment to provide safe access inside the home and yard maintenance and snow plowing to provide access to and egress outside of the home. This service includes tasks such as heavy household chores (washing floors, windows, and walls), tacking loose rugs and tiles, moving heavy items of furniture, mowing, raking, and cleaning hazardous debris such as fallen branches and trees. May include materials and disposable supplies used to complete chore tasks.

Pest control suppliers must be properly licensed.

Chore services are allowed only in cases when neither the enrollee nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Other Requirements:
- Only properly licensed suppliers may provide pest control services. Contracted/subcontracted providers must have any appropriate state licensure or certification required to complete or provide the service or item.
- Ability to communicate effectively both verbally and in writing as well as to follow instructions.
- Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be able to prevent transmission of communicable disease (as applicable for job duties), and be in good standing with the law as validated by a criminal history.
- Previous relevant experience and training to meet MDCH operating standards.
- Must be deemed capable of performing the required tasks.
**Community Transition Services**

**Community Transition Services** includes non-reoccurring expenses for enrollees transitioning from a nursing facility to another residence where the enrollee is responsible for his or her own living arrangement. Allowable transition costs include the following:

- Housing or security deposits: A one-time expense to secure housing or obtain a lease.
- Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television and internet are excluded).
- Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are excluded).
- Cleaning: A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and over-all cleaning.
- Coordination and support services: To facilitate transitioning of enrollee to a community setting.
- Other: Services deemed necessary and documented within the enrollee’s plan of service to accomplish the transition into a community setting. Costs for Community Transition Services are billable upon enrollment into the MI Health Link HCBS waiver.

**Environmental Modifications**

**Environmental Modifications** are physical adaptations to the home, required by the enrollee’s service plan, that are necessary to ensure the health and welfare of the enrollee or that enable the enrollee to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the enrollee. Complex kitchen and bathroom modifications may be competed if medically necessary for the enrollee. Environmental modifications are those which are installed in the residence versus enhanced equipment or assistive technology which are portable from residence to residence.

**Expanded Community Living Supports**

To receive **Expanded Community Living Supports (ECLS)**, enrollees MUST have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to independently complete activities of daily living (ADLs) such as eating, bathing, dressing, toileting, other personal hygiene, etc. ECLS does not include hands-on assistance for ADLs unless something happens to occur incidental to this service. Enrollees may also receive hands-on assistance for instrumental activities of daily living (IADLs) such as laundry, meal preparation, transportation, help with finances, help with medication, shopping, attending medical appointments, and other household tasks, as needed. ECLS also includes prompting, cueing, guiding, teaching, observing, reminding, and/or other support for the enrollee to complete the IADLs independently if he or she chooses. ECLS also includes social/community participation, relationship maintenance, and attendance at medical appointments.

ECLS may be furnished outside the enrollee’s home. The enrollee oversees and supervises individual providers on an on-going basis when participating in arrangements that support self-determination. This may also include transportation to allow people to get out into the community when it is incidental to IICSP.

Members of an enrollee’s family may provide ECLS to the enrollee. However, Aetna Better Health will not directly authorize funds to pay for services furnished to an enrollee by that person’s spouse or legal guardian. Family members who provide this service must meet the same standards as providers who are unrelated to the enrollee.

Providers must be trained to perform each required task prior to service delivery. The supervisor must assure the provider can competently and confidently perform each assigned task.

ECLS provided in licensed settings includes only those services and supports that are in addition to and shall not replace usual customary care furnished to residents in the licensed setting.

ECLS does not include room and board costs.

When transportation is included as part of ECLS, Aetna Better Health of Michigan will not also authorize transportation as a separate waiver service.

ECLS does not include nursing and skilled therapy services.

ECLS may be provided in addition to Medicaid State Plan Personal Care Services if the enrollee requires hands-on assistance with some ADLs and/or IADLs, as covered under Personal Care Services, but requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete other ADLs or IADLs independently, but to ensure safety, health, and welfare of the enrollee.
**Expanded Community Living Supports**

**Cont.**

Other Standards:

- Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be able to prevent transmission of communicable disease and be in good standing with the law as validated by a criminal history review. If providing transportation incidental to this service, the provider must possess a valid Michigan driver’s license.

- Individuals providing Expanded Community Living Supports must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, recording information, and reporting and identifying abuse and neglect. The individual(s) must also be trained in the enrollee’s IICSP. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures are highly desirable.

- Previous relevant experience and training to meet MDCH operating standards.

- Must be deemed capable of performing the required tasks.

- Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid, be trained in universal precautions and blood-born pathogens, and be in good standing with the law as validated by a criminal history review.

- A registered nurse licensed to practice nursing in the State shall furnish supervision of Expanded Community Living Support providers. At the State’s discretion, other qualified individuals may supervise Expanded Community Living Supports providers. The direct care worker’s supervisor shall be available to the worker at all times the worker is furnishing Expanded Community Living Support services.

- Expanded Community Living Support providers may perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each enrollee who requires such care. The supervising RN must assure each workers confidence and competence in the performance of each task required.

- Individuals providing Expanded Community Living Support services must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, recording information. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

**Fiscal Intermediary (FI)** services assist the enrollee, or a representative identified in the enrollee’s Integrated Care and Supports Plan (IICSP) to live independently in the community while controlling his/her individual budget and choosing the staff to work with him/her. The FI helps the enrollee to manage and distribute funds contained in the individual budget. The enrollee uses funds to purchase home and community based services authorized in the IICSP.

FI services include, but are not limited to, the facilitation of the employment of service workers by the enrollee, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring enrollee-directed budget expenditures and identify potential over and under expenditures; ensuring compliance with documentation requirements related to management of public funds. The FI helps the enrollee manage and distribute funds contained in the individual budget. The FI also assists with training the enrollee and providers, as necessary, in tasks related to the duties of the FI including, but not limited to, billing processes and documentation requirements.

**Other Standards:**

Provider must be bonded and insured for an amount that meets or exceeds the total budgetary amount the fiscal intermediary is responsible for administering. The provider must have demonstrated ability to manage budgets and perform all functions of the Fiscal Intermediary including all activities related to employment taxation, worker’s compensation and state, local and federal regulations. Fiscal Intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Providers of other covered services to the enrollee, the family or guardians of the enrollee may not provide Fiscal Intermediary services to the enrollee. Fiscal Intermediary service providers must pass a readiness review and meet all criteria sanctioned by the state. Fiscal intermediaries will comply with all requirements.

**Home Delivered Meals**

**Home Delivered Meals** is the provision of one to two nutritionally sound meals per day to enrollees who are unable to care for their nutritional needs.

This service must include and prioritize healthy meal choices that meet any established criteria under state or federal law.

Meal options must meet enrollee preferences in relation to specific food items, portion size, dietary needs, and cultural and/or religious preferences.

Each provider shall document meals served.
**Home Delivered Meals Cont.**

**Other Standards:**

- Each Home Delivered Meals provider shall have the capacity to provide two meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider shall have meals available at least five days per week.
- Each provider shall develop and have available written plans for continuing services in emergency situations such as short term natural disasters (e.g., snow or ice storms), loss of power, physical plant malfunctions, etc. The provider shall train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan.
- Each provider shall carry product liability insurance sufficient to cover its operation.
- The provider shall deliver food at safe temperatures as defined in Home Delivered Meals service standards.

**Non Medical Transportation**

*Non Medical Transportation* are service that are offered to enable enrollees to gain access to waiver and other community services, activities, and resources, specified by the Individual Integrated Care and Supports Plan (IICSP).

Direct service providers shall be a centrally organized transportation company or agency. The following methods can be used for transportation: 1) demand/response (door-to-door, curb-to-curb service on demand), 2) public transit, 3) volunteer, 4) ambulance (on demand wheelchair accessible van). Transportation vehicles must be properly licensed and inspected by the State and must be covered with liability insurance.

As applicable, other funding sources shall be utilized prior to using waiver funds, including Department of Human Services authorizations for medical transportation.

Waiver funds may not be used to purchase or lease vehicles for providing transportation services to waiver enrollees.

Waiver funds shall not be used to reimburse caregivers (paid or informal) to run errands for enrollees when the enrollee does not accompany the driver of the vehicle.

**Other Standards:**

- All drivers must be licensed and all vehicles registered by the Michigan Secretary of State for transportation supported by MI Health Link waiver funds. The provider must cover all vehicles used with automobile insurance.
- All paid drivers for transportation providers supported entirely or in part by waiver funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall ensure such assistance unless expressly prohibited by either a labor contract or insurance policy.
- The provider shall train all paid drivers for transportation programs supported entirely or in part by waiver funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
- Each provider shall comply with Public Act 1 of 1985 regarding seat belt usage.
- All drivers must be licensed and all vehicles registered by the Michigan Secretary of State for transportation supported by MI Health Link waiver funds. The participant or vehicle owner must cover all vehicles used with automobile insurance.
- Each provider shall operate in compliance with Public Act 1 of 1985 regarding seat belt usage.

**Personal Emergency Response System**

*Personal Emergency Response System* is an electronic device that enables enrollees to secure help in an emergency. The enrollee may also wear a portable “help” button to allow for mobility. The system is connected to the enrollee’s phone and programmed to signal a response center once a “help” button is activated.

The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment. The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The enrollee must reside in an area where the cellular or mobile coverage is reliable. When the enrollee uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards.

The provider will assure at least monthly testing of each PERS unit to assure continued functioning.

**Other Standards:**

- The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.
- The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.
- The response center must maintain the monitoring capacity to respond to all incoming emergency signals.
- The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.
Preventive Nursing Services

Preventive Nursing Services are covered on a part-time, intermittent (separated intervals of time) basis for an enrollee who generally requires nursing services for the management of a chronic illness or physical disorder in the enrollee’s home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN. Nursing services are for enrollees who require more periodic or intermittent nursing than otherwise available for the purpose of preventative interventions to reduce the occurrence of adverse outcomes for the enrollee such as hospitalizations and nursing facility admissions. An enrollee using this service must demonstrate a need for observation and evaluation. In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more nursing services. Observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, and physical status. Additional nursing services include medication set-up, administration and monitoring, dressing changes, range of motion assistance and/or monitoring, refresher training to the beneficiary and/or caregivers to assure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician’s orders, proper use of medical equipment, performing activities of daily living, or safe ambulation within the home.

Other Standards:
- All nurses providing Preventive Nursing Services to enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.
- Services paid for with waiver funds shall not duplicate nor replace other services available through the Michigan Medicaid state plan or Medicare.
- This service may include medication administration as defined under the referenced statutes.
- It is the responsibility of the LPN to secure the services of an RN to supervise his or her work.
- All nurses providing nursing services to enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.
- Each direct service provider must have written policies and procedures compatible with the operating standards document(s).
- Services paid for with waiver funds shall not duplicate nor replace other services available through the Michigan Medicaid state plan or Medicare.
- This service may include medication administration as defined under the referenced statutes.

Private Duty Nursing

Private Duty Nursing (PDN) Services are skilled nursing interventions provided to an enrollee age 21 and older on an individual and continuous basis, up to a maximum of 16 hours per day, to meet the enrollee’s health needs directly related to the enrollee’s physical disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State’s Nurse Practice Act, consistent with physician’s orders and in accordance with the enrollee’s IICSP.

Medical Criteria I – The enrollee is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
- Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate dependent respiration (e.g., some models of Bi-PAP); or
- Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder.

Definitions:
- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
- "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.
**Private Duty Nursing**

- "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in 3 or more activities of daily living.
- "Substantiated" means documented in the clinical or medical record, including the nursing notes. Medical Criteria III – The enrollee requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

**Definitions:**
- "Continuous" means at least once every 3 hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
  - Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
  - Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;
  - Deep oral (past the tonsils) or tracheostomy suctioning;
  - Injections when there is a regular or predicted schedule, or injections that are required as the situation demands (prn), but at least once per month (insulin administration is not considered a skilled nursing intervention);
  - Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;
  - Total parenteral nutrition delivered via a central line and care of the central line;
  - Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;
- Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

**Other Standards:**
- All nurses providing private duty nursing to enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.
- Services paid for with waiver funds shall not duplicate nor replace services available through the Michigan Medicaid state plan or Medicare.
- This service may include medication administration as defined under the referenced statutes.
- All nurses providing Private Duty Nursing to enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.
- 2 Services paid for with waiver funds shall not duplicate nor replace services available through the Michigan Medicaid state plan or Medicare.
- This service may include medication administration as defined under the referenced statutes.
- It is the responsibility of the LPN to secure the services of an RN to supervise his or her work.

**Respite Care**

*Respite Care* services are provided on a short-term, intermittent basis to relieve the enrollee’s family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.

Respite services may be provided in the enrollee’s home, in the home of another, or in licensed Adult Foster Care or Home for the Aged facility.

- Respite does not include the cost of room and board in instances when the service is provided in the enrollee’s home or in the home of another person. The enrollee may not choose to have respite provided in the home of another person unless he or she is participating in an arrangement that supports self-determination
- Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home or licensed Home for the Aged.
Respite Care Cont.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- Respite services cannot be scheduled on a daily basis
- Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers
- Respite services shall not be provided by the enrollee’s usual caregiver who provides other waiver services to the enrollee

Other Standards:
When providing care in the home of the enrollee:
- When Chore Services or Expanded Community Living Supports services are provided as a form of respite care, these services must also meet the requirements of the respective service category. The enrollee’s records should include a clear distinction of when Respite is provided instead of Chore Services and Expanded Community Living Supports.
- Each direct service provider shall establish written procedures that govern the assistance given by staff to enrollees with self-medication. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:
  - The provider staff authorized to assist enrollees with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the enrollee takes and its impact upon the enrollee.
  - Verification of prescription medications and their dosages.
  - Instructions for entering medication information in participant files.
  - A clear statement of the enrollees and responsibilities of the enrollee’s family member(s) regarding medications taken by the enrollee and the provision for informing the enrollee and the enrollee’s family of the provider’s procedures and responsibilities regarding assisted self administration of medications.

- Each direct service provider shall employ a professionally qualified supervisor that is available to staff while staff provide respite.

When providing respite in a licensed setting:
- Each out of home respite service provider must be either a licensed group home as defined in MCL 400.701 ff, which includes adult foster care homes and homes for the aged.
- Each direct service provider shall employ a professionally qualified program director that directly supervises program staff.

- Each direct service provider shall demonstrate a working relationship with a hospital or other health care facility for the provision of emergency health care services, as needed.

- When Chore Services or Community Living Supports services are provided as a form of respite care, these services must also meet the requirements of the respective service category. The enrollee’s records should include a clear distinction of when Respite is provided instead of Chore Services and Expanded Community Living Supports.
- Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.
- Providers must be at least 18 years of age, have the ability to communicate effectively both verbally and in writing, and be able to follow instructions.
Prior Authorization

Long Term Supports and Services (LTSS) help a person remain independent in their home. The following services require authorization and face to face member assessment for qualification. None of the services below require physician orders. Please call our toll free number at 1-855-676-5772 if you have questions.

- Adaptive Medical Equipment & Supplies
- Adult Day Program
- Assistive Technology
- Chore Services
- Community Transition Services
- Environmental Modifications
- Expanded Community Living Supports (ECLS)
- Fiscal Intermediary (FI)
- Home Delivered Meals Supports
- Non Medical Transportation
- Personal Emergency Response System
- Preventive Nursing Services
- Private Duty Nursing (PDN) Services
- Respite Care
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<td><strong>S5101</strong>, day care services, adult, per half day</td>
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<td><strong>T1028</strong> Assessment of home, physical and family environment, to determine suitability to meet enrollee’s medical needs, per encounter</td>
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<td><strong>S0209</strong>, Wheelchair van, mileage, per mile</td>
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