OhioRISE Program 2024 Provider Manual

OhioRISE, specialized behavioral healthcare from Aetna Better Health® of Ohio

AetnaBetterHealth.com/OhioRISE

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OhioRISE | aetna®

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Section I - Introduction

Welcome

Welcome to Aetna Better Health® of Ohio Inc., an Ohio corporation, d/b/a Aetna Better Health of Ohio, the OhioRISE plan. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Ohioans who need us most.

About Aetna Better Health

Aetna Better Health is Aetna's Medicaid managed care plan. Backed by over 30 years of experience managing the care of those with a broad array of healthcare needs, our Medicaid plans have demonstrated that getting the right help when members need it is essential to better health. That's why Aetna Medicaid plans include the guidance and support needed to connect our members with the right coverage, resources, and care.

Experience and Innovation

We are dedicated to enhancing member and provider satisfaction, using tools such as predictive modeling, care coordination and state-of-the art technology to achieve cost savings and help members attain the best possible health, through a variety of service models.

We work closely and cooperatively with physicians and hospitals to achieve durable improvements in service delivery. We are committed to building on the dramatic improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

Today, Aetna owns and administers Medicaid managed health care plans for more than three million members. In addition, Aetna provides care coordination services to hundreds of thousands of high-costs, high-need Medicaid members. Aetna utilizes a variety of delivery systems, including fully capitated health plans, complex care management, and administrative service organizations.

OhioRISE

Ohio Resilience through Integrated Systems and Excellence (OhioRISE) program is a specialized managed care program for youth with complex behavioral health and multisystem needs. OhioRISE aims to expand access to in-home and community-based services for enrollees.

Aetna Better Health of Ohio care coordinators and care coordinators with our regional contracted care management entities (CME) would ensure OhioRISE members and families have the resources they need to navigate their interactions with multiple systems such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others. An individual who is enrolled in the OhioRISE program would keep their managed care

organization (MCO) or fee-for-service (FFS) enrollment for their physical health benefit. A member's MCO also will be included in their care coordination .

The Ohio Department of Medicaid (ODM), state agencies, the Child and Adolescent Behavioral Health Center of Excellence (CABHCOE), providers, families, Aetna, and other stakeholders from local and state child-serving systems are engaging through an advisory council and workgroups to develop and implement major components of OhioRISE and the new and improved services. OhioRISE will also feature a new 1915© Waiver. The waiver aims to reduce risks and prevent negative health and life outcomes for children and youth with serious emotional disturbances and functional impairments.

OhioRISE eligibility

Children and youth who may be eligible for OhioRISE are:

- Enrolled in Ohio Medicaid – either managed care or fee for service,
- Under the age of 21,
- Not enrolled in a MyCare plan, and
- Meet a functional needs threshold for behavioral healthcare, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment tool, or an inpatient admission for a behavioral health service.

OhioRISE services

All OhioRISE covered services are outlined in the Ohio Administrative Code rule 5160-59-03, including existing behavioral health services and the following new and improved services available through OhioRISE:

- **Care coordination at three different levels:**
    - Tier 1: Limited Care Coordination (LCC) is delivered by Aetna and is for children or youth needing lower intensity care coordination.
    - Tier 2: Moderate Care Coordination (MCC) is delivered by contracted regional care management entities (CMEs) and includes strategies informed by wraparound principles.
    - Tier 3: Intensive Care Coordination (ICC) is delivered by contracted regional CMEs and is consistent with principles of High-Fidelity Wraparound. Tier 3 is for children and youth with the greatest behavioral health needs.
- **Intensive Home-Based Treatment (IHBT)** – Provides intensive, time-limited behavioral health services for children, youth, and families that help stabilize and improve the child or youth's behavioral health functioning.
- **In-state Psychiatric Residential Treatment Facilities (PRTFs**) – This service will be available in-state beginning in November 2023. Today it's covered when children or youth need this level of care from facilities located outside Ohio. Ohio's PRTF service will keep children and youth with the most intensive behavioral health needs in-state and closer to their families and support systems.

- **Behavioral Health Respite** – Provides short-term, temporary relief to the primary caregiver(s) of an OhioRISE plan enrolled youth, to support and preserve the primary caregiving relationship.
- **Primary Flex Funds** – Provides funding to purchase services, equipment, or supplies not otherwise provided through Medicaid that addresses a need in a child or youth's service plan. Funds must be used to purchase services/items that will reduce the need for other Medicaid services, keep kids and families safe in their homes, or help the child or youth be better integrated into the community. See page 45 for more information on primary flex funds.
- **Mobile Response and Stabilization Services (MRSS)** – MRSS provides rapid in-person care when a child or youth is experiencing significant behavioral or emotional distress. It's available 24 hours a day, 365 days a year, and is delivered in the home, school, or at another location in the community. This service is available to any child or youth covered by Ohio Medicaid.

OhioRISE 1915(c) Waiver Services

- **Out-of-Home Respite:** A service provided outside of the youth's home that will provide short-term temporary relief to the primary caregiver or caregivers of an OhioRISE plan enrolled youth.
- **Transitional Services and Supports**: Services to support youth and their families who are experiencing changes in circumstances/locations or other qualifying conditions.
- **Secondary Flex Funds:** Services, equipment, or supplies, not otherwise provided through the waiver or through the Medicaid state plan, that are designed to meet a need of the youth in order to address behaviors. Additional information on the OhioRISE 1915(c) waiver services is available in chapters: 5160-59-05 OhioRISE HCBS waiver: covered services and providers; 5160-59-05.1 OhioRISE HCBS waiver: out-of-home respite; 5160-59-05.2 OhioRISE HCBS waiver: transitional services and supports; and 5160-59-05.3 OhioRISE HCBS waiver: secondary flex funds

About this Provider Manual

The Provider Manual serves as a resource and outlines operations for Aetna Better Health of Ohio. Through the Provider Manual, providers should be able to locate information on the majority of issues that may affect working with us. If you have a question, problem, or concern that the Provider Manual does not fully address, please call our Provider Experience Department at **1-833-711-0773 (option 2)** for concerns.

Our Provider Experience Department will update the Provider Manual at least annually and will distribute bulletins as needed to incorporate any revisions/changes. Please check our website at www.aetnabetterhealth.com/OhioRISE for the most recent version of the Provider Manual and/or updates. The OhioRISE Provider Manual is available at no charge in hard copy form, or on CD-ROM. Please contact Provider Services at **1-833-711-0773 (option 2)** to request a copy.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the OhioRISE plan, and with your Aetna Better Health of Ohio Provider Agreement, including all requirements described in this manual, in addition to all state and federal regulations governing a provider.

While this manual contains basic information about Aetna Better Health of Ohio, ODM providers are required to fully understand and apply any additional Ohio Department of Medicaid (ODM) or federal requirements when administering covered services. Please refer to ODM's Medicaid Managed Care website for further information: **https://managedcare.medicaid.ohio.gov/home.**

Section II - Basic Plan Information

Contact Information

Providers who have additional questions can refer to the following Aetna Better Health of Ohio phone numbers:

Important Contacts	Phone Number	Hours and Days of Operation (Excluding Aetna Better Health of Ohio holidays)
Aetna Better Health of Ohio	**1-833-711-0773** (Follow the prompts to reach the appropriate departments)	7 a.m. - 8 p.m. EST Monday-Friday
Aetna Better Health of Ohio Compliance Hotline for Fraud, Waste or Abuse	**1-833-865-0278**	24 hours a day, 7 days a week through voicemail inbox
Aetna Better Health of Ohio Special Investigations Unit (SIU) for Fraud, Waste or Abuse)	**1-800-338-6361**	24 hours a day, 7 days a week

Aetna Better Health of Ohio Department	Phone Number
Member Services	**1-833-711-0773**
Provider Services and Provider Claim Disputes	**1-833-711-0773**
Care Coordination (includes behavioral health services)	**1-833-711-0773**
Medical Prior Authorization	**1-833-711-0773**
Pharmacy Prior Authorization	OhioRISE covers provider administered medications given in the office to treat mental health and substance use disorders. For all OhioRISE members, all other pharmacy services and benefits are provided through Gainwell Technologies. Their member support line is **1-833-491-0344 (TTY: 1-833-655-2437)**. Refer to the MCO member handbook for assistance. On and after July 1, 2023, pharmacy claims and prior authorizations for members enrolled in Medicaid FFS will be submitted to the SPBM.

Community Resource	Contact Information
Ohio Statewide Crisis Line and Mobile Response and Stabilization Services (MRSS)	**1-800-720-9616**

Contractors	Phone Number	Fax	Hours and Days of Operation
Interpreter Services (Language interpretation services, including sign language, special services for the hearing impaired, oral translation, and oral interpretation.)	Please contact our Member Services Department at **1-833-711-0773** for more information on how to schedule these services in advance of an appointment.	N/A	7 a.m. - 8 p.m. EST Monday-Friday

Agency Contacts and Important Contacts	Phone Number	Fax	Hours and Days of Operation
The Ohio Department of Medicaid (ODM) Main Website: **medicaid.ohio.gov/** Provider Website: **medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/managed-care** 50 West Town Street, Suite 400 Columbus, Ohio 43215 **Note:** ODM Provider Call Center - If you have questions or need assistance with your Ohio Medicaid enrollment, call the ODM Provider Hotline at **1-800-686-1516** through the Interactive Voice Response (IVR) system. It provides 24 hour, 7 days a week access to information regarding provider information. Provider representatives are available via the IVR system Monday through Friday from 8 a.m. through 4:30 p.m. to assist providers.	Provider Hotline: **1-800-686-1516**	N/A	8 a.m. - 4:30 p.m. EST Monday- Friday
Change Healthcare Customer Service Email Support: **hdsupport@webmd.com** Submit Electronic Claims: **https://office.emdeon.com**	**1-800-845-6592**	N/A	24 hours a day, 7 days a week

Reporting Suspected Fraud, Waste, and Abuse to State and Federal Agencies			
Ohio Attorney General Complaints Hotline	**1-800-282-0515**	N/A	8 a.m. - 7 p.m. EST Monday-Friday (Excluding holidays and weekends. Voicemail service will be available whenever the hotline is closed.)
Ohio Auditor of State	**1-866-372-8364**	N/A	24 hours a day, 7 days a week
The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	**1-800-HHS-TIPS (1-800-447-8477)**	N/A	24 hours a day, 7 days a week

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

ODM's Contracted Medicaid Vendors			
Agency Contacts & Important Contacts	**Phone Number**	**Website**	**Email**
United Healthcare Community Plan of Ohio	**1-800-600-9007**	**uhcprovider.com/en/health-plans-by-state/ohio-health-plans/oh-comm-plan-home.html**	TBD
Humana Health Plan of Ohio	**1-877-856-5707**	**Humana.com/HealthyOH**	OHMedicaidProviderRelations@humana.com
Molina Health Plan of Ohio	**1-855-322-4079**	**molinahealthcare.com/providers/oh/medicaid/home.aspx**	OHContractRequests@MolinaHealthCare.com
AmeriHealth of Ohio	**1-833-296-2259**	**amerihealthcaritas.com/become-a-provider/join-now-ohio.aspx**	ProviderRecruitmentOH@amerihealthcaritas.com
Anthem Blue Cross and Blue Shield	**1-833-623-1513**	**anthem.com/provider/getting-started/**	OHMedicaidProviderQuestions@Anthem.com
CareSource Ohio	**1-800-488-0134**	**caresource.com/oh/providers/education/become-caresource-provider/**	Ohio_Provider_Contracting@caresource.com
Buckeye Community Health Plan	**1-866-246-4356 Ext 24291**	**buckeyehealthplan.com/providers/become-a-provider.html**	OHNegotiators@CENTENE.COM

Provider Representative information

Provider Experience Department Overview

Our Provider Experience Department serves as a liaison between Aetna Better Health of Ohio and the provider community. Our staff is comprised of Network Relation Managers and Network Relation Consultants, as well as Provider Experience Representatives. Our Network Relations team conducts onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Provider Experience Representatives are available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas where we provide assistance:

- Contracting status.
- Provide information on how to update location/address via the PNM.
- Information about recent health plan policy and/or regulatory updates.
- Assistance on how to locate forms.
- Assistance with reviewing claims or remittance advices including questions surrounding claims and billing.
- Information on provider denials.
- Instructions for providers needing to file a complaint and/or challenging or appealing the failure of the health plan to provide covered services (including state services).
- Information on member grievance and appeals.
- Information on translation/interpreter services.
- Information about member covered services.
- Instruction on how to submit a prior authorization and/or cover determination (including exceptions).
- Information on how to look up services that need a prior authorization.
- Information about provider orientations.
- Information about coordination of services.
- Information about provider responsibilities.
- Assistance with checking member eligibility.
- Assistance with reviewing member information on the Member Care Portal.
- Instructions on how to locate a participating provider or specialist in our network.
- Instructions on how to locate the Ohio Department of Medicaid's (ODM) managed care organization (MCO) provider web search pages.
- Instructions on how to search the ODM Unified Preferred Drug List.
- Instructions on how to contact Availity.

Section III - Provider Resources

Provider Portal

Aetna Better Health of Ohio Disputes (Participating Providers)	**apps.availity.com/availity/Demos/Registration/index.htm** Disputes are filed online through Availity.

CPSE Report

Claims Payment Systemic Errors

Claims Payment Systemic Errors (CPSE) are claims that were submitted to Aetna, but adjudication occurred incorrectly. These claims were either: under paid, overpaid, or denied due to systemic error. In order to fall into the category of a CPSE, impact must have occurred for five or more providers.

If a CPSE error occurs, notification to Ohio Department of Medicaid (ODM) will be sent. The notification will include:

- Definition of the error.
- Date error occurred.
- Provider types which are impacted.
- Number of impacted claims.
- Timeline to fix systemic issue.
- Tentative date correction will be made.

Aetna will provide ODM monthly updates on the status of error and completion of resolution. The information for CPSE will be posted on our website and updated monthly for the provider community to review the status for each CPSE. Providers can find this information at **AetnaBetterHealth.com/OhioRISE**

Provider Advisory Council

Aetna Provider Advisory Council (PAC)

The purpose of the Provider Advisory Council (PAC) is for the OhioRISE plan to gather input, discuss and learn about issues affecting providers, identify challenges and barriers, problem-solve, share information, and collectively find ways to improve and strengthen the healthcare service delivery system. The PAC would review the Annual Provider Satisfaction Survey questions and provide input for changes/edits/updates prior to those surveys being executed. The council would focus an ongoing review of the program's operation, identification of potential program enhancements and opportunities for improvement.

Provider policies

Aetna Better Health of Ohio Policies and Procedures

Our comprehensive and robust policies and procedures are in place throughout our entire health plan to make certain all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and required updates are made as needed. In the event of a policy change, Aetna Better Health will notify providers 30 days before implementation. Our policies are captured throughout this Provider Manual in addition to being available online at: **AetnaBetterHealth.com/OhioRISE**.

Provider Services (Call Center) Information

Provider Toll-Free Help Line

The Provider Toll-free Help Line, **1-833-711-0773** (option 2), will be staffed by Provider Experience Representatives between the hours of 7 a.m. and 8 p.m., EST, Monday through Friday, excluding the following Aetna Better Health of Ohio holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

An automated system and secure voicemail will be available to providers between the hours of 8:01 p.m. and 6:59 a.m., EST, Monday through Friday, and 24 hours on weekends and holidays. Voicemails will be returned in a timely manner by our Provider Services staff.

Provider Services closure days

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

Provider Complaints

Reporting Suspected Fraud, Waste, and Abuse to State and Federal Agencies			
Ohio Attorney General Complaints Hotline	**1-800-282-0515**	N/A	8 a.m. - 7 p.m. EST Monday-Friday (Excluding holidays and weekends. Voicemail service will be available whenever the hotline is closed.)
Ohio Auditor of State	**1-866-372-8364**	N/A	24 hours a day, 7 days a week
The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	**1-800-HHS-TIPS (1-800-447-8477)**	N/A	24 hours a day, 7 days a week

Provider Orientation and Trainings

Our Provider Experience Department provides initial orientation for newly contracted providers. Providers are required to attend an orientation session within 75 calendar days after joining our network.In follow-up to initial orientation, our Provider Experience Department provides a variety of forums for ongoing provider training and education, such as routine office/site visits, webinars, group or individualized training sessions on select topics, (e.g., appointment availability standards, claims coding, member benefits, and website navigation), distribution of periodic provider newsletters and bulletins containing updates and reminders, and online resources through our website at **AetnaBetterHealth.com/OhioRISE**.

Forms

Ohio Department of Medicaid form page	**medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/forms/forms**
Consent Form	Consent forms can be updated directly in **Dynamo.** Template located in **Dynamo**: **Care Coordination Consent Event.docx (aetna.com)** **Non-Dynamo** users contact Care Coordination **OhioRISECareCoordination@Aetna.com** with the information required to fill out the event.

Standardized Appeal Form

Aetna Better Health of Ohio Disputes (Participating Providers)	**apps.availity.com/availity/Demos/Registration/index.htm** Disputes are filed online through Availity.
Aetna Better Health of Ohio Appeals (Participating Providers)	**apps.availity.com/availity/Demos/Registration/index.htm**

Provider specific appeal forms

Aetna Better Health of Ohio Appeals (Non-Participating Providers)	Aetna Better Health of Ohio Provider A&G Mail Aetna Better Health of Ohio PO Box 81040 5801 Postal Road Cleveland, OH 44181
Claim Submission	Claims submission to occur through Change Healthcare Payer ID: 45221 **AetnaBetterHealth.com/ohio/assets/pdf/OH_WebConnect_user_guide_Claims.pdf**

Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organizations and providers and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachment A is needed to identify the providers' capacity and service location. Attachment B is only required for hospital providers to identify services or religious/moral objections. Attachment C is only required when the contract between the managed care entity and the provider includes less specialties than the provider identified in the Provider Network Management System. The most current Medicaid Addendum is posted on the ODM website here:

medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/medicaid-addendum

The addendum must be completed along with your OhioRISE plan provider contract.

Section IV - Provider Responsibilities

Health Insurance Portability and Accountability Act of 1997 (HIPAA)
The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the healthcare industry, including transaction code sets, privacy, and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, managed care organizations (MCOs), and healthcare clearinghouses that transmit healthcare information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic healthcare transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit: **hhs.gov/ocr/hipaa/**.

In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA.
- Consider how to ensure privacy if you're using a patient sign-in sheet.
- Keep patient records, papers, and computer monitors out of view.
- Have an electric shredder or locked shred bins available.

Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health of Ohio.

Release of data to third parties requires advance written approval from the Ohio Department of Medicaid (ODM), except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health, or condition.
- The provision of healthcare to the individual.
- The past, present, or future payment for the provision of healthcare to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
- Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, or Social Security Number).

Additional privacy requirements are located throughout this manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records.

Breach of Protected Health Information (PHI)

If a provider and or the provider's staff discovers a breach (i.e., when the incident that involves the impermissible use or disclosure of PHI becomes first known), a notification will need to be sent to affected patients without unreasonable delay and in no case later than sixty (60) calendar days after the date of the breach (unless requested by law enforcement). The sixty (60) day period should be seen as an outer limit. So, if the risk analysis and the necessary information to provide notification is completed earlier, waiting until day sixty (60) would be an unreasonable delay. However, if during the sixty (60) day period a prompt risk analysis and investigation is conducted and it is concluded that no breach occurred, then no notification is necessary.

The breach notification should be sent to patients in written form by first-class mail at the last known address. If a patient agrees to receive a notification via e-mail and this agreement has not been rescinded, then the written notification can be sent electronically. In the case of minors or patients who lack legal capacity due to a mental or physical condition, the parent, personal representative, and/or authorized representative should be notified. If the provider knows that a patient is deceased, the notification should be sent to the patient's next of kin or personal representative (i.e., a person who has the authority to act on behalf of the decedent or the decedent's estate), if the address is known. In urgent situations where there is a possibility for imminent misuse of the unsecured PHI, additional notice by telephone or other means may be made. However, direct written notice must still be provided.

Substitute notice must be provided if contact information is not available for some or all the affected patients, or if some notifications that were sent are returned as undeliverable. The form of the substitute notice is based on the number of patients for whom contact information was unavailable or out-of-date. If the number of patients is fewer than ten (10), the provider should choose a form that can be reasonably calculated to reach the individual who should be notified. Possible forms may be an e-mail message, a phone call (keeping in mind that sensitive information should not be left on voicemail or in messages to other household members), or possibly a web posting if no other contact information is available, and this is reasonably calculated to reach the patient. If the number of patients is ten (10) or more, the provider should

place a conspicuous notice that includes a toll-free number: (1) on its homepage or a hyperlink that conveys the nature and important of the information to the actual notice, or (2) in major print or broadcast media in geographic areas where the affected individuals of the breach likely live. If the provider can update the contact information and provide written notice to one or more patients so as to bring the total number of patients for whom contact information is unavailable or out-of-date to less than ten, then the conspicuous notice requirement can be avoided.

For additional details surrounding media coverage and notification to the Secretary of the Department of Health and Human Services, please visit the following site at:
For additional training or Q&A, please visit the following site at:
aspe.hhs.gov/admnsimp/final/pvcguide1.htm

Providers must notify Aetna Better Health of Ohio if a breach occurs regardless of the number of patients impacted.

Member Privacy Requests

Members may make the following requests related to their protected health information ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint.
- Receive a copy of all or part of the designated record set.
- Amend records containing protected health information (PHI).
- Receive an accounting of health plan disclosures of PHI.
- Restrict the use and disclosure of PHI.
- Receive confidential communications.
- Receive a Notice of Privacy Practices.

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that they are authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health of Ohio in writing.

Provider obligations for oral translation, oral interpretation, and sign language services in accordance with OAC rule 5160-26-05.1

Interpretation and Translation Requirements

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, we make our telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially

responsible for associated costs. The Ohio Relay number is available for members by calling 711. Our Member Services staff are trained and available to take TTY phone calls from members.

Our language interpreter vendor provides interpreter services at no cost to providers and members. Language interpretation services are available for use in the following scenarios:

- For face-to-face meetings, our staff (e.g., care coordinators) can conference in an interpreter to communicate with a member in their home or another location.
- Providers can call Aetna Better Health of Ohio Member Services Department at **1-833-711-0773,** option 2 to connect to OhioRISE, then select "2" or "hold on the line" to be connected with a Member Services Staff Member. From the next menu press "7" to link with an interpreter.
- For outgoing calls, our Member Services Staff dials the language interpretation service and uses an interactive voice response system to conference with the member and the interpreter.

We provide alternative methods of communication for members who are visually or hearing impaired, including large print and/or other formats. If a member has a question about alternative formats, please have them contact our Member Services Department at **1-833-711-0773**, option 2.

We strongly recommend the use of professional interpreters, rather than family or friends. Providers must also deliver information in a manner that is understood by the member.

Cultural competency information as well as languages spoken by office location would be collected in ODM's Provider Network Management (PNM) system and will be utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the managed care organizations on a weekly basis for them to align their directories with the information contained in the PNM.
Procedure to notify the OhioRISE plan of changes to provider practice in accordance with OAC rule 5160-26-05.1

Office Administration Changes and Training

Providers are responsible to notify our Provider Experience Department on any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Experience Department to request additional staff training and our Provider Experience Department will work with you and your office to schedule training.
Providers are also responsible for notifying Aetna Better Health of Ohio and the Ohio Department of Medicaid (ODM) of address, phone number, acceptance of new patients, and office hour changes. Please notify Aetna Better Health's Provider Experience Department within two weeks of these changes. Please update your changes in the ODM portal as well.

Cultural competency and linguistics services

Cultural Competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations.

Members are to receive covered services without concern about age, race, color, national origin, religion, sex, gender identity, sexual orientation, religion, marital status, mental or physical disability, medical history, health status, genetic information, evidence of insurability, or geographic location. We expect our providers to treat all members with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

We have effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups, and explain the relationship between cultural competency and health outcomes. These programs provide information on our members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter, and we develop and implement acknowledged methods for responding to those challenges.

Providers receive education about such important topics as:

- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment.
- The impact that a member's religious and/or cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices).
- Promoting health literacy and the importance of providing patients with information in a way that is meaningful and understandable (e.g., simple diagrams, communicating in the vernacular, etc.).
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care.

Our Provider Experience Representatives will reference the cultural competency training during provider orientation meetings and explain how providers can access the education.

Cultural competency information as well as languages spoken by office location will be collected in ODM's Provider Network Management (PNM) system and will be utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the managed care organizations on a weekly basis for them to align their directories with the information contained in the PNM.

Access and Availability Standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Our Provider Experience Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standard. Providers are contractually required to meet the Ohio Department of Medicaid (ODM) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services. Providers are required to notify Aetna Better Health of Ohio within 3 business days if they are not able to comply with access and availability standards.

The table below shows appointment wait time standards for Behavioral Health providers.

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency as a result of a behavior health condition.	24 hours, 7 days/week
Urgent Care for Behavioral Health Conditions	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care. This includes acute illness or substance dependence that impacts the ability to function but does not present imminent danger.	24 hours, 7 days/week within 48 hours of request
Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
CANS Initial Assessment	Assessment for the purposes of OhioRISE eligibility	Within 72 hours of identification

CANS Ongoing Assessment	Assessment of functional progress within the course of OhioRISE Plan treatment as facilitated by the CME.	Every 6 months or when a change in member's condition warrants a re-assessment
ASAM Residential/Inpatient Services – 3: 3.1, 3.5, 3.7	Initial screening, assessment, and referral to treatment.	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services – 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week
Psychiatric Residential Treatment Facilities	Initial screening for admission.	Within 48 hours of request
Specialty Behavioral Health Care Appointment	Care provided for a non-emergent/non-urgent illness requiring consultation, diagnosis, and/or treatment from a specialist (e.g., eating disorders, fire-setting).	Within 6 weeks

Provider participation in the twice a year appointment availability surveys is mandatory and critical to ensure you remain compliant. We follow a 5-communication channel approach at different times of the year to remind you of the standards and the surveys:

- Conduct and record annual training on Access & Availability requirements and post on our website
- Include an annual reminder in our Provider Newsletter
- Send an annual notification to existing providers via Blast Fax
- Include requirements in the Provider Onboarding Training Manual
- Educate the provider within 30 days of effective date

Failure to participate in the studies and comply with appointment availability standards may result in progressive enforcement action that could lead to termination of our agreement with you.

Section V - Provider Enrollment, Credentialing, and Contracting

Provider Enrollment (ODM Functions)

Credentialing/Recredentialing

Ohio Department of Medicaid (ODM) is partnering with all managed care entities (MCEs) to centralize the credentialing function. This will require all credentialing to occur through ODM and not Aetna.
Credentialing adheres to the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS) federal guidelines for both processes and the types of providers who are subject to the credentialing process. Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled, and credentialed (if required) by the Ohio Department of Medicaid (ODM). For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through the credentialing process. Medical students, residents, fellows, and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with the OhioRISE plan while you are enrolling and being credentialed at ODM, in order to render services as of your effective date.

The Universal Credentialing DataSource program allows practitioners to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the practitioners obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the practitioner for the same standard information. Practitioners update their information on a quarterly basis to ensure data is maintained in a constant state of readiness. The CAQH gathers and stores detailed data from more than 600,000 practitioners nationwide.

Initial Credentialing Individual Practitioners

Effective October 1, 2022, all provider enrollment applications must be submitted using Ohio Medicaid's Provider Network Management (PNM) module: **ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx**.

The PNM module is the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service.

For more information about the PNM please visit:
managedcare.medicaid.ohio.gov/managedcare/centralized-credentialing/pnm-centralized-credentialing

Every provider is required to undergo the enrollment process, but credentialing is not mandatory for all providers. For initial credentialing and recredentialing, the application is paired with the enrollment or revalidation application. For more information, please refer to: **managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing/pnm-centralized-credentialing.**

Recredentialing Individual Practitioners

Aetna Better Health of Ohio recredentials practitioners on a regular basis (every thirty-six (36) months based on state regulations) to ensure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (such as National Committee for Quality Assurance NCQA and Utilization Review Accreditation Commission) requirements (as applicable to the health plan). Termination of the provider contract can occur if a provider misses the thirty-six (36) month timeframe for recredentialing.

Facilities Recredentialing

As a prerequisite for participation or continued participation in our network, all facilities must be contracted under a facility agreement and satisfy applicable assessment standards. Prior to participation in the network, and every three years thereafter, Aetna Better Health of Ohio Credentialing (or entity to which Aetna Better Health of Ohio has formally delegated credentialing to) will confirm that each organizational provider meets assessment requirements.

General Provider Information/Enrollment Information

Pursuant to 42 Code of Federal Regulations (CFR) 438.602, the Ohio Department of Medicaid (ODM) is required to screen, enroll, and revalidate all managed care entities' (MCE) network providers. This provision does not require an MCE network provider to render services to fee-for-service (FFS) beneficiaries.
There are many resources available on the ODM website about the requirements to become a participating provider. Please visit **medicaid.ohio.gov/resources-for-providers/enrollment-and-support/enrollment-and-support**
for several useful documents that answer relevant questions.

Organizational provider types will be required to pay a fee. The fee applies to organizational providers only; it does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFS 445.460 and in OAC 5160:1-17.8. The fee for 2021 is $599 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, Ohio Medicaid will require that the enrolling organizational providers submit proof of payment with their application. (See OAC 5160:1-17.8

There are many resources available on the Ohio Department of Medicaid website about the requirements to become a participating provider. Please visit:

medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support for several useful documents that answer relevant questions.

Termination, Suspension, or Denial of ODM Provider Enrollment

Termination, Suspension, or Denial of ODM Provider

For a list of termination, suspension and denial actions initiated by the State of Ohio against a provider or applicant that allow for hearing rights, please refer to Ohio Revised Code section 5164.38.

For a list of termination, suspension, and denial actions initiated by the ODM against a provider or applicant that allows for reconsideration, please refer to Ohio Administrative Code 5160-70-02.

Loss of Licensure

In accordance with Ohio Administrative Code rule 5160-1-17.6, a Medicaid provider agreement will be terminated when any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited, and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

Enrollment and Reinstatement After Termination or Denial

Due to the multiple number of reasons that a provider may be terminated or have an application denied, it is highly advised that the applicant/provider contact ODM via the Provider Enrollment Hotline (1-800-686-1516) to discuss the specific requirements needed to reapply. These discussions or guidance may include conversations with our Compliance Unit who will provide specific instruction on reinstatement requirements, if applicable.

Provider Maintenance

The Provider Network Management module serves as the source of truth for provider data for ODM and for the MCEs. Updates and change requests originate through the system itself, without the need for sending e-mails or mail back and forth. As the PNM drives both the OhioRISE plan directory and the ODM directory, it is imperative that the provider data in the system is kept current. When there is a change, please log in to the system, choose the provider you are editing, and click the appropriate button to begin an update. Self service functions include location changes, specialty changes, and key demographic (IE name, NPI etc.) changes. This information is sent to the OhioRISE plan on a daily basis for use in their individual directories. Maintenance of data is required in the PNM prior to changing this in the OhioRISE plan directory, since this is the source of truth. The MCEs are required to direct providers back to the PNM if

there are changes and cannot update their information unless it has already been updated in PNM.

ODM Provider Call Center

If you have questions or need assistance with your Ohio Medicaid enrollment, call the ODM Provider Hotline at 1-800-686-1516 through the Interactive Voice Response (IVR) system. It provides 24-hour, 7 days a week access to information regarding provider information. Provider representatives are available via the IVR system weekdays from 8:00 a.m. through 4:30 p.m. to assist providers.

Provider Complaints
Provider Grievances

Both network and out-of-network providers may file a complaint verbally or in writing, directly to us regarding our policies, procedures, or any aspect of our administrative functions. Providers can file a verbal grievance with us by calling **1-833-711-0773**.

To file a grievance in writing, providers should write to:

Aetna Better Health of Ohio
PO Box 81040 5801 Postal Road
Cleveland, OH 44181

The Grievance System Manager assumes primary responsibility for coordinating and managing provider grievances and for disseminating information to the provider about the status of the grievance.

An acknowledgement letter will be sent within five (5) business days summarizing the grievance and will include instruction on how to:

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

If the grievance requires research or input by another department, the Grievance System Manager will forward the information to the affected department and coordinate with the affected department to thoroughly research each grievance using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of Ohio's written policies and procedures, collecting pertinent facts from all parties. The grievance, with all research, will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider with the same or similar specialty if the complaint is related to a clinical issue. The Grievance Committee will consider the additional information and will resolve the complaint within fifteen (15) business days. The Grievance System Manager will send written notification within fifteen (15) business days of the resolution.

Provider Appeals

A provider may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with us verbally or in writing, in writing no later than 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. The expiration date to file an appeal is included in the Notice of Action. Providers can file a verbal appeal with us by calling 1-833-711-0773. All verbal appeals must be followed up in writing.

Providers can also submit appeals online at:
apps.availity.com/availity/Demos/Registration/index.htm

Or via mail to the following:
Aetna Better Health of Ohio
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

The Grievance System Manager assumes primary responsibility for coordinating and managing provider appeals, and for disseminating information to the provider about the status of the appeal.
An acknowledgement letter will be sent within five (5) business days summarizing the appeal and will include instruction on how to:

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

The appeal with all research will be presented to the Appeal Committee for decision. The Appeal Committee will include a provider with the same or similar specialty. The Appeal Committee will consider the additional information and will issue an appeal decision within fifteen (15) business days for claims related appeals and thirty (30) business days for all other non-claim related appeals. The Grievance System Manager will send written notification within two (2) business days of the resolution.

Management of the Process

The Appeal and Grievance Department is responsible for the management of appeals and grievances. The Appeal and Grievance Department staff reports to the Director of Operations. All data collected is reported to the appropriate quality committees which includes representation from compliance.
The Grievance System Manager has overall responsibility for the management of the member grievance system process. Responsibilities include:

- Documenting individual grievances, appeals, and state hearings.
- Coordinating resolutions of grievances and appeals.
- Tracking, trending, and reporting data.
- Identification of opportunities for improvement.
- Ensuring complete appeal and grievance records.
- Real time Quality Assurance (QA) review.

Oversight activities are the responsibility of the Aetna Better Health, the Aetna Medicaid Administrators (AMA) Appeal and Grievance oversight team, Grievance System Governance Committee, and Compliance. The Compliance Department has oversight responsibility of the grievance and appeals process. This includes:

- Review of individual grievances and appeals.
- Monitoring for compliance with contractual obligations.
- Monitoring for compliance with state and federal regulatory requirements.

The AMA Appeal and Grievance oversight team is responsible for:

- Conducting an annual file review to validate that appeal and grievance timeliness results are accurate and that case documentation is complete.
- A formal report will be created and reported to the health plan leaders, Grievance System Governance Committee (GSGC) and are monitored through completion of any recommended actions or any identified management action plans.
- Conducting a full biennial assessment including staff interviews, policy and procedure reviews for compliance and a file review. A formal report will be created and reported to the health plan leaders, Grievance System Governance Committee (GSGC) and monitored through completion of identified management action plans or recommended actions.

Our Grievance System Manager will serve as the primary contact person for the grievance and appeals process.

Our Member Services Department, in collaboration with the Quality Management (QM) Department and Provider Services Department, is responsible for informing and educating members and providers about a member's right to file a grievance or appeal, request a state hearing, and for assisting members throughout the grievance or appeal process.

Members are advised of their grievance, appeal, and state hearings rights and processes, as applicable, at the time of enrollment and at least annually thereafter. Providers receive this information via the Provider Manual, during initial provider orientation, within the Provider Agreement, and on our website.

Helpful Information

- Medicaid Provider Resources
- **medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support**
- Federal guidelines for enrollment and screening (42 CFR 455 Subpart E)
- **law.cornell.edu/cfr/text/42/part-455/subpart-E**
- Ohio Revised Code
- **codes.ohio.gov/ohio-revised-code/chapter-5160**
- **codes.ohio.gov/ohio-revised-code/chapter-3963**
- Ohio Administrative Code
- **codes.ohio.gov/ohio-administrative-code/5160**

Provider Contracting (OhioRISE plan functions)

Information about contracting process

Interested Providers

ADDING: Must ensure they have an NPI, if they need to apply, they can go to NPPES (hhs.gov)

If you are interested in applying for participation with us, you must first register with the State of Ohio's Provider Network Management (PNM) system **ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx**.

The following steps need to be conducted with Ohio Department of Medicaid (ODM):

- Register with the PNM system to obtain a PIN. The link below is an instruction guide of obtaining a PIN:
    - **managedcare.medicaid.ohio.gov/static/PNM/QRG/QRG+-+Creating+OH+ID+for+IOP+PNM+Login.pdf**
- Obtain an active Medicaid ID number. If you are not registered with ODM and need to get a Medicaid ID number, the reference guide will help walk through the steps:
    - **managedcare.medicaid.ohio.gov/static/PNM/QRG/QRG+-+New+Provider+Application.pdf**
- If you are already a provider and attempting to add a new specialty to service OhioRISE members, please refer to the guide below:
    - **managedcare.medicaid.ohio.gov/static/PNM/QRG/QRG+-+Updating+a+Provider+File.pdf**

    - Ohio Department of Medicaid conducts all credentialing activities for Ohio Medicaid providers. Please review the link below for more information: **managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/f8ec9486-cd62-4ac9-843c-**

9facd5ef629a/Centralized+Credentialing+FAQ+September+Update.pdf?MOD=AJPERES&CVID=oczS2pK

Once you have a valid Medicaid ID and the PNM system is updated with your information, send an email requesting to be added to OhioRISE network. The email address is:
OHRISE-Network@aetna.com
If there are additional questions, please feel free to call our Provider Experience Department at **1-833-711-0773 (option 2).**

Sample provider network agreements
Provider agreement and Medicaid product addendum (PDF):
aetnabetterhealth.com/content/dam/aetna/medicaid/ohio-rise/providers/pdf/3%20-%20Provider%20Agreement.pdf

Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organizations and providers and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachment A is needed to identify the providers' capacity and service location. Attachment B is only required for hospital providers to identify services or religious/moral objections. Attachment C is only required when the contract between the managed care entity and the provider includes less specialties than the provider identified in the Provider Network Management System. The most current Medicaid Addendum is posted on the ODM website here:
medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/medicaid-addendum
The addendum must be completed along with your OhioRISE plan provider contract.

Termination, Suspension, or Denial of ODM Provider

Due to the multiple number of reasons that a provider may be terminated or have an application denied, it is highly advised that the applicant/provider contact ODM via the Provider Enrollment Hotline (**1-800-686-1516**) to discuss the specific requirements needed to reapply. These discussions or guidance may include conversations with our Compliance Unit who will provide specific instruction on reinstatement requirements, if applicable.

For a list of termination, suspension and denial actions initiated by the State against a provider or applicant that allow for hearing rights please refer to Ohio Revised Code 5164.38.
For a list of termination, suspension and denial actions initiated by the State Medicaid agency against a provider or applicant that allow for reconsideration please refer to Ohio Administrative Code 5160-70-02.

Provider appeals process for denial of contract

Provider Appeals

A provider may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with us verbally or in writing, in writing no later than 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. The expiration date to file an appeal is included in the Notice of Action. Providers can file a verbal appeal with us by calling **1-833-711-0773**. All verbal appeals must be followed up in writing.
Providers can also submit appeals online at
apps.availity.com/availity/Demos/Registration/index.htm

Via mail to the following:
Aetna Better Health of Ohio
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

The Grievance System Manager assumes primary responsibility for coordinating and managing provider appeals, and for disseminating information to the provider about the status of the appeal.
An acknowledgement letter will be sent within five (5) business days summarizing the appeal and will include instruction on how to:

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

The appeal with all research will be presented to the Appeal Committee for decision. The Appeal Committee will include a provider with the same or similar specialty. The Appeal Committee will consider the additional information and will issue an appeal decision within fifteen (15) business days for claims related appeals and thirty (30) business days for all other non-claim related appeals. The Grievance System Manager will send written notification within two (2) business days of the resolution.

Out-of-state providers/non-contracted providers

Out of Network Providers – Transition of Care

We will authorize service through an Out-of-Network Provider Agreement when a member with a special need or service is not able to be served through a contracted provider. Our Medical Management team will arrange care by authorizing services to an out-of-network provider and facilitating transportation through the member's managed care organization (MCO) when there are no providers that can meet the member's special need available in a nearby location. If needed, our Provider Experience Department will negotiate a Single Case Agreement (SCA) for the service and refer the provider to our Network Development Team for recruitment to join the provider network. The member may be transitioned to a network provider when the treatment or service has been completed or the member's condition is stable enough to allow a transfer of care.

Plan Provider Call Center

Provider Experience Department Overview

Our Provider Experience Department serves as a liaison between Aetna Better Health of Ohio and the provider community. Our staff is comprised of Network Relation Managers and Network Relation Consultants, as well as Provider Experience Representatives. Our Network Relations team conducts onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Provider Experience Representatives are available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas where we provide assistance:

- Contracting status.
- Provide information on how to update location/address via the PNM.
- Information about recent health plan policy and/or regulatory updates.
- Assistance on how to locate forms.
- Assistance with reviewing claims or remittance advices including questions surrounding claims and billing.
- Information on provider denials.
- Instructions for providers needing to file a complaint and/or challenging or appealing the failure of the health plan to provide covered services (including state services).
- Information on member grievance and appeals.
- Information on translation/interpreter services.
- Information about member covered services.
- Instruction on how to submit a prior authorization and/or cover determination (including exceptions).
- Information on how to look up services that require prior authorization.
- Information about provider orientations.
- Information about coordination of services.

- Information about provider responsibilities.
- Assistance with checking member eligibility.
- Assistance with reviewing member information on the Member Care Portal.
- Instructions on how to locate a participating provider or specialist in our network.
- Instructions on how to locate the Ohio Department of Medicaid's (ODM) managed care organization (MCO) provider web search pages.
- Instructions on how to contact the Single Pharmacy Benefit Manager (SPBM), Gainwell Technologies (coming in late 2022).
- Instructions on how to search the ODM Unified Preferred Drug List.
- Instructions on how to contact Availity.

Provider Toll-Free Help Line

The Provider Experience Toll-free Help Line, **1-833-711-0773** (option 2), will be staffed by Provider Experience Representatives between the hours of 7 a.m. and 8 p.m., EST, Monday through Friday, excluding the following Aetna Better Health of Ohio holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

An automated system and secure voicemail will be available to providers between the hours of 8:01 p.m. and 6:59 a.m., EST, Monday through Friday, and 24 hours on weekends and holidays. Voicemails will be returned in a timely manner by our Provider Experience staff.

Credentialing/Recredentialing Process

Credentialing will be done by MCEs for any provider prior to July 1, 2022. The OhioRISE plan may insert their own language into the credentialing section until that date.
Credentialing will be done by ODM for any provider on or after July 1, 2022, however the following ODM model language must be included in the credentialing section at all times

ODM is responsible for credentialing all Medicaid Managed Care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the Provider Network Management system. This process adheres to NCQA and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.

Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled, and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. Medical Students, Residents, Fellows, and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with the OhioRISE plan while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the State Medicaid level, you are still required to contract with the OhioRISE plan.

When you submit your initial application to be an Ohio Medicaid provider, you can designate managed care plan interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the OhioRISE plan so they can start contracting with you

Section VI - Covered Services

List of covered services in accordance with 5160-26-03, including any additional benefits like value-added services, pilot, and trial incentive programs, and in lieu of services

OhioRISE members will receive medically necessary Medicaid-covered behavioral health services at no cost. OhioRISE provides access to all inpatient and outpatient behavioral health services noted in the **Ohio Medicaid Behavioral Health Manual** OhioRISE also offers additional services that are only available to OhioRISE members.

OhioRISE will not pay for services that are not covered by Medicaid or are not medically necessary. If you have a question about whether a service is covered, please call Member Services at **1-833-711-0773 (TTY: 711).** Representatives are available from 7 a.m. to 8 p.m. Monday through Friday.

Some behavioral healthcare is covered only when it is approved before the service is provided (prior authorization). See page 46 on getting prior approval for services. Emergency services do not require prior authorization. Providers can get a full listing of services that need prior authorization on the Aetna Better Health of Ohio Provider Portal. This list may change from time to time. Providers can also call **1-833-711-0773 (TTY: 711)** to request the most current list of services that need prior authorization.

Behavioral health services covered by OhioRISE:

Service	Coverage/ Limitations*	Prior Approval
Assertive Community Treatment for Adults	Covered	No prior approval needed for first 180 days.
Behavioral Health Emergency Services provided in an emergency room	Covered by your physical health benefit	No prior approval needed
Behavioral Health Services provided through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)	Covered	No prior approval needed
Care Coordination	Covered	No prior approval needed
Community Psychiatric Supportive Treatment	Covered	No prior approval needed
Crisis Services	Covered	No prior approval needed
Diagnostic Evaluation and Assessment	Covered/1 per year for certain evaluations	No prior approval needed unless limitation met
Drug Testing and Other Select Laboratory Services	Covered	No prior approval needed
Electroconvulsive therapy	Covered	Prior approval needed
Health Behavior Assessment and Intervention	Covered	No prior approval needed
Home Visits with Behavioral Health Providers	Covered	No prior approval needed
Inpatient Hospital Substance Use Disorder Services	Covered	Prior approval needed
Inpatient Hospital Psychiatric Services	Covered	Prior approval needed
Intensive Home-Based Treatment for Children/Adolescents	Covered	No prior approval needed for first 180 days.
Medication-Assisted Treatment for Addiction	Covered	No prior approval needed
Mobile Response Stabilization Services	Covered	Prior approval is needed beyond six weeks.
Behavioral Health Nursing Services	Covered	No prior approval needed.
Office Visits with Behavioral Health Providers	Covered	No prior approval needed
Opioid Treatment Program (OTP) Services	Covered	No prior approval needed
Physician or Pharmacist Administered Drugs	Covered	No prior approval needed

Psychiatric Residential Treatment Facility (PRTF) Services	**Coverage available out of state now and in Ohio in 2023**	**Prior approval needed**
Psychological Testing	**Covered 20 visits per calendar year.**	**No prior approval needed for first 20 visits per year.**
Psychosocial Rehabilitation	**Covered**	**No prior approval needed**
Psychotherapy and Counseling	**Covered**	**No prior approval needed**
Psychiatry Services	**Covered**	**No prior approval needed**
Behavioral Health Respite Services	**Covered**	**Prior approval needed only after first 50 days.**
Screening Brief Intervention and Referral to Treatment (SBIRT)	**Covered/1 of each screening type per year**	**No prior approval needed unless limit is met**
Smoking and Tobacco Use Cessation	**Covered**	**No prior approval needed**
Substance Use Assessment	**Covered/2 assessments per year**	**No prior approval needed**
Substance Use Case Management	**Covered**	**No prior approval needed**
Substance Use Intensive Outpatient	**Covered**	**No prior approval needed**
Substance Use Partial Hospitalization	**Covered**	**Prior approval needed**
Substance Use Peer Recovery Support	**Covered/Up to 4 hours per day**	**No prior approval needed unless limit is met**
Substance Use Residential Treatment	**Covered/Up to 30 consecutive days for the first 2 stays**	**No prior approval needed unless limit is met**
Substance Use Therapy	**Covered**	**No prior approval needed**
Substance Use Withdrawal Management	**Covered**	**No prior approval needed**
Telehealth Services for Behavioral Health	**Covered**	**No prior approval needed**
Therapeutic Behavioral Service	**Covered**	**No prior approval needed**

Primary Flex Funds	**Covered**	**Primary flex funds will need prior approval through the Child and Family-Centered Care Plan review process**

Requirements regarding the submission and processing of requests for specialist referrals in accordance with OAC rule 5160-26-05.1

Documenting Referrals

Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including mental health/substance abuse (MH/SA) providers, within our network. Providers must follow the respective practices for emergency room care, second opinion, and noncompliant members.

Telehealth

OhioRISE will cover applicable behavioral health telehealth services as specified in the *ODM Telehealth Services: Guidelines for Managed Care Organizations* manual (Telehealth-Services-guidelines-for-MCOs-Version-3.pdf). OhioRISE will implement any changes outlined in this manual within 30 calendar days of being notified by the Ohio Department of Medicaid (ODM) of change.

OhioRISE will educate members and providers about the availability of telehealth, considerations of using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.
The OhioRISE Provider Directory will clearly identify providers that offer telehealth, and if so, when telehealth is available.

Workforce Development Plan

Aetna OhioRISE's approach to workforce development is to cultivate skilled workers and quality partners aligned with our mission and values, invested in continued success, and positioned to make a difference in the lives of the Ohio families we serve.
The goals of Aetna Better Health of Ohio workforce development plan:

- Continue to recruit new service providers to the OhioRISE Program.
- Increase the capacity and quality of OhioRISE service delivery providers.
- Ensure the demographics of our provider workforce reflects culturally competent, family-driven and youth-guided practice and principles that support families, children, and youth who are being served through the OhioRISE.

Our strategies include:

- Develop healthcare worker career maps as recruitment and retention resources.
- Increase access to Peer Support Specialists, Mobile Response and Stabilization Services (MRSS), and expand availability of Behavioral Health Respite providers.
- Develop value-based payments to providers to improve service quality and encourage providers to expand their service areas.
- Develop a pipeline through the education systems to expand employment opportunities for the Ohio workforce.

We will accomplish this by:

- Partnering with ODM and other state agencies, Ohio trade associations, providers, and the Child and Adolescent Behavioral Health Center of Excellence to determine OhioRISE workforce development goals and needs.
- Soliciting feedback and input via the Aetna OhioRISE Provider Advisory Committee, Youth Advisory Council, and the Member and Family Advisory Council.
- Collaborate with Ohio Association of Health Plans to coordinate workforce development strategies with other Ohio managed care organizations.

Non-Covered Benefits

Aetna Better Health of Ohio will not pay for services or supplies received that are not covered by OhioRISE:

- All services or supplies that are not medically necessary.
- Paternity testing.
  - Services to find cause of death (autopsy) or services related to forensic studies.
  - Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual.

Grievance, appeal, and state hearing procedures and time frames per OAC rule 5160-26-05.1

Member Grievance System Overview

Aetna Better Health of Ohio takes grievances and appeals very seriously. We want to know what is wrong so we can make our services better. Members can file a grievance or appeal if they are not satisfied. A network provider, acting on behalf of a member and with the member's written consent, may file a grievance, appeal, and a state hearing as applicable.

A member or their authorized representative may request a state hearing through the Ohio Department of Job and Family Services (ODJFS) after the appeal process.

We inform members of the complaint/grievance, appeal, and state hearing procedures. This information is contained in the Member Handbook and within this Provider Manual, including being available on our website at **AetnaBetterHealth.com/OhioRISE**. When requested, we provide members reasonable assistance in completing forms and taking other procedural steps.

Grievances

Members or their representatives may submit grievances orally or in writing to any OhioRISE staff person. Standard grievances may be filed at any time. Expedited grievances related to the denial of expedited prior authorization or appeal processing, related to OhioRISE taking an extension on the decision-making timeframe for a prior authorization, or an appeal must be requested within sixty (60) calendar days of the Expedited Processing letter or the Extension letter.

Grievance Extension

If we are unable to resolve a standard grievance within the specified timeframe, we may ask to extend the grievance decision date by fourteen (14) calendar days. We will only take an extension if it is in the member's best interest. In these cases, we will provide information describing the reason for the delay in writing to the member and to the Ohio Department of Medicaid.

Expedited Grievance Resolution

Grievances will be resolved within the following time frames and the member will be notified orally the same day as resolution for expedited grievances and in writing within seventy-two (72) hours of resolution for all grievances, unless an extension of time is warranted. The timeframe for the disposition of a grievance and notice to the affected parties is as follows:

- Within seventy-two (72) hours of receipt for:
    - Clinically urgent situations.
    - Grievances related to when OhioRISE extends the timeframe for decision making.
    - When the grievance is the result of the denial of expedited appeal decision making.
- Within two (2) business days of receipt if the grievance is regarding access to services.
- Within thirty (30) calendar days of receipt for non-claims related grievances.
- Within sixty (60) calendar days of receipt for claims related grievances.

Regulatory Complaints

At any time throughout the appeal or grievance process, or instead of the appeal and grievance process, the member may file a complaint with a regulatory body for any reason including dissatisfaction with the outcome of an appeal or grievance. Regulatory complaints may be received from any area in the State of Ohio. For example complaints can be filed through the Ohio Department of Insurance via their website **insurance.ohio.gov/home** or through the Ohio Attorney General using their website as well **ohioattorneygeneral.gov/Individuals-and-Families/Consumers/File-A-Complaint**.

Appeals

A member may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care, or service issue), with us. Authorized member representatives, including providers, may also file an appeal on the member's behalf with the written consent of the member. Appeals must be filed no later than sixty (60) calendar days from the postmark on the Aetna Better Health of Ohio Notice of Action. The expiration date to file an appeal is included in the Notice of Action.

The Notice of Action informs the member of the following:

- Our decision and the reasons for our decision.
- The requirement and timeframes for filing an appeal.
- The availability of assistance in the filing process.
- The toll-free numbers that the member can use to file an appeal by phone.
- The procedures for exercising their rights to appeal and/or a state hearing.
- That the member may represent themself or designate legal counsel, a relative, a friend, a provider or other spokesperson to represent them.
- The specific regulations that support, or the change in federal or state law, that requires the action.
- The fact that, when requested by the member, benefits will continue if the member files an appeal or requests a state hearing within the timeframes specified for filing.

Appeals may be filed either verbally, by contacting our Member Services Department, or by submitting a request in writing.

- Members may file an appeal and request a further review of our actions. Examples of appeals include:
- The denial or limited approval of a requested service, including the type or level of service.
- The reduction, suspension, or termination of a previously approved service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure to respond to an appeal in a timely manner. The denial of a member's request to obtain services outside of the contracting area when Aetna Better Health of Ohio is the only health plan servicing a rural area.

Members may file an appeal by:

- Call our Member Services Department at **1-833-711-0773 (TTY: 711)** from 7 a.m. to 8 p.m. Monday through Friday.
- Writing Aetna Better Health of Ohio at:

  Aetna Better Health of Ohio - Appeal and Grievance Department
  PO Box 81139 5801 Postal Road
  Cleveland, OH 44181

Continuation of Benefits

A member may continue to receive services for an ongoing course of treatment that were previously approved during the appeals process under the following circumstances unless the member or their representative requests not to continue:

The appeal is filed within fifteen (15) calendar days of the health plan mailing the notice of adverse benefit determination,

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment,
- The services were ordered by an authorized provider; and
- The original period covered by the original authorization has not expired.

Appeal Process

A brief overview of the appeals process follows:

- We notify members of receipt of the appeal within three (3) business days via an acknowledgment letter.
- Members are advised of their, or their authorized representative's, rights to provide more information and documents for their appeal either in person or in writing.
- Members are advised of their, or their authorized representative's right to view their appeal file.
- Members or their authorized representatives may be present either onsite, or via telephone, when the Appeal Committee reviews their appeal.
- Appeals will be resolved within fifteen (15) calendar days (or twenty-nine (29) calendar days if an extension is granted and we provide a reason for the extension, or the member or their authorized representative requests the extension) after Aetna Better Health of Ohio receives the appeal.
- We make a reasonable effort to provide verbal notice and mail the decision letter, including an explanation for the decision, within two (2) calendar days of the Appeal Committee's decision.

- If we do not agree with the member's appeal, the member can ask for a state hearing and request to receive benefits while the hearing is pending.
- If we, or the state hearing officer, reverse the original decision and approve the appeal, services will begin soon after the decision.

We resolve appeals effectively and efficiently, as the member's health requires. On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where a member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the member's condition cannot be adequately managed without urgent care or services. If the member's ability to attain, maintain, or regain maximum function is not at risk, the request to process the appeal in an expedited time frame may be denied and the appeal processed within the normal fifteen (15) calendar daytime frame. A member or their authorized representative, including providers, may request an expedited appeal either verbally, or in writing, within sixty (60) calendar days from the day of the decision or event in question. Written confirmation or the member's written consent is not required to have the provider act on the member's behalf for an expedited appeal.

Upon receipt of an expedited appeal, we begin the appeal process immediately. We attempt to acknowledge expedited appeals by telephone and in writing on the day the expedited request is received. Initial review of the issue begins in order to determine if the issue meets the definition of an expedited appeal. If the issue fails to meet the definition of an expedited appeal, the issue is transferred to the standard appeal process. We make reasonable efforts to give the member prompt verbal notice of the denial of expedited processing time and follow up within two (2) calendar days of receipt of request with a written notice that the appeal will be handled through the non-expedited standard process.

In cases where the health plan determines if a member's request meets expedited urgency, or a provider supports the member's request, our Chief Medical Officer (CMO) will render a decision as expeditiously as the member's health requires, but no later than seventy-two (72) hours from the receipt of the expedited appeal.

Appeal Extension

OhioRISE may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the member requests the extension, or if we are unable to resolve a standard or an expedited appeal within the specified timeframe. We may extend the period by up to fourteen (14) calendar days. We will only take an extension if it is in the member's best interest. In these cases, we will provide information describing the reason for the delay in writing to the member and, upon request, to the Ohio Department of Medicaid (ODM).

Failure to Make a Timely Decision

Appeals must be resolved within stated timeframes and parties must be informed of our decision.

For items/services covered by Medicaid only: if a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

The Ohio Department of Job and Family Services (ODJFS) State Hearing

The member and/or the member's authorized representative acting on behalf of the member may request a state hearing through ODJFS within ninety (90) calendar days from Aetna Better Health's Notice of Action (NOA) Letter or the Appeal Decision Letter. A state hearing is a meeting with the member, and/or their authorized representative, along with representatives from the County Department of Job and Family Services (if needed), OhioRISE, and the hearing officer from ODJFS. In this meeting, the member will explain why they think OhioRISE did not make the right decision and OhioRISE will explain the reasons for making their decision. The hearing officer will decide based on the rules and the information given.
If a member wishes to continue receiving services while their state hearing is reviewed, they must request a state hearing within fifteen (15) calendar days from the date of the Notice of Action Letter or the Appeal Decision Letter. Members can request a state hearing through the following ways:

- Electronically – Submit the hearing request to the Bureau of State Hearings SHARE Portal at https://hearings.jfs.ohio.gov/SHARE. Members log into the SHARE Portal using their Ohio Benefits ID and password to submit the request. (If they do not have an Ohio Benefits account, they can sign up at ssp.benefits.ohio.gov); or
- Email – Email the ODJFS Bureau of State Hearings at bsh@jfs.ohio.gov. In the subject, put "State Hearing Request". In the message, list all information from the boxes at the top of this page and any additional information below; or
- Phone – Phone the ODJFS Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention the notice; or
- Fax – Fax both pages of the notice to the ODJFS Bureau of State Hearings at (614) 728-9574; or
- Mail – Mail both pages of the notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, OhioRISE or ODJFS may decide that the health condition meets the criteria for an expedited decision. An expedited decision will be issued as quickly as needed, but no later than three business days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function.

Provider Grievances

Both network and out-of-network providers may file a complaint verbally or in writing, directly with us in regard to our policies, procedures, or any aspect of our administrative functions. Providers can file a verbal grievance with us by calling 1-833-711-0773.

To file a grievance in writing, providers should write to:

Aetna Better Health of Ohio
PO Box 81040 5801 Postal Road
Cleveland, OH 44181

The Grievance System Manager assumes primary responsibility for coordinating and managing provider grievances and for disseminating information to the provider about the status of the grievance.

An acknowledgement letter will be sent within five (5) business days summarizing the grievance and will include instruction on how to:

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

If the grievance requires research or input by another department, the Grievance System Manager will forward the information to the affected department and coordinate with the affected department to thoroughly research each grievance using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of Ohio's written policies and procedures, collecting pertinent facts from all parties. The grievance, with all research, will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider with the same or similar specialty if the complaint is related to a clinical issue. The Grievance Committee will consider the additional information and will resolve the complaint within fifteen (15) business days. The Grievance System Manager will send written notification within fifteen (15) business days of the resolution.

Provider Appeals

A provider may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with us verbally or in writing, in writing no later than 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. The expiration date to file an appeal is included in the Notice of Action. Providers can file a verbal appeal with us by calling **1-833-711-0773**. All verbal appeals must be followed up in writing.

Providers can also submit appeals online at
apps.availity.com/availity/Demos/Registration/index.htm

Via mail to the following:

Aetna Better Health of Ohio
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

The Grievance System Manager assumes primary responsibility for coordinating and managing provider appeals, and for disseminating information to the provider about the status of the appeal.
An acknowledgement letter will be sent within five (5) business days summarizing the appeal and will include instruction on how to:

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

The appeal with all research will be presented to the Appeal Committee for decision. The Appeal Committee will include a provider with the same or similar specialty. The Appeal Committee will consider the additional information and will issue an appeal decision within fifteen (15) business days for claims related appeals and thirty (30) business days for all other non-claim related appeals. The Grievance System Manager will send written notification within two (2) business days of the resolution.

Management of the Process

The Appeal and Grievance Department is responsible for the management of appeals and grievances. The Appeal and Grievance Department staff reports to the Director of Operations. All data collected is reported to the appropriate quality committees which includes representation from compliance.

The Grievance System Manager has overall responsibility for the management of the member grievance system process. Responsibilities include:

- Documenting individual grievances, appeals, and state hearings.
- Coordinating resolutions of grievances and appeals.
- Tracking, trending, and reporting data.
- Identification of opportunities for improvement.
- Ensuring complete appeal and grievance records.
- Real time Quality Assurance (QA) review.

Oversight activities are the responsibility of the Aetna Better Health, the Aetna Medicaid Administrators (AMA) Appeal and Grievance oversight team, Grievance System Governance Committee, and Compliance. The Compliance Department has oversight responsibility of the grievance and appeals process. This includes:

- Review of individual grievances and appeals.
- Monitoring for compliance with contractual obligations.
- Monitoring for compliance with state and federal regulatory requirements.

The AMA Appeal and Grievance oversight team is responsible for:

- Conducting an annual file review to validate that appeal and grievance timeliness results are accurate and that case documentation is complete.
- A formal report will be created and reported to the health plan leaders, Grievance System Governance Committee (GSGC) and are monitored through completion of any recommended actions or any identified management action plans.
- Conducting a full biennial assessment including staff interviews, policy and procedure reviews for compliance and a file review. A formal report will be created and reported to the health plan leaders, Grievance System Governance Committee (GSGC) and monitored through completion of identified management action plans or recommended actions.

Our Grievance System Manager will serve as the primary contact person for the grievance and appeals process.

Our Member Services Department, in collaboration with the Quality Management (QM) Department and Provider Services Department, is responsible for informing and educating members and providers about a member's right to file a grievance or appeal, request a state hearing, and for assisting members throughout the grievance or appeal process.

Members are advised of their grievance, appeal, and state hearings rights and processes, as applicable, at the time of enrollment and at least annually thereafter. Providers receive this information via the Provider Manual, during initial provider orientation, within the Provider Agreement, and on our website.

Section VII - Utilization Management

Behavioral health services covered by OhioRISE:

Service	Coverage/ Limitations*	Prior Approval
Assertive Community Treatment for Adults	Covered	No prior approval needed for first 180 days.
Behavioral Health Emergency Services provided in an emergency room	Covered by your physical health benefit	No prior approval needed
Behavioral Health Services provided through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)	Covered	No prior approval needed
Care Coordination	Covered	No prior approval needed
Community Psychiatric Supportive Treatment	Covered	No prior approval needed
Crisis Services	Covered	No prior approval needed
Diagnostic Evaluation and Assessment	Covered/1 per year for certain evaluations	No prior approval needed unless limitation met
Drug Testing and Other Select Laboratory Services	Covered	No prior approval needed
Electroconvulsive therapy	Covered	Prior approval needed
Health Behavior Assessment and Intervention	Covered	No prior approval needed
Home Visits with Behavioral Health Providers	Covered	No prior approval needed
Inpatient Hospital Substance Use Disorder Services	Covered	Prior approval needed
Inpatient Hospital Psychiatric Services	Covered	Prior approval needed
Intensive Home-Based Treatment for Children/Adolescents	Covered	No prior approval needed for first 180 days.
Medication-Assisted Treatment for Addiction	Covered	No prior approval needed
Mobile Response Stabilization Services	Covered	Prior approval is needed beyond six weeks.
Behavioral Health Nursing Services	Covered	No prior approval needed.

Office Visits with Behavioral Health Providers	**Covered**	**No prior approval needed**
Opioid Treatment Program (OTP) Services	**Covered**	**No prior approval needed**
Physician or Pharmacist Administered Drugs	**Covered**	**No prior approval needed**
Psychiatric Residential Treatment Facility (PRTF) Services	**Coverage available out of state now and in Ohio in 2023**	**Prior approval needed**
Psychological Testing	**Covered 20 visits per calendar year.**	**No prior approval needed for first 20 visits per year.**
Psychosocial Rehabilitation	**Covered**	**No prior approval needed**
Psychotherapy and Counseling	**Covered**	**No prior approval needed**
Psychiatry Services	**Covered**	**No prior approval needed**
Behavioral Health Respite Services	**Covered**	**Prior approval needed only after first 50 days.**
Screening Brief Intervention and Referral to Treatment (SBIRT)	**Covered/1 of each screening type per year**	**No prior approval needed unless limit is met**
Smoking and Tobacco Use Cessation	**Covered**	**No prior approval needed**
Substance Use Assessment	**Covered/2 assessments per year**	**No prior approval needed**
Substance Use Case Management	**Covered**	**No prior approval needed**
Substance Use Intensive Outpatient	**Covered**	**No prior approval needed**
Substance Use Partial Hospitalization	**Covered**	**Prior approval needed**
Substance Use Peer Recovery Support	**Covered/Up to 4 hours per day**	**No prior approval needed unless limit is met**
Substance Use Residential Treatment	**Covered/Up to 30 consecutive days for the first 2 stays**	**No prior approval needed unless limit is met**
Substance Use Therapy	**Covered**	**No prior approval needed**
Substance Use Withdrawal Management	**Covered**	**No prior approval needed**
Telehealth Services for Behavioral Health	**Covered**	**No prior approval needed**
Therapeutic Behavioral Service	**Covered**	**No prior approval needed**

Primary Flex Funds	**Covered**	**Primary flex funds will need prior approval through the Child and Family-Centered Care Plan review process**

Non-Covered Benefits

Aetna Better Health of Ohio will not pay for services or supplies received that are not covered by OhioRISE:

- All services or supplies that are not medically necessary
- Paternity testing
- Services to find cause of death (autopsy) or services related to forensic studies
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual

Prior authorization submission Process – process and format

How to Request Prior Authorizations

Prior authorizations may be obtained through Aetna's Secure Web Portal, Availity. Providers can access Availity directly at the web address below, or by going through our OhioRISE webpage **apps.availity.com/availity/Demos/Registration/index.htm**

Timeframes for Responding to standard and expedited PA requests

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Forty-eight (48) hours from receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent pre-service denial	Forty-eight (48) hours from receipt of request	Practitioner/Provider Member	Oral or Electronic/Written
Non-urgent pre- service approval	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider	Oral or Electronic/Written
Non-urgent pre- service denial	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider Member	Electronic/Written
Urgent concurrent approval	Forty-eight (48) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written

Urgent concurrent denial	Forty-eight (48) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written
Post-service approval	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider	Oral or Electronic/Written
Post-service denial	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider Member	Electronic/Written
Termination, Suspension, Reduction of prior authorization	At least fifteen (15) Calendar Days before the date of the action.	Practitioner/Provider Member	Electronic/Written

Provider Appeal Procedures

Peer-To-Peer Consultations

When an adverse benefit determination has been issued, Aetna Better Health will notify the provider of the option to request a peer-to-peer consultation. A peer-to-peer consultation can be requested by calling **1- 800-711-0773,** Monday through Friday, 8 a.m. to 5 p.m. ET. If the peer-to-peer consultation request is pertaining to a pre-service denial, the provider has five (5) business days from the date of notification of the adverse benefit determination to request the consultation. For subsequent reviews, the provider has two (2) business days from the date of notification of the adverse benefit determination to request a peer-to-peer consultation. Medical Management Staff will coordinate the peer-to-peer consultation between the Aetna Better Health Medical Director and the requesting provider.

External Medical Review

External Medical Review (EMR) –The review process conducted by an independent, external medical review entity that is initiated by a provider who disagrees with a managed care organizations (OhioRISE Plan's) decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.
In the Next Generation Medicaid managed care program, the EMR will be conducted by Permedion. This vendor has a contract with ODM to perform the EMR.

To request an EMR, providers must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the OHIORISE's internal provider appeal or claim dispute resolution process. Failure to exhaust OhioRISE's internal appeals or claim dispute resolution process will result in the provider's inability to request an EMR.

EMR is only available to providers for services delivered to members enrolled in Medicaid managed care and/or OhioRISE. The EMR process is not currently available in the MyCare Ohio and the Single Pharmacy Benefit Manager (SPBM) programs.

An EMR can be requested by a provider as a result of:

- The OhioRISE Plan's service authorization denial, limitation, reduction, suspension, or termination (includes pre-service, concurrent, or retrospective authorization requests) based on medical necessity; or

- The OhioRISE Plan's claim payment denial, limitation, reduction, suspension, or termination based on medical necessity.

Denials, limitations, reductions, suspensions, or terminations based on lack of medical necessity include, but are not limited to decisions made by the plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes pre-service, concurrent, and retrospective reviews).
- Clinical judgement or medical decision making (i.e., referred to a licensed practitioner for review) is involved.
- A clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC 5160-1- 01, including EPSDT criteria, and/or the OHIORISE's clinical coverage or utilization management policy or policies) is not met.

The OhioRISE Plan is required to notify providers of their option to request an EMR as part of any denial notification.

How to Request External Medical Review

Requesting EMR:

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or provider claim dispute process has been exhausted. Providers must complete the "Ohio Medicaid MCE External Review Request" form located at www.hmspermedion.com (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from the OhioRISE Plan (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing case.

Providers must upload the request form and all supporting documentation to Permedion's provider portal located at **ecenter.hmsy.com** (new users will send their documentation through secured email at **IMR@gainwelltechnologies.com** to establish portal access).
Note: When requesting an EMR, providers may submit new or other relevant documentation as part of the EMR request. If the OhioRISE Plan determines the provider's EMR request is not

eligible for an EMR and the provider disagrees, ODM or its designee will determine if an EMR is appropriate. The EMR process does not interfere with the provider's right to request a peer-to-peer review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions. Once the provider has submitted the EMR request, they do not need to take further action.

The EMR Review:
After the EMR request has been submitted, Permedion will share any documentation shared by the provider with the OhioRISE Plan. Following its review of this information the OhioRISE Plan may reverse its denial, in part or in whole. If the OhioRISE Plan reverses any part of its decision the provider will receive a written decision within one business day for expedited prior authorization requests and 5 business days for standard prior authorization requests and notify the EMR entity. If the OhioRISE Plan decides to reverse its decision in part, the remaining will continue as an EMR.

Permedion has 30 calendar days for a standard request and three business days for an expedited request to perform its review and issue a decision.
If the decision reverses the OhioRISE Plan's coverage decision in part or in whole, that decision is final and binding on the OhioRISE Plan.

If the decision agrees with the OhioRISE Plan’s decision to deny, limit, reduce, suspend, or terminate a service, that decision is final.

For reversed service authorization decisions, the OhioRISE Plan must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the OhioRISE Plan receives the EMR decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the OhioRISE Plan must pay for the disputed services within the timeframes established for claims payment in Appendix L of the Provider Agreement.
For more information about the External Medical Review, please contact Permedion at **1-800-473-0802**, and select Option 2.

Section VIII - Claims Information

Process and requirements for the submission of claims
Link to PNM system

Provider Network Management (PNM) System Overview

Under Ohio Next Generation of Managed Care, the introduction of Provider Network Management System was developed to help providers, managed care organization and entities (MCEs), and Ohio Department of Medicaid (ODM) to improve data exchanges. The new system will replace the current MITS system and provider portal.

The PNM module serves as the single-entry point for secure portal functions such as claims submissions, prior authorizations, and member eligibility verification.
For more information, please refer to:
managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

Overview

Aetna Better Health of Ohio processes claims for covered services provided to members in accordance with applicable policies and procedures, and in compliance with applicable state and federal laws, rules, and regulations. On February 1, 2023 the Fiscal Intermediary (FI) began processing of claims via **the Electronic Data Interchange (EDI)**. Fee-for-service claims submitted to the EDI are processed, adjudicated, and paid by the FI. Managed care claims submitted via the EDI will be routed to the MCOs for processing, adjudication, and payment. Additional FI functionality will come later related to portal claims submitted via the Provider Network Management (PNM) portal. Providers, trading partners, and managed care entities will not directly interact with the FI.

Billing Encounters and Claims Overview

Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the claim processing system.

Again, failure to use current coding guidelines may result in a delay in payment and/or rejection of a claim.

When to Bill a member

All providers must adhere to federal financial protection laws and are prohibited from balance billing any member beyond the member's cost sharing.

- A member may be billed only when the member knowingly agrees to receive non-covered services under the OhioRISE plan.
- Provider MUST notify the member in advance that the charges will not be covered under the program.
- Provider MUST have the member sign a statement prior to the services being rendered agreeing to pay for the services and place the document in the member's medical record.

When to File a Claim

All claims are to be submitted electronically to through the ODM Fiscal Intermediary/EDI using the Payer ID#: 45221. Before submitting a claim through your clearinghouse, please make sure your clearinghouse is compatible with the FI.

Clean Claims

We require clean claim submissions for processing. A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.

Timely Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

Participating Providers:

- New Claim Submissions – Please consult your contract for your contractual timely filing limit for new claims. For hospital inpatient claims, date of service means the date of discharge of the member.
- Claim Disputes and Resubmissions – Please consult your contract for your contractual timely filing limit for disputes and corrected claims. For hospital inpatient claims, date of service means the date of discharge of the member.

Non-Participating Providers New Claim Submissions

- Claim submissions must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. For hospital inpatient claims, date of service means the date of discharge of the member.
- Claim Disputes and Resubmissions – Claim disputes and corrected claims must be filed within 365 days from the date of provision of the covered service or eligibility-posting

deadline, whichever is later. For hospital inpatient claims, date of service means the date of discharge of the member.

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

Injuries Due to an Accident

Medicare and Medicaid laws only permit subrogation in cases where there is a reasonable expectation of third-party payment. In cases where legally required insurance (i.e., auto-liability) is not actually in force, we are required to assume responsibility for primary payment.

How to File a Claim

Beginning February 1, 2023, all claims submitted by trading partners, with dates of service on and after February 1 must be sent to the new Electronic Data Interchange (EDI), flow through the FI, and then route to the health plan for processing and payment

Important Points to Remember

We do not accept direct Electronic Data Interchange (EDI) submissions from our providers. We do not perform any 837 testing directly with our providers but perform such testing with Change Healthcare.

Correct Coding Initiative

We follow the same standards as Correct Coding Initiative (CCI) policy and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit: **cms.hhs.gov/NationalCorrectCodInitEd/** . We utilize ClaimsXten® as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim ConnectionTM.

Clear Claim Connection is a web-based, stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimsXten. It enables us to share with our providers, the claim auditing rules, and clinical rationale inherent in ClaimsXten.

Providers will have access to Clear Claim Connection through our website (**AetnaBetterHealth.com/Ohiorise/index.html**) and a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim, so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure.
- Are necessary to accomplish the comprehensive procedure.
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of incorrect coding include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

Modifiers

In order to communicate detailed information in an efficient, standardized way, modifiers are two character suffixes that healthcare providers or coders attach to a CPT or HCPCS code to provide additional information about the practitioner or procedure. It is extremely important to accurately report modifiers as they are used to count towards soft limits, price services, and adjudicate claims. Procedure modifiers designated to practitioner type and licensure level are required for OhioRISE in order to describe specific circumstances and align appropriate rate pricing.

Applicable behavioral health provider type and specialty modifiers can be found in the Provider Requirements and Reimbursement Manual. Please see this reference for more information: **bh.medicaid.ohio.gov/Portals/0/2-1-2022%20BH%20Manual%20FV%201_21.pdf**

Claim Disputes and Resubmissions – Please consult your contract for your contractual timely filing limit for disputes and corrected claims. For hospital inpatient claims, date of service means the date of discharge of the member.

Claim Resubmission

Non-participating providers have 365 days from the date of service to resubmit a revised version of a processed claim. Participating providers should refer to their contract for timely filing and resubmission timeframes. The review and reprocessing of a claim do not constitute a reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

Resubmissions must be submitted electronically with a frequency code of 7 or 8.

Checking Status of Claims

Providers may check the status of a claim by accessing our secure website **AetnaBetterHealth.com/Ohio** or by calling the Claims Inquiry Claims Research (CICR) Department **1-833-711-0773 (option 2)**.

Online Status through our Secure Web Portal

We encourage providers to take advantage of using online status, as it is quick, convenient, and can be used to determine status for multiple claims.

Monitoring claims and EOBs

Provider Remittance Advice

We generate checks weekly. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to make certain proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission.

Providers who are interested in receiving electronic remittance advices from the new EDI will need to sign up. Providers must have enrolled using the ODM-06306 835 designation form which is located **Authorized Trading Partners (ohio.gov)**. By using this form, providers will receive all 835 electronic remittance advices (ERA) from all payers, i.e., Change Healthcare and MCEs. The PDF versions of the remittance advices from all payers will be available via the PNM portal.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.
Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Ohio for previous overpayments not yet recouped or funds advanced.

- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment, depending on the terms of the Provider Agreement.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of Ohio due to overpayment.
- Reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of "REVERSED" in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of Ohio after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically, then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed, along with the last four digits of the bank account to which the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.

  The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.

The Claim Header area of the remit lists information pertinent to the entire claim.

This includes:

- Member Name
- ID
- Birth Date
- Account Number
- Authorization ID, if obtained
- Provider Name
- Claim Status
- Claim Number
- Refund Amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information, as well as grievance rights information.

An electronic version of the Remittance Advice can be obtained. In order to qualify for Electronic Remittance Advice (ERA), you must submit claims through Electronic Data Interchange (EDI) submissions and receive payment for the claim by Electronic Funds Transfer (EFT). You must also have the ability to receive ERA through 835 files. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Experience Department for assistance with this process.

Payment in Full Information

The OhioRISE payment for any covered services constitutes payment in full and OhioRISE will ensure its subcontractors do not charge members, their custodians, or ODM any additional co-payment, cost sharing, down payment, or similar charge, refundable or otherwise.

Payment of Claims

We process claims and notify providers of outcomes using remittance advice. Providers may choose to receive checks through the mail or electronically. We encourage providers to take advantage of receiving Electronic Remittance Advices (ERA), which are received much sooner than remittance advice received through the mail, enabling you to post payments sooner.

All managed care claims submitted by trading partners, with dates of service on and after February 1 must be sent to the new Electronic Data Interchange (EDI), flow through the FI, and then route to the selected MCEs for processing and payment. Providers who submit managed care claims through direct data entry (DDE) will do so via the appropriate managed care portal. Aetna will conduct the usual adjudication of the claim.

Through Electronic Funds Transfer (EFT), providers have the ability to direct funds to a designated bank account. We encourage you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. Payment from the OhioRISE plan will be made on separate check.

Aetna Better Health of Ohio is partnering with Change Healthcare to introduce the new EFT Registration Services (EERS), a better and more streamlined way for our providers to access payment services. EERS will offer providers a standardized method of electronic payment while also expediting the payee enrollment and verification process. Providers will be able to use the Change Healthcare tool to manage EFT with multiple payers on a single platform.
EERS will give payees multiple ways to set up EFT in order to receive transactions from multiple payers. If a provider's tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the payee for multiple payers. Registration can also be completed using a national provider identifier (NPI) for payment across multiple accounts.

Providers who currently use Change Healthcare as a clearinghouse will still need to complete EERS enrollment, but providers who currently have an application pending with Change Healthcare will not need to resubmit. Once enrolled, payees will have access to the Change Healthcare user guide to aid in navigation of the new system.

Process and requirements for appeal of denied claims

Provider Claims Dispute Process

Claim Resubmission

Non-participating providers have 365 days from the date of service to resubmit a revised version of a processed claim. Participating providers should refer to their contract for timely filing and resubmission timeframes. The review and reprocessing of a claim do not constitute a reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

Resubmissions must be submitted electronically with a frequency code of 7 or 8.

Section IX - Care Coordination

Aetna Better Health of Ohio focuses on relationship building, promoting choice among members and caregivers; and assisting in the coordination of the full continuum of behavioral health, social care, and other services. The objective is to make certain that members receive care in the most integrated, least-restrictive community setting compatible with optimal functioning and personal preferences.

Identifying Members Needs

The OhioRISE plan offers care coordination to all members enrolled in the OhioRISE program. Care coordinators are experienced at working with children, youth, and families and they know what services are available for a member through the OhioRISE program, from the member's Medicaid managed care organization (MCO), and within the community. Every OhioRISE member is contacted soon after they enroll. Based on the assessment that was done to determine eligibility for the OhioRISE program, the member will be assigned an initial level of care coordination, called a tier.

For members who are placed in Tier 2 (moderate) or Tier 3 (intensive) care coordination, the care coordination services will be provided by a care management entity (CME). CMEs are contracted with the OhioRISE plan to provide care coordination. For moderate and intensive levels, the CME will assign a care coordinator. CMEs and their care coordinators are located in the area where the members live and know what services are available. They have experience in working with the child-serving systems in the state and will be your partner in care decisions to improve your member's behavioral health outcomes. If a member is assigned to Tier 1 (limited), the care coordination will be provided directly by the OhioRISE Plan care coordinator.

Once members are enrolled in the plan, the assigned care coordinator will schedule an initial visit at the member's home or a place of choice. During this first and subsequent visit, the member, the care coordinator, and family members or responsible parties will:

- Complete an initial assessment. This assessment lets us learn more about behavioral and medical healthcare needs. We also obtain information about the member's past health care and what services they are currently receiving.
- Review and discuss member's current behavioral health concerns to learn more about the needs.
- Help the member/family to learn more about their condition(s).
- Talk about what level of care coordination (tier) may be needed and most beneficial and whether the member/family agree or disagree with that level.
- Identify who the member/family wants to participate in the Child and Family Team (CFT).
- Work together on a Child and Family-Centered Care Plan (CFCP) which makes sure that the member's behavioral health needs are met.
- Explain how to get services for crisis situations.
- Set up a schedule for regular contacts through visits and telephone calls.
- Identify what services the member/family need help with arranging and how the care

coordinator can assist.
- Learn how the care coordinator will help with referrals to specialist care, work with healthcare providers, state child-serving agencies, and organizations.
- Learn how to contact their assigned care coordinator.
- Explain what to do if the member/family want to change assigned care coordinator or assigned care management entity (CME).

OhioRISE services

All OhioRISE covered services are outlined in the Ohio Administrative Code rule 5160-59-03, including existing behavior health services and the following new and improved services available through OhioRISE:

- **Care coordination at three different levels:**
  - Tier 1: Limited Care Coordination (LCC) is delivered by Aetna and is for children or youth needing lower intensity care coordination.
  - Tier 2: Moderate Care Coordination (MCC) is delivered by contracted regional care management entities (CMEs) and includes strategies informed by wraparound principles.
  - Tier 3: Intensive Care Coordination (ICC) is delivered by contracted regional CMEs and is consistent with principles of High-Fidelity Wraparound. Tier 3 is for children and youth with the greatest behavioral health needs.
- **Intensive Home-Based Treatment (IHBT)** – Provides intensive, time-limited behavioral health services for children, youth, and families that help stabilize and improve the child or youth's behavioral health functioning.
- **In-state Psychiatric Residential Treatment Facilities (PRTFs**) – This service will be available in-state beginning in January 2023. Today it's covered when children or youth need this level of care from facilities located outside Ohio. Ohio's PRTF service will keep children and youth with the most intensive behavioral health needs in-state and closer to their families and support systems.
- **Behavioral Health Respite** – Provides short-term, temporary relief to the primary caregiver(s) of an OhioRISE plan enrolled youth, to support and preserve the primary caregiving relationship.
- **Primary Flex Funds** – Provides funding to purchase services, equipment, or supplies not otherwise provided through Medicaid that addresses a need in a child or youth's service plan. Funds must be used to purchase services/items that will reduce the need for other Medicaid services, keep kids and families safe in their homes, or help the child or youth be better integrated into the community. See page 45 for more information on primary flex funds.
- **Mobile Response and Stabilization Services (MRSS)** – MRSS provides rapid in-person care when a child or youth is experiencing significant behavioral or emotional distress. It's available 24 hours a day, 365 days a year, and is delivered in the home, school, or at another location in the community. This service is available to any child or youth covered by Ohio Medicaid.

OhioRISE 1915(c) Waiver Services

- **Out-of-Home Respite:** A service provided outside of the youth's home that will provide short-term temporary relief to the primary caregiver or caregivers of an OhioRISE plan enrolled youth.
- **Transitional Services and Supports**: Services to support youth and their families who are experiencing changes in circumstances/locations or other qualifying conditions.
- **Secondary Flex Funds:** Services, equipment, or supplies, not otherwise provided through the waiver or through the Medicaid state plan, that are designed to meet a need of the youth in order to address behaviors. Additional information on the OhioRISE 1915(c) waiver services is available in chapters: **5160-59-05 OhioRISE HCBS waiver: covered services and providers; 5160-59-05.1 OhioRISE HCBS waiver: out-of-home respite; 5160-59-05.2 OhioRISE HCBS waiver: transitional services and supports; and 5160-59-05.3 OhioRISE HCBS waiver: secondary flex funds**
- Role of provider in care coordination and care management programs in accordance with OAC rule 5160-26-05.1

A primary care physician (PCP) assigned care coordinators, members of the Child and Family Team (CFT) or treating practitioners/providers are responsible for initiating and coordinating a member request for authorization through Aetna's Secure web portal, Availity, or they may need to contact the Aetna Better Health of Ohio's Prior Authorization Department directly to verify or confirm a prior authorization.

The requesting provider is responsible for complying with our prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims.

Utilization Management (UM) decision making is based on appropriateness of care and service and existence of coverage. Aetna does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

For those services requiring prior authorization, participating and nonparticipating providers must obtain pre-service authorization from us before providing clinical services, procedures, or hospitalizations which require prior authorization. Noncompliance with pre-service authorization policies and procedures may result in denial or delay of reimbursement. A list of services that require prior authorization can be found on our website. Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out-of-network services require authorization (see below for exceptions). Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment.

Care Coordination Delegation information

Mental Health/Substance Abuse Services

In order to meet the needs of our members, Aetna Better Health of Ohio will provide a continuum of behavioral health services to members at risk of or suffering from mental, addictive, or other behavioral disorders. We are an experienced behavioral healthcare organization and have contracted with providers who are experienced in providing behavioral health services to the Ohio population.

Referral Process for Members Needing Mental Health/Substance Abuse Assistance

Members will be able to self-refer to any participating mental health/substance abuse (MH/SA) provider within our network without a referral from their primary care provider (PCP).

Coordination of Mental Health and Physical Health Services

We coordinate physical and mental health care services for members through our Child and Family Team (CFT) that is led by each member's assigned care coordinator or their care management entity (CME). Coordination and care and services includes screening, evaluations, evidence-based treatment and/or referrals for physical health, behavioral health, or substance use disorder, dual or multiple diagnoses, and developmental disabilities. With the member's permission, our care coordination staff can facilitate coordination of care coordination related to substance abuse screening, evaluation, and treatment.

Members seen in the primary care setting may present with a behavioral health condition, which the primary care provider (PCP) must be prepared to recognize. PCPs are encouraged to use behavioral health screening tools, treat behavioral health issues that are within their scope of practice and refer members to behavioral health providers when appropriate. Members seen by behavioral health providers must be screened for co-existing medical issues. Behavioral health providers must refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's consent.

Behavioral health providers may also provide physical health care services if they are licensed to do so. Mental Health/Substance Abuse (MH/SA) providers are asked to communicate any concerns regarding the member's medical condition to the PCP, with the members consent if required, and work collaboratively on a plan of care.

Section X - Reporting

Member Medical Records – the OhioRISE plan's documentation, legibility, confidentiality, maintenance, and access standards for member medical records; member's right to amend or correct medical record in accordance with OAC rule 5160-26-05.1

Medical Records Review

Our standards for medical records have been adopted from the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within our provider network. Below is a list of our medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of our Quality Management initiatives to maintain continuity and effective, quality patient care.
Provider records must be maintained in a legible, current, organized, and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health of Ohio members immediately and completely available for review by the Ohio Department of Medicaid (ODM) and/or federal officials at the provider's place of business, or forward copies of records to the ODM upon written request without charge.
Medical records must reflect the different aspects of patient care, including ancillary services. The member's medical record must be legible, organized in a consistent manner and must remain confidential and accessible to authorized persons only. Medical records must also comply with Ohio Administrative Code rule 5160-26-05.1.
All medical records, where applicable and required by regulatory agencies, must be made available electronically. All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements:

- Member identification information on each page of the medical record
- Documentation of identifying demographics including the member's name, address, telephone number, employer, Member identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative.
- Complying with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to, obtaining any required written member consents to disclose confidential medical records for complaint and appeal reviews.
- Hospital discharge summaries. (Discharge summaries are included as part of the medical record for (1) hospital admissions that occur while the patient is enrolled in Aetna Better Health of Ohio and (2) prior admissions as necessary.)
- Mental health/substance abuse (MH/SA) health history and MH/SA health referrals and services provided, if applicable, including notification of MH/SA providers, if known, when a member's health status changes or new medications are prescribed.
- Documentation as to whether an adult member has completed advance directives and location of the document. (Advance directives include Living Will and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of healthcare when the individual is incapacitated.)

- Documentation related to requests for release of information and subsequent releases, and
- Documentation that reflects that diagnostic, treatment, and disposition information related to a specific member was transmitted to the primary care physician (PCP) and other providers, including MH/SA providers, as appropriate, to promote continuity of care and quality management of the member's healthcare.
- Entries – Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider should countersign care rendered by ancillary staff. Alterations of the record will be signed and dated.
- Provider identification – Entries are identified as to author.
- Legibility – Again, the record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

Medical Records Standards

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals must agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services. Detailed information on Medical Records Standards can be found in Chapter 4 of this manual.

Medical Records

The advance directive must be prominently displayed in the adult patient's medical record. Requirements include:

- Providing written information to an adult patient regarding each individual's rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting, in the member's medical record, whether the adult patient has been provided the information, and whether an advance directive has been executed.
- Not discriminating against a member because of their decision to execute, or not execute, an advance directive and not making it a condition for the provision of care.
- Educating staff on issues related to advance directives, as well as communicating the member's wishes to attending staff at hospitals or other facilities.
- Educate patients on advance directives.

For additional information about medical record requirements, please visit Chapter 10 of this manual.

As a prerequisite for participation or continued participation in our network, all providers must maintain advance directive policies and make them available to Aetna Better Health of Ohio upon request.

Policies and procedures for the OhioRISE plan's action in response to undelivered, inappropriate, or substandard health care services in accordance with OAC rule 5160-26-05.1

Aetna Better Health of Ohio has an aggressive, proactive Fraud, Waste, and Abuse (FWA) Program that complies with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. Our Special Investigations Unit (SIU) is a key element of the program. The SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste, or abuse to the appropriate state and federal agencies as mandated by Ohio Administrative Code rule 5160-26-06. During the investigation process, the confidentiality of the patient and or people referring the potential fraud and abuse case is maintained.

We use a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Experience, Member Services, Medical Management, as well as providers and members, share the responsibility to detect and report fraud. Our review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Special Investigations Unit (SIU)

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

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information, or want to report potential fraud, waste, or abuse. The number is 1-800-338-6361. The hotline has been acknowledged as an effective tool, and we encourage providers and contractors to use it.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna's huge volume of claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely, both internally with the Compliance Department, and externally with law enforcement as appropriate, to conduct in-depth analyses of case-related data.

Reporting Provider Preventable Conditions (PPCs)/Hospital Acquired Conditions (HACs)

Provider Preventable Conditions (PPCs)/Hospital Acquired Conditions (HACs)

Medicaid funding is not permitted to be used for any provider-preventable condition (PPC). Aetna Better Health of Ohio is responsible for ensuring that the prohibition will not negatively affect the loss of access to care or services of a member. In addition, ODM reporting is required for all PPCs regardless of the reason for the event.

Incident Reporting –

Information to Report

When reporting the incident, please be prepared to provide the following information if applicable:

- The identity of the person making the report and where they can be found.
- The name and address of the healthcare facility.
- The names of the operator and administrator of the facility, if known.
- The name of the subject of the alleged physical abuse, mistreatment, or neglect, if known.
- The nature and extent of the physical abuse, mistreatment, or neglect.
- The date, time, and specific location of the occurrence.
- The names of next of kin or sponsors of the subject of the alleged physical abuse, mistreatment, or neglect, if known.
- Any other information which the person making the report believes would be helpful to assist in investigating the incident.

Reporting Party	Suggested Reporting Timeframes	Agency	Additional Agency
Children and youth 21 years of age or younger)	Immediately if in danger	The Ohio Department of Job and Family Services at **1-855-O-H-CHILD (855-642-4453**). An automated telephone directory will link caller directly to a child welfare or law enforcement office in their county. Reports can be anonymous. **jfs.ohio.gov/ocf/reportchildabuseandneglect.stm**	Local police department (**911**)

All Others	Within 24 hours	If the incident and/or events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion. (Section 1150B of the Social Security Act) Ohio Department of Health (ODH) Hotline **1-800-342-0553**	N/A
Domestic Violence	N/A	The State of Ohio requires that healthcare providers handle reports of domestic violence in a specific manner. If the victim presents with felony-level injuries, such as gunshot wounds, stabbings, second- or third-degree burns, or other serious injuries, healthcare workers providing aid to these victims are required to report these injuries to law enforcement. For additional reporting details, please visit the following website: **familysafetyandhealing.org/site/assets/files/1404/odvn_protocol.pdf**	N/A

Section XI - Next Generation Managed Care Program

The Single Pharmacy Benefit Manager (SPBM) provides pharmacy services across all Ohio Medicaid managed care plans and members. The SPBM does not include MyCare Ohio members.

The following processes are in place:

- If the member is only enrolled in OhioRISE, continue to submit pharmacy claims and prior authorizations to the fee-for-service (FFS) pharmacy benefits administrator, Change Healthcare.
- Pharmacy claims and prior authorizations for members enrolled in Medicaid FFS should continue to be submitted to the FFS pharmacy benefits administrator, Change Healthcare.
- Pharmacy claims and prior authorizations for members enrolled in Medicaid FFS will be submitted to the SPBM.

All Medicaid Managed Care members will be automatically enrolled with the SPBM under a 1915(b) waiver. Additionally, Gainwell Technologies will be required to contract with all enrolled pharmacy providers that are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that will ensure access for all members statewide.

For more information about the SPBM or PPAC initiatives, please email:
MedicaidSPBM@medicaid.ohio.gov

OhioRISE | aetna