MANAGED CARE – BEHAVIORAL HEALTH CONTACTS & RESOURCES

Updated 6/7/2018

**AETNA BETTER HEALTH**

Provider Contracting: Matt Koblens
Provider Relations: Rick Welch
KoblensM@AETNA.com WelchR@aetna.com

Director of Behavioral Health:
Afet Kilinc
Office: 959-299-7278; Cell: 614-254-3229
KilincA@AETNA.com

Authorizations: 1-855-364-0974, option 2, then 4
Provider Manual:
https://www.aetnabetterhealth.com/ohio/providers/manual

**BUCKEYE HEALTH PLAN**

Provider Contracting: Christy L. Wilson
Provider Relations: Amy Daggett or Charlene McCarthy
Christy.L.Wilson@centene.com BehavioralHealth@centene.com
Phone: 866-246-4356 ext. 24291 Phone: 866-246-4356 ext. 24291

Director of Behavioral Health:
Laura Paynter
lpaynter@centene.com
Phone: 216-643-1846; Cell: 216-319-0481

Authorizations: 800-224-1991
Provider Manual:
https://www.buckeyehealthplan.com/providers/resources/forms-resources.html

*NOTE: Please see contracting for questions related to your MCO contract and questions about your how your contract is configured in our claims system (e.g. timely filing, services billable). Please use provider relations for any issues related to claims payment, general questions about member or provider resources, and information about provider initiatives at the MCO. If you would like to be added to a distribution list to make sure you receive all provider newsletters and fax blasts, please notify the Provider Relations team.*
CARESOURCE:

Provider Contracting:
www.caresource.com/providers/ohio/ohio‐providers/plan‐participation/

Provider Relations:
Terri Opalka
Phone: (216) 896-8191 (440) 361-9885 Cell
Terri.Opalka@CareSource.com

Director of Behavioral Health:
Terry R. Jones
Phone: (614) 318-3483
Terry.Jones@caresource.com

Authorizations: (800) 488-0134
Provider Manual:
https://www.caresource.com/providers/ohio/ohio‐providers/

MOLINA

Provider Contracting: Provider Relations:
Ellen Landingham Valerie Brandt
(614) 557-3041 (855) 322-4079
MHOBHProviderTeam@molinahealthcare.com BHProviderServices@molinahealthcare.com

Director of Behavioral Health:
Emily Higgins
Emily.Higgins@molinahealthcare.com

Authorizations: (855) 322-4079
Provider Manual:
http://www.molinahealthcare.com/providers/oh/medicaid/manual/Pages/provman.aspx
PARAMOUNT

Provider Contracting: Barb Hoyt
PHCProvider.Contracting@ProMedica.org
Director of Behavioral Health: Hy Kisin, Ph.D.
Hy.Kisin@Promedica.org
Authorizations: (800) 891-2520

UNITED HEALTHCARE

Provider Contracting and Provider Relations: Amanda Fling
Amanda.fling@optum
Director of Behavioral Health: Tracey Izzard
Tracey.Izzard-everett@optum.com
Authorizations: 866-261-7692 or www.uhconline.com
## Managed Care Plans - Operations Guide

### 1. If a member has complex treatment issues and a provider would like additional support from a MCP care manager, how can a provider make a request for this service (incl. urgent requests for assistance)?

<table>
<thead>
<tr>
<th>MCP</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Health Plan</td>
<td>Providers can contact our 24/7 Care Management Call line at the health plan toll free number: 1-855-364-0974 and select option 5. Providers may make a referral to Care Management via fax at 1-866-206-0610 or phone at 1-800-993-6902. If non-urgent, the provider may also use the Provider Portal.</td>
</tr>
<tr>
<td>Buckeye Health Plan</td>
<td>Providers can contact Buckeye Provider Services (866-296-8731) and ask to be directed to a Care Manager or the Care Management Department.</td>
</tr>
<tr>
<td>CareSource</td>
<td>Provider may make a referral to Care Management via fax at 1-866-206-0610 or phone at 1-800-993-6902. If non-urgent, the provider may also use the Provider Portal.</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>Providers can contact us at 1-800-642-4168 and request to be transferred to our Care Management program to make a referral. If urgent assistance is needed for an individual member at the time of referral, please let us know.</td>
</tr>
<tr>
<td>Paramount Advantage</td>
<td>Specific to referring a member for CM: Mon‐Friday 8A‐5P: contact the Utilization/Care Management Department at 419-887-2520 or 1-800-891-2520 After hours: Ask Paramount nurse line number: 1-877-336-6161</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>Behavioral Care Management can be requested by calling 866-261-7692. Medical Care Management can be requested using the following number: 800-508-2581 or faxing 866-508-2581. Please indicate if this request is urgent at the time of referral.</td>
</tr>
</tbody>
</table>

### 2. What transportation vendor do you use and what is the standard benefit for your members?

<table>
<thead>
<tr>
<th>MCP</th>
<th>Transportation Vendor and Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Health Plan</td>
<td>Aetna Better Health of Ohio utilizes Logisticare as our transportation vendor. All emergency transportation is a covered benefit billed directly to the health plan. Non-emergency transportation must be arranged through the Aetna Better Health transportation broker. Waiver members may receive medical or non medical transportation. Non-Waiver members may receive medical transportation only. In order to receive the member must be non-ambulatory with no mileage restriction; for members who are ambulatory they must be traveling over 30 miles. Per our Value Added Benefit Non-Waiver members enrolled in the Dual Program receiving both Medicare and Medicaid benefits are eligible for 30 round trip or 60 one-way transports per calendar year, medical or non-medical with no mileage restrictions</td>
</tr>
<tr>
<td>Buckeye Health Plan</td>
<td>Buckeye utilizes Access2Care for Wheelchair and ambulatory trips. Contact Access2Care at: Medicaid 866-246-4358; MyCare Ohio: 866-548-8289. Stretcher level of service: Members and facilities can call providers directly and they do not need to be in network. The standard transportation benefit for our members is Transportation to and from medically necessary, Medicaid-covered services that are not available within 30 miles of the participant’s home. When the appointment is less than 30 one-way miles from the participant’s home and other transportation is unavailable, transportation is provided for 15 round trip visits or 30 one-way visits per calendar year. Medically necessary trips by wheelchair can do not count towards the member’s annual trip limit. Transportation to Medicaid-covered appointments greater than 30 one-way miles (because services are not available within 30 miles) also does not count towards the member's annual trip limit. NOTE: Members in the Central &amp; Southeast Medicaid region receive 30 round trip or 60 one-way trips</td>
</tr>
<tr>
<td>CareSource</td>
<td>CareSource utilizes Provide-A-Ride for the north half of Ohio and Logisticare for the south half of Ohio. The standard transportation benefit for our members is Transportation to and from medically necessary, Medicaid-covered services that are not available within 30 miles of the participant’s home. When the appointment is less than 30 miles from the participant’s home and other transportation is unavailable, transportation is also provided for 15 round trips or 30 one-way trips per member per calendar year to covered medical, vision, dental appointments, WIC appointments and CDFIS redetermination appointments.</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>Our vendor is Access2Care. Molina Healthcare members get an extra transportation benefit - 30 one-way trips every calendar year to health care services like medical provider, dentist and non-emergency hospital visits, WIC and County Department of Job and Family Services Medicaid renewal appointments. Right after a medical appointment, members can get a ride to the pharmacy to pick up a prescription.</td>
</tr>
<tr>
<td>Paramount Advantage</td>
<td>Our vendor is Access2Care. Molina Healthcare members get an extra transportation benefit - 30 one-way trips every calendar year to health care services like medical provider, dentist and non-emergency hospital visits, WIC and County Department of Job and Family Services Medicaid renewal appointments. Right after a medical appointment, members can get a ride to the pharmacy to pick up a prescription.</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>UnitedHealthcare utilizes Access2Care as our transportation vendor. The standard transportation benefit is 30 one-way trips per calendar year (January 1st - December 31st, home to appointment (one-way) + appointment to home (one-way) = 2 one-way trips). The Aged Blind Disabled population receive 60 one-way trips per calendar year. Members can use transportation for appointments to standard Medicaid covered services as well as JFS appointments for redetermination.</td>
</tr>
</tbody>
</table>

---

**Aetna Better Health of Ohio utilizes Logisticare as our transportation vendor. All emergency transportation is a covered benefit billed directly to the health plan. Non-emergency transportation must be arranged through the Aetna Better Health transportation broker. Waiver members may receive medical or non medical transportation. Non-Waiver members may receive medical transportation only. In order to receive the member must be non-ambulatory with no mileage restriction; for members who are ambulatory they must be traveling over 30 miles. Per our Value Added Benefit Non-Waiver members enrolled in the Dual Program receiving both Medicare and Medicaid benefits are eligible for 30 round trip or 60 one-way transports per calendar year, medical or non-medical with no mileage restrictions.**
3. How can members access the transportation benefit, and can members choose the type of transport they prefer such as local bus tickets if that is an option?

Please contact Member Services at 1-855-364-0974 (TTY: 7-1-1) or call LogistiCare directly at 1-866-799-4405 for reservation confirmations and no-call returns. Local bus tickets are not currently an option for Aetna Better Health of Ohio members. Members can request their preferred transportation company.

Buckeye Transportation Line: member Services Medicaid: 1-866-246-4588; Member Services: MyCare Ohio: 1-866-549-8288; TTY for hearing impaired: 1-800-750-0750

Transportation for non-emergency ambulance services should be arranged directly by the member with their preferred provider and not scheduled through the Buckeye Transportation Line. The ambulance provider does not need to be in-network. The transportation options for members include bus passes and family and friends mileage reimbursement. When members call to arrange transportation, they are asked if they would be interested in a mass transit option, i.e. bus pass (if available in their area) as those options give the member more control over their schedule. If a member has more than 5 scheduled trips in a month, the transportation vendor may offer a monthly bus pass as an alternative to daily bus passes as a more convenient and cost-effective option for the member.

To schedule transportation members may call 866-383-9817 (M-F/8:30-5:00). Rides can be scheduled up to 30 days in advance of the appointment, with a minimum 2 business day notification requirement (Monday - Friday). To schedule, members must provide:

- Paramount Advantage ID #
- Member's home address and phone #
- Date and time of appointment
- Address and phone # of the appointment destination
- Members may choose the transportation option that best suits them including daily or monthly bus pass (in available markets), gas reimbursement or scheduled taxi/ambulette/paravan service. All options are arranged through the transportation vendor Access2Care.

To schedule transportation members may call 1-800-895-2017 (M-F 7:00A-7:00P) and ask to schedule transportation. The call should be made 48 hours in advance of the appointment unless it is an emergency. Members have access to 15 round trips or 30 one-way trips per calendar year. If the service being sought is more than 30 miles one way, the health plan must provide transportation if needed and such trips do not count towards the health plan transportation benefit limits. Trips may be used to get to doctor's visits, WIC appointments, vision care, dental care, pharmacy, and to the CDIFS offices for eligibility re-determination appointments. When scheduling transportation, our transportation consultants will help evaluate the best form of transportation for members. We can provide bus tokens if appropriate.

4. If a parent needs children or a caregiver to accompany them on transportation, how do they need to make a special request?

Members can have children or a caregiver accompany them on trips. At the time of the trip reservation set-up the representative will note that the child will be accompanied by another person/people. Names and relationship to the member will have to be provided for any additional riders. Members and one additional passenger (escort) are allowed on a space available, case-by-case basis. An escort is necessary for a Member who is blind, deaf, mentally ill, mentally disabled/develomentally delayed, or under the age of 18; escort not permitted otherwise. The escort can be the member's parent, legal guardian, caregiver, care worker, or an employee of the transportation provider. If the child is under 18 years of age, must be accompanied by a parent or guardian.

The member or representative needs to inform Buckeye of additional passengers or special needs required at the time of the transportation request. One additional passenger allowed, unless member is the sole caregiver of more than one minor child. Accommodation is dependent upon notification & available space and will be facilitated whenever possible without impacting other member's pre-arranged transportation. If under 18 years of age, must be accompanied by a parent or guardian.

The member or representative needs to inform CareSource of additional passengers or special needs required at the time of the transportation request. One additional passenger allowed, unless member is the sole caregiver of more than one minor child. Accommodation is dependent upon notification & available space and will be facilitated whenever possible without impacting other member's pre-arranged transportation. If under 18 years of age, must be accompanied by a parent or guardian.

If the child is a member of Molina Healthcare, the parent/guardian can get a ride to appointments with the child's provider, even if the child will not be at the appointment. A parent/guardian can get this ride even if they are not a member.
The parent/guardian should tell the transportation representative about your situation when you call.

If members over 18 years of age, without an established medical need, are expected to use Paramount Advantage transportation without an escorting rider. They are permitted to have one additional passenger. Exceptions to this rule include:

- Members unable to secure child care for additional children. *Authorised additional rider information MUST be provided by the member when scheduling transportation of the driver can deny the transport at the time of pickup.
- It is the responsibility of the parent or guardian to provide a safety/car seat as required by Ohio law. There is no exception to this safety policy.

Should a member need special assistance when scheduling transportation, they should inform the transportation consultant of such needs when scheduling the transport. This might include providing transportation for a caregiver, other children or other mobility needs. Accommodation is also dependent upon available space or availability to meet the full transportation needs of the member. If the member is under the age of 18 years, the member must be accompanied by a parent or guardian or other authorised representative.
<table>
<thead>
<tr>
<th>MCO</th>
<th>Outcomes Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health of Ohio</td>
<td>Measured through HEDIS measures developed by our accrediting body NCQA and CMS Core measures. Please see the MyCare Ohio Provider Agreement on the Ohio Medicaid website for detailed information on the HEDIS measures being utilized specifically in MyCare Ohio Program. In addition, Aetna Better Health of Ohio performs annual member satisfaction surveys that inquire about ability to obtain timely access to treatment services and satisfaction with services received. The results are reviewed for any corrective action plans needed with our provider network.</td>
</tr>
<tr>
<td>Buckeye</td>
<td>Will be monitoring quality performance through the HEDIS measures outcomes developed by NCQA. For access to the specific measures, please view the Managed Care Provider Agreement located on Medicaid's website. Buckeye also monitors member satisfaction through annual surveys.</td>
</tr>
<tr>
<td>Medicaid Managed Care plans</td>
<td>Measured through HEDIS measures developed by our accrediting body NCQA. Please see the Managed Care Provider Agreement on the Ohio Medicaid website for detailed information on the HEDIS measures being utilized specifically in Ohio Medicaid. In addition, all NCQA accredited health plans perform periodic member satisfaction surveys that inquire about ability to obtain timely access to treatment services and satisfaction with services received. The results are reviewed for any correction action plans needed with our provider network.</td>
</tr>
<tr>
<td>Medicaid Managed Care plans</td>
<td>Measured through HEDIS measures developed by our accrediting body NCQA. Please see the Managed Care Provider Agreement on the Ohio Medicaid website for detailed information on the HEDIS measures being utilized specifically in Ohio Medicaid.</td>
</tr>
<tr>
<td>Medicaid Managed Care plans</td>
<td>Measured through HEDIS measures developed by our accrediting body NCQA. Please see the Managed Care Provider Agreement on the Ohio Medicaid website for detailed information on the HEDIS measures being utilized specifically in Ohio Medicaid.</td>
</tr>
</tbody>
</table>

(Added 6/7/2018)
Contracting and Credentialing

1. Can I bill a Managed Care Plan without being contracted?

Non-participating providers may submit claims to Aetna for services rendered to MyCare members during the transition period. However, after the transition period, non-participating providers will need an authorization for services in order for claims to pay.

You can request a contract by submitting a Non-Participating Provider Contract Request Form, which can be found on our website at: http://www.molinahealthcare.com/providers/oh/duals/forms/Pages/fuf.aspx

Please fax the form to 866-384-1226 and note on the form that your organization is a MHAS and/or ODADAS certified facility. Once your contract request is received, you will be contacted by a Provider Relations Representative who can assist you with any questions you might have.

Yes, providers without a contract can bill the health plan through the transition period. UHC will require basic information to execute the payment. After the continuity of care period, non-contracted providers will need a prior authorization for all services in order for claims to pay.

2. How do I start the contracting process?

Call us at 1-855-384-0574, Option 2, then Option 5 or you can email us at OH_ProviderServices@Aetna.com. When OhioMHAS certified Community Mental Health Centers (CMHC) or Community Behavioral Health Centers (CBHC) contact Aetna for contracting, please indicate that you are a CMHC or CBHC provider and currently do not have a contract with Aetna.

You can find contact information for our contracting team on the “Plan Contacts” tab.

You can find contact information for our contracting team on the “Plan Contacts” tab.

Call us at 800-488-0134 and follow the prompts to be directed to one of our Credentialing staff.

Payment for services rendered by non-contracted out-of-network providers are not guaranteed and are subject to additional prior authorization requirements. Additionally, non-contracted out-of-network providers are not eligible for value-based reimbursement payment methods.

CareSource will honor the continuity of care period post Re-design and Carve-in and, if services are being rendered by a non-contracted out-of-network provider, continue to attempt to contract with that organization and/or attempt to link that member with an in-network provider.

Yes, non-contracted providers can bill and submit claims as long as their information is loaded into the CareSource claims systems. If a Non-Parr Provider Profile form will need to be submitted.

This form is available by calling Provider Services (1-800-488-0134) or visiting our website: https://www.caresource.com/providers/ohio/oip"r-providers/provider-materials/forms/

Payment for services rendered by non-contracted out-of-network providers are not guaranteed and are subject to additional prior authorization requirements. Additionally, non-contracted out-of-network providers are not eligible for value-based reimbursement payment methods.

CareSource will honor the continuity of care period post Re-design and Carve-in and, if services are being rendered by a non-contracted out-of-network provider, continue to attempt to contract with that organization and/or attempt to link that member with an in-network provider.

Molina will honor the continuity of care period set by Ohio Medicaid as part of the managed care implementation and if services are being rendered by an out-of-network provider, continue to attempt to contract with that organization and/or attempt to link that member with an in-network provider.

After the continuity of care period, non-participating providers will need an authorization for services in order for claims to pay.

Participating Provider Contract Request Form, which can be found on our website at: http://www.molinahealthcare.com/providers/oh/duals/forms/Pages/fuf.aspx

Please fax the form to 866-384-1226 and note on the form that your organization is a MHAS and/or ODADAS certified facility. Once your contract request is received, you will be contacted by a Provider Relations Representative who can assist you with any questions you might have.

Yes, non-contracted providers can bill for services without a contract during the transition of care period. Please include, or send through the mail, a W-9 when submitting the claim. A non-participating provider, behavioral health services following the transition period will require an authorization in order for claims to pay.

You can request a contract by submitting a Non-Participating Provider Contract Request Form, which can be found on our website at: http://www.molinahealthcare.com/providers/oh/duals/forms/Pages/fuf.aspx

Please fax the form to 866-384-1226 and note on the form that your organization is a MHAS and/or ODADAS certified facility. Once your contract request is received, you should receive a response within 30 days. Our contract manager will reach out to you and will be your point of contact for all contracting questions and status updates.

You can find contact information for our contracting team on the “Plan Contacts” tab.

You can find contact information for our contracting team on the “Plan Contacts” tab.

Contracted providers are identified in directories, have been credentialed and have fully executed contracts. Participating providers have a Provider Relations Representative that can assist them with any questions they might have.

You can find contact information for our contracting team on the “Plan Contacts” tab.

Yes, any behavioral health provider can bill for services without a contract during the transition of care period. Please include, or send through the mail, a W-9 when submitting the claim. A non-participating provider, behavioral health services following the transition period will require an authorization in order for claims to pay.

You can request a contract by submitting a Non-Participating Provider Contract Request Form, which can be found on our website at: http://www.molinahealthcare.com/providers/oh/duals/forms/Pages/fuf.aspx

Please fax the form to 866-384-1226 and note on the form that your organization is a MHAS and/or ODADAS certified facility. Once your contract request is received, you should receive a response within 30 days. Our contract manager will reach out to you and will be your point of contact for all contracting questions and status updates.

You can find contact information for our contracting team on the “Plan Contacts” tab.

You can find contact information for our contracting team on the “Plan Contacts” tab.
3. What are some common questions that providers have about the Medicaid Provider Services Agreements?

Aetna Better Health of Ohio has received the following questions: the timely filing deadline for claims, the effective date of the contract, obtaining a copy of the signed contract, amending or negotiating the terms of the contract, and the fee schedules. The timely filing deadline may vary from contract to contract and providers should check the terms of the contract for their specific timely filing deadline. The effective date of the contract is the date when it is counter-signed by Aetna. A paper copy of the counter-signed contract is mailed to the provider. If you need a copy of your contract, please contact Aetna’s Provider services at OH_PreviderServices@Aetna.com. Providers should contact Aetna’s contracting contact on Plan Contacts Tab for amending and negotiating the terms of the contract. Providers are reimbursed at 100% of the ODM fee schedule for Medicaid and 100% of the CMS fee schedule for Medicare for behavioral health services. Providers can go to the ODM and CMS websites to review current fee schedules.

CareSource has received questions regarding the effective date of the contract—the effective date is the date the contract was signed but does not obligate the Provider to deliver the service until BH carve-in occurs. Other questions include shared risk and value based contracting—these two areas will be explored in 2019.

Why is no rate sheet included with the contract? Providers are reimbursed at 100% of the ODM fee schedule for Medicaid and 100% of the CMS fee schedule for Medicare and Marketplace for behavioral health services. Providers can go to the ODM and CMS websites to review current fee schedules.

Any service agreement questions can be addressed through our Contracting Team at 866‐246‐4356 ext.24291.

Any service agreements are handled through Credentialing / contracting which will be coordinated via Provider relations which can be reached at 619‐867‐2535 or 1‐800‐891‐2542

4. How can I check my contracting status?

Call us at 1‐855‐384‐0974, Option 2, then Option 5 or you can email us at BH_Contracting@Aetna.com. Please provide the provider’s name, TIN, and NPI. We will respond in 3-5 business days.

For specific questions about the contract, please contact CareSource’s BH Re-design/Carve-in Rapid Response Team by telephone: 855‐708‐4840 or by email: OhioBHInfo@caresource.com.

5. How long does it take to complete the contracting & credentialing process?

What is your process for credentialing community behavioral health providers?

Provider contract / manual includes language, terms, rules, etc. for setting up as a trading partner. Go to www.uhconline.com, Tools & Resources, to access information for how an organization can enroll as a trading partner.

If we do not already have a relationship with the trading partner, they can send emails directly to the following addresses and Paramount will coordinate the process of becoming a trading partner with Paramount.

PHCEDIhelpdesk@ProMedica.org

Information on Trading Partner Enrollment is located within the Molina EDI Companion Guide that can be found on the Molina website at www.MolinaHealthcare.com. The Molina EDI Team is responsible for assisting providers and vendors with trading partner enrollment, testing, and Connectivity Setup. Providers can call 1-866-409-2935 or email the EDI Team at EDI.Claims@MolinaHealthcare.com.

As part of the contracting process, Paramount will credential all provider types (physician, group, facility) in accordance with OAC rule 5160-26-05. We must also follow guidelines from NCQA and URAC on credentialing. The process can take up to 90 days upon receipt of a signed contract and all appropriate credentialing documents.

5. What will an organization need to do to obtain a trading partner agreement (TPA) or business associate agreement (BAA) with your clearinghouse in order to submit claims to your plan?

Providers are not required to obtain a TPA or BAA with your clearinghouse in order to submit claims to your plan.

As part of the contracting process, Ohio Medicaid plans must credential all provider types in accordance with OAC rule 5160-26-05. We must also follow guidelines from NCQA and URAC on credentialing. A contract can take up to 90 days upon receipt of a signed contract and all appropriate credentialing documents.

MyCare Ohio Plans must credential all provider types in accordance with OAC rule 5160-26-05. We must also follow guidelines from NCQA and URAC on credentialing. A contract can take up to 90 days upon receipt of a signed contract and all appropriate credentialing documents.

Ohio Medicaid and MyCare Plans must credential all provider types (physician, group, facility) in accordance with OAC rule 5160-26-05. Ohio plans must also follow guidelines from NCQA and URAC on credentialing. The process can take up to 90 days upon receipt of a signed contract and all appropriate documents.

If contracting as a CBHC facility, Buckeye will not require credentialing of practitioners within the agency but MITS registration is still required for all practitioner types. Buckeye is encouraging agencies to submit a roster of practitioners to ensure we have all practitioner information in our system while MITS registration is being processed. Providers can request a copy of an email at BT_BH_Redesign@AETNA.com.

As part of the contracting process, Paramount will credential all provider types (physician, group, facility) in accordance with OAC rule 5160-26-05. We must also follow guidelines from NCQA and URAC on credentialing. The process can take up to 90 days upon receipt of a signed contract and all appropriate credentialing documents.

## Contact Information

**Billing Guide 7/2/2018**

**MCP Resource Document for CBHCS_06292018**
1. How can I register for your Provider Portal?

Both Par and Non-par providers have several options to register for the Secure Provider Portal. • Call us at 1-800-364-0974, Option 2, then Option 5. • Email us at OH_ProviderServices@Aetna.com. 

Completing the Paper Registration Form is our preferred method of registration. Your form helps us register you for additional systems. Your form also gives us the opportunity to check that your demographic information is also correct in our system.

Go to https://www.buckeyehealthplan.com/login.html. You will be asked various questions regarding your practice to create an account.

Both PAR and non-PAR providers can register on our portal. To register for the portal, visit https://providerportal.caresource.com/OH and click on “Register Here.” You will need your group name, tax name, provider ID and zip code. 

Please note: In order to register, your information must be loaded into the CareSource system. You must have a CareSource assigned provider ID which is auto-generated at the time provider is loaded to our system. Participating providers will receive a letter with their provider ID once they are loaded to the system. Non-participating providers and participating providers who don’t have their provider ID will need to contact Provider Services at 1-800-488-1134 to obtain their ID for portal registration.

Go to www.mymammam.com scroll down to bottom right under providers and click on “create an account.” You will need your tax ID number and NPI number along with a claim number when registering. After following the prompts make sure to check your email for the activation link.

Participating and non-participating Providers can access the portal at My Paramount.org or by calling our Provider Inquiry department at 1-888-891-2564.

2. How can I check client eligibility?

Providers have several options to verify eligibility:

• Call us at 1-855-364-0974, Option 2, then Option 5; 
• Email us at OH_ProviderServices@Aetna.com; 
• Or, you can view a member’s eligibility status through our Secure Provider Portal once you are registered. 

Providers can continue to utilize the MITS portal to check member eligibility as needed.

Providers who would like to use 270/271 transactions to verify Aetna enrollment and obtain the Aetna Member ID can register with our clearinghouse vendor Change Healthcare for this service. Change Healthcare does not require UAT for 270/271 transactions.


Providers can search for members in the portal using multiple types of identification including the CareSource ID, Medicaid ID, Member Name & Date of Birth. If you are not already registered for the CareSource Provider Portal, please register here https://providerportal.caresource.com/CsAuth/Provider/Register.aspx. You can refer to the Portal Registration Training Module for step-by-step instructions at https://www.caresource.com/app-content/uploads/Provider_Portal_Registration.html.

270/271 exchange must be verified with your clearinghouse or using one. CareSource throwhouses that support 270/271 exchanges include the following: Access, AskyFit, ChangeHealthcare, Orlando Systems, Experian Health, RedbendHealth, and TransUnion. CareSource does not require UAT, but new providers may want to check with their trading partner/clearinghouse to verify of UAT is required.

Providers will be able to use the MITS portal to check member eligibility, as well as 270/271 eligibility exchanges through MITS to obtain information on MCO enrollment.

Providers can utilize the Molina Interactive Voice Response (IVR) system at 855-322-4079 or the Molina Webportal to check member eligibility. Providers who would like to use 270/271 transactions to verify Molina enrollment and obtain the Molina Member ID can register with our clearinghouse vendor Change Healthcare for this service. Please see information on how to contact Change Healthcare for EDI/EFT/ERA services on our website at www.MolinaHealthcare.com.

Change Healthcare does not require UAT for 270/271 transactions.

Providers can utilize the MITS portal to identity and validate eligibility also the CareSource’s Member Services department can confirm eligibility specific dates and other eligibility related inquiries at 1-800-462-3589 or 1-888-740-5570.

MITS portal will help identify and validate eligibility also the CareSource’s Member Services department can confirm eligibility specific dates and other eligibility related inquiries at 1-800-462-3589 or 1-888-740-5570.

MITS portal. You may also contact Member Services at 877-542-8306 to verify specific dates of eligibility.
9. How do I get set up to submit claims electronically, including no cost options that you offer?

You can register for WebConnect, our claim portal, at no cost. To register, go to www.aetnabetterhealth.com/ohio/providers/claims. Click the link, WebConnect, to register. Here is where you will find:

- Support information;
- Training materials;
- And, a link to complete your registration.

Call us at 1-855-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com for more information or if you have any trouble.

Best practice is for a provider to establish a relationship with a clearinghouse, because they can submit claims electronically across multiple providers. This reduces administrative cost to the provider. When you establish a relationship with a clearinghouse using the following information specific to CareSource, CareSource payer ID 31114, File Format is 837 ANSI ASC X12N (005010X ERRATA Version)

You can also use RealMed (aka Availty) to submit claims to us at no charge. Information about enrolling with RealMed (aka Availty) can be found at www.availity.com.

Providers can submit electronic claims, one at a time and free of charge on our provider portal.

No cost option: You can sign up for a web portal called “ProviderNet” that offers batch submission of EDI claims to Change Healthcare at no cost to you by visiting https://office.amdevon.com/vendorfiles/molina.html. Providers can register for this service once their first payment has been received by paper check. Providers will need their agency NPI, Tax ID Number, and a nearest check number to register.

Clearinghouse options: Providers can use any clearinghouse. Providers may elect to call Office Ally at 866-575-4120 and ask to sign up with them or simply go out to their website at www.officeally.com - they offer clearinghouse services at low to no charge.

For the complete list of Buckeye’s Trading Partners go to our website https://www.buckeyehealthplan.com/providers/resources/electronic-transactions.html

Although we have direct connections to specific Clearinghouses/Trading Partners, as shown below, provider can submit claims through any Clearinghouses/Trading Partner they wish. Direct connections are with:

- Avecco
- Availty
- Change Healthcare
- Practice Insight
- Quadax
- RelayHealth
- ZirMed

Molina Healthcare currently contracts with Change Healthcare, who is able to accept claims from any trading partner including a clearinghouse or provider acting as their own trading partner. Change Healthcare offers a web portal for submission of batch EDI claims at no cost to providers who act as their own trading partner.

For the complete list of Buckeye’s Trading Partners go to our website https://www.buckeyehealthplan.com/providers/resources/electronic-transactions.html

Although we have direct connections to specific Clearinghouses/Trading Partners, as shown below, provider can submit claims through any Clearinghouses/Trading Partner they wish. Direct connections are with:

- Avecco
- Availty
- Change Healthcare
- Practice Insight
- Quadax
- RelayHealth
- ZirMed

Molina Healthcare currently contracts with Change Healthcare, who is able to accept claims from any trading partner including a clearinghouse or provider acting as their own trading partner. Change Healthcare offers a web portal for submission of batch EDI claims at no cost to providers who act as their own trading partner.

Please utilize the Molina payer ID of 20149 for all types of member coverage.
11. What NPI do I submit on a claim header and at the service line?

If the claim contains multiple rendering practitioners at different service lines the header level rendering provider NPI should be blank and the line level NPI should be that of the provider who rendered that service. For providers that are not required to obtain an NPI, the line level NPI would also be blank. If the claim contains one rendering provider that applies to all service lines the header level NPI field can contain the NPI of the rendering provider as well as each service line. Aetna uses the Medicaid Provider Master File to obtain rendering practitioner information as long as all required practitioners are registered in MITS and affiliated to your agency. Aetna uses rosters as needed if the information needed is not listed on PMF. 

Please submit your organization's NPI number in box 24J as well as box 33a. If your organization is dually certified by MHAS (Provider type 84 and 95) you will need to use specific NPI numbers on claims to distinguish between services under these provider types.

Agency Rosters are not required, but are encouraged. Rosters can be submitted to your organization's Health Partner Manager.

Molina uses the Provider Master File received weekly from Medicaid to obtain rendering practitioner information as long as all required practitioners are registered in MITS and affiliated to your agency. A roster of agency practitioners is requested as part of Molina’s CBHC contracting process for claims system loading purposes. The NPI of the rendering provider should be provided at the header level of the claim. A roster would be required, if the information needed is not listed on the claim, or during credentialing.

If the claim contains multiple rendering practitioners at different service lines the header level rendering provider NPI should be blank and the line level NPI should be that of the provider who rendered that service. For providers that are not required to obtain an NPI, the line level NPI would also be blank. If the claim contains one rendering provider that applies to all service lines the header level NPI field can contain the NPI of the rendering provider as well as each service line.

All practitioners required to have an NPI should be registered in MITS and affiliated to your agency.

Please submit your organization's NPI number in box 24J as well as box 33a. If your organization is dually certified by MHAS (Provider type 84 and 95) you will need to use specific NPI numbers on claims to distinguish between services under these provider types.

Agency Rosters are not required, but are encouraged. Rosters can be submitted to your organization's Health Partner Manager.

CareSource uses the Provider Master File received weekly from Medicaid to obtain rendering practitioner information as long as all required practitioners are registered in MITS and affiliated to your agency. A roster of agency practitioners is requested as part of Molina’s CBHC contracting process for claims system loading purposes. The NPI of the rendering provider should be provided at the header level of the claim. A roster would be required, if the information needed is not listed on the claim, or during credentialing.

If the claim contains multiple rendering practitioners at different service lines the header level rendering provider NPI should be blank and the line level NPI should be that of the provider who rendered that service. For providers that are not required to obtain an NPI, the line level NPI would also be blank. If the claim contains one rendering provider that applies to all service lines the header level NPI field can contain the NPI of the rendering provider as well as each service line.

All practitioners required to have an NPI should be registered in MITS and affiliated to your agency.

If the claim contains multiple rendering practitioners at different service lines the header level rendering provider NPI should be blank and the line level NPI should be that of the provider who rendered that service. For providers that are not required to obtain an NPI, the line level NPI would also be blank. If the claim contains one rendering provider that applies to all service lines the header level NPI field can contain the NPI of the rendering provider as well as each service line.

12. What tax ID do I submit on a claim?

You will need to complete your claim submissions with the tax identification number and national provider identification number affiliated to you as an independent provider, your group practice or organization that is affiliated with the member care you are billing for. If you are filing claims with a vendor or clearinghouse, contact your vendor to verify where this information needs to be entered. If you are filing a paper claim, you will need to put these identifying numbers on your CMS 1500 Claim Form as indicated.

Please use the Tax ID of the provider that provided the services.

Please use the Tax ID of the provider that provided the services.

Please use the Tax ID of the provider that provided the services.

Please use the Tax ID of the provider/agency.

Please use the Tax ID of the rendering provider/agency.

A roster of agency practitioners is requested as part of Molina’s CBHC contracting process for claims system loading purposes. The NPI of the rendering provider should be provided at the header level of the claim. A roster would be required, if the information needed is not listed on the claim, or during credentialing.

If the claim contains multiple rendering practitioners at different service lines the header level rendering provider NPI should be blank and the line level NPI should be that of the provider who rendered that service. For providers that are not required to obtain an NPI, the line level NPI would also be blank. If the claim contains one rendering provider that applies to all service lines the header level NPI field can contain the NPI of the rendering provider as well as each service line.

All practitioners required to have an NPI should be registered in MITS and affiliated to your agency.

Please use the Tax ID of the rendering provider/agency.

If the claim contains multiple rendering practitioners at different service lines the header level rendering provider NPI should be blank and the line level NPI should be that of the provider who rendered that service. For providers that are not required to obtain an NPI, the line level NPI would also be blank. If the claim contains one rendering provider that applies to all service lines the header level NPI field can contain the NPI of the rendering provider as well as each service line.

All practitioners required to have an NPI should be registered in MITS and affiliated to your agency.
24. Who should I identify as the primary payer on the claim?

**Updated 6/7/2018**

Most of our MyCare members have opted to have Aetna cover both their Medicare and Medicaid benefits, in which case Aetna would be the primary payer. If a member is covered by Aetna for Medicare only and you are billing for a Medicare covered service, then you would need to identify the member’s primary insurance coverage on the claim form. If the service is not a Medicare covered benefit you would need to indicate the member’s primary insurance coverage on the claim but you will not be required to submit a COB from the primary payer.

Most of our MyCare members have opted to have Buckeye Health Plan cover both their Medicare and Medicaid benefits, in which case Buckeye would be the primary payer. If a member is covered by Buckeye for Medicare only and you are billing for a Medicare covered service, then you would need to identify the member’s primary insurance coverage on the claim form. If the service is not a Medicare covered benefit you would need to indicate the member’s primary insurance coverage on the claim but you will not be required to submit a COB from the primary payer.

Most of our MyCare members have opted to have CareSource cover both their Medicare and Medicaid benefits, in which case CareSource would be the primary payer. If a member is covered by CareSource for Medicare only and you are billing for a Medicare covered service, then you would need to identify the member’s primary insurance coverage on the claim form. If the service is not a Medicare covered benefit you would need to indicate the member’s primary insurance coverage on the claim but you will not be required to submit a COB from the primary payer.

If a member is covered by Molina for Medicaid only, Molina would be the primary payer. If a member has additional coverage (MyCare, Medicare, commercial insurance), you need to identify the member’s primary insurance coverage on the claim form and ensure that COB information is entered on the claim if Molina Medicaid is the secondary payer.

**NOTE:** Please see the document named “Final Service Billable to Medicare” on the BH Redesign website for a list of service codes that do not require COB on a MyCare claim because the services are not covered by Medicare.

If Paramount is the only payer, nothing needs to be added, otherwise, the member’s primary insurance carrier should be listed as appropriate. Please refer back to our member Coordination of Benefits (COB).

Most of our MyCare members have opted to have UHC Community Plan cover both their Medicare and Medicaid benefits, in which case UHC would be the primary payer. If a member is covered by UHC Community Plan for Medicare only and you are billing for a Medicare covered service, then you would need to identify the member’s primary insurance coverage on the claim form. If the service is not a Medicare covered benefit you would need to indicate the member’s primary insurance coverage on the claim but you will not be required to submit a COB from the primary payer.

25. When Medicaid is the secondary payer, is the electronic COB information from the 837 sufficient to process and pay the claim?

**Added 6/20/2018**

The information from the 837 is sufficient to process COB claims.

For BHP Opt-in members, the claim will automatically cross over with the electronic COB information, no additional documentation is needed. For Opt-Out members, the explanation of benefits is required to process and pay.

Electronic COB is acceptable. If provider submits a paper claim, the primary COB should be attached.

Electronic COB information is sufficient for EDI claims to process when Medicaid is the secondary payer.

When a claim is submitted through the Molina Portal look for a “Patient” tab under “Other Insurance” is a question “Is there another benefit plan?” If marked YES fields will appear asking for additional information. There is another question below this asking “Do you have an EOB?” If marked YES a field will appear asking for Payor Paid Date. On the Provider Tab there is a section called “Supporting Information” in this section look for a drop down list to choose a type of attachment. In this case choose “EB Explanation of Benefits” and you will get the option to upload the EOB as an attachment.

If submitting a paper claim please include a copy of the EOB with the claim and mail both to: Molina Healthcare at P.O. Box 22712 in Long Beach, CA 90801.

The information from the 837 is sufficient to process COB claims.

Yes, if providers submit COB information on the 837 that is sufficient to pay the claim. We won’t ask for additional documentation, such as the Explanation of Benefits (EOB).
During the first year of transition to managed care (July 2018 to July 2019) timely filing requirements for CBHCs are set at 180 days. After the transition period, the standard timely filing limit is 90 days, but providers should go by their specific provider agreement.

Clean claims are 120 days from date of service for commercial and Medicare plans, and 365 days from date of service for Medicaid plans. From the date the claim is processed, providers have 60 days to appeal, unless the provider's agreement states otherwise.

Yes, during the first year of transition to managed care (July 2018 to July 2019) timely filing requirements for CBHCs are set at 180 days. After the transition period, the standard timely filing limit is 90 days, but providers should go by their specific provider agreement.

CareSource will honor the 90-calendar day continuity of care period post-Redesign and Carve-in and, if services are being rendered by a non-contracted out-of-network provider, will establish an agreement with that organization or attempt to link that member with an in-network provider.

EDI testing requires a ticket through our clearinghouse in order to move the test files into the test environment. Providers who want to test their claims via the Molina Web Portal can submit an excel spreadsheet. Contact the Billing Services at 419-887-2557 for assistance with testing through our clearinghouse.

18. How should I handle claims rejected or unable to be processed by Aetna’s clearinghouse due to claims submission errors by the provider when dates of service are beyond the timely filing limit?

Claims initially rejected or unable to be processed by Aetna’s clearinghouse due to claims submission errors by the provider will deny by Aetna’s claims processing system due to being beyond the timely filing limit if the corrected claim is not submitted within the timely filing limit. We strongly encourage Providers to contact us for assistance if they are experiencing difficulties billing. Our provider service team can be reached at 1-855-364-0974 option 2.

Timely filing is 365 days from date of service or discharge. Any claims submitted after this timeframe would be denied due to timely filing. In order to have reevaluation of claims that are submitted after timely filing deadlines, providers would need to submit an appeal to the health plan.

Molina will make special consideration for clearinghouse rejections that result from Molina system issues. For any rejected claims that fall beyond the timely filing limit, please use the reevaluation form on the Molina website at http://www.molinahealthcare.com/providers/claims/forms/Pages/fulfa.aspx. If you have any problems receiving technical assistance from Molina’s clearinghouse, please call the provider inquiry department at 419-887-2574 or our 24/7/365 call center 419-887-2557.

If it is a corrected claim, the provider would follow the corrected claim process, and must be submitted within timely filing. Otherwise, we will require proper documentation with proof of timely filing for reconsideration.

19. How should I handle denials due to inaccurate billing configuration in the MCO’s system when dates of service are beyond the timely filing limit?

Molina will review and re-process any claims that were denied due to any system configuration issues with our system. Providers should call us at 1-855-364-0974, Option 2, then Option 5 or email us at DI_ProviderServices@Aetna.com. Providers can also contact Aetna’s Single Point of Contact or Regional Provider Services Liaison for assistance.

Timely filing is 365 days from date of service. Any claims submitted after this timeframe would be denied due to timely filing. In order to have reevaluation of claims that are submitted after timely filing deadlines, providers would need to submit an appeal to the health plan.

Molina will make special consideration for clearinghouse rejections that result from Molina system issues. For any rejected claims that fall beyond the timely filing limit, please use the reevaluation form on the Molina website at http://www.molinahealthcare.com/providers/claims/forms/Pages/fulfa.aspx. If you have any problems receiving technical assistance from Molina’s clearinghouse, please call the provider inquiry department at 419-887-2574 or our 24/7/365 call center 419-887-2557.

If it is a corrected claim, the provider would follow the corrected claim process, and must be submitted within timely filing. Otherwise, we will require proper documentation with proof of timely filing for reconsideration.

20. How should I handle denials due to Medicaid eligibility or MCO enrollment errors in MITS when dates of service are beyond the timely filing limit?

Provider should submit the claim as soon as the eligibility is confirmed. If the claim has a date of service beyond the timely filing limit and gets denied by Aetna’s claim processing system Provider should contact Aetna, provide any supporting documentation for Medicaid eligibility or Plan enrollment errors in MTS and request that the claim be reprocessed. Providers should call us at 1-855-364-0974, Option 2, then Option 5 or email us at DI_ProviderServices@Aetna.com.

Timely filing is 365 days from date of service. Any claims submitted after this timeframe would be denied due to timely filing. In order to have reevaluation of claims that are submitted after timely filing deadlines, providers would need to submit an appeal to the health plan.

Molina will make special consideration for clearinghouse rejections that result from Molina system issues. For any rejected claims that fall beyond the timely filing limit, please use the reevaluation form on the Molina website at http://www.molinahealthcare.com/providers/claims/forms/Pages/fulfa.aspx. If you have any problems receiving technical assistance from Molina’s clearinghouse, please call the provider inquiry department at 419-887-2574 or our 24/7/365 call center 419-887-2557.

If it is a corrected claim, the provider would follow the corrected claim process, and must be submitted within timely filing. Otherwise, we will require proper documentation with proof of timely filing for reconsideration.

21. How do I get set up for Electronic Funds Transfer (EFT) instead of receiving paper checks by mail?

Providers can submit Electronic Funds Transfer (EFT) form to be set up for EFT. The form can be obtained at the following link: https://www.aetnahealthcare.com/ohio/assets/pdf/ERATermForm2017.pdf. You are also welcome to call us at 855-355-3474, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com and we will send you the EFT form at your request.

To register to receive Electronic Funds Transfer (EFT) please use the following link: https://www.healthcarepartnership.com/providers/resources/electronic-transactions/transactions.html. Complete the EFT enrollment form located on CareSource.com in the Claims section or the Provider portal. Providers will be contacted by our EFT partner. Installed/installed will work directly with Providers to enroll in the EFT process. Providers who enroll will see their first electronic payments within seven business days for clean claims. Questions: Call InstaMed at 215-787-3682, or call CareSource Provider Services at 1-855-210-1058.

Pros, for EFT Registration is through the Change Healthcare ProviderNet at https://provider.enrollment.com. Additional registration instructions can be found on Molina’s website http://www.MolinaHealthcare.com/OhioProvider Resources. Providers can submit their claims electronically through their web portal free of charge at https://office.emdeon.com/vendorfiles/molina.html. While Molina is trying to encourage all providers to submit electronically, paper claims will be accepted in special situations and should be sent to: Molina Healthcare, Inc., PO Box 22712, Long Beach, CA 90801.

The instructions to sign up for EFT can be found on the Explanation of Payment (EOP) with both a phone number and web address as Change Healthcare facilitates the EFT process for providers with Paramount. Contact Change Healthcare at 1-877-271-0054 or 1-866-506-2830.

Providers can go to www.uhconline.com, Tools & Resources and select EDI Education for Electronic Transactions.

22. How do I get set up for Electronic Remittance Advice (ERA)?

You can complete our Electronic Remittance Advice Agreement by visiting https://www.aetnahealthcare.com/ohio/assets/pdf/ERAADRRouting.pdf. You are also welcome to call us at 855-355-3474, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com and we will send you the ERA form at your request.


Contact OptumInsight at 800-341-6141 to get set up. Online under Tools & Resources there are tutorials under the EDI Education for Electronic Transactions section to assist providers in getting set up - step-by-step.

23. Who can I contract for medicaid EDI questions including trading partner setup and information about 837 file formats? (Updated 6/7/2018)

All services at: 855-355-3074, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com

Contact your EDI Vendor at the CareSource EDI Department at 1-800-231-5773, ext 00735525 or fax at 1-800-266-6985.

Start by reaching out to your clearinghouse. During the Bh Re-Design/Care in transition period, CMHC Providers can also initiate contact with CareSource’s BH Re-design/Care in Rapid Response Team by telephone: 855-708-4640 or by email: OHTIPS@ caresource.com.

EDI questions including trading partner enrollment and 837 file format providers can call 1-866-409-2935 or email directly at EDI.Claims@Molinahealthcare.com.

Please contact our EDI Support Line at 419-887-2793. Or contact our ECS coordinator 419-887-2793 if necessary also contact Change Healthcare at 1-866-506-2830.

Contact Optum Insight at 800-220-8325.

24. What are my options for claims submission if I am having technical problems with EDI submission? (Updated 6/7/2018)

Aetna accepts claims in electronic or paper format. Send paper claims to: Aetna Better Health of Ohio PO Box 64305 Phoenix, AZ 85082

Buckeye accepts claims electronically or paper CMS 1500. To submit claims electronically use the Buckeye Secure Web Portal or through any EDI vendor. For the address to submit paper claims claims go to: https://www.buckeyehealthplan.com/providers/resources/forms-resource.html.

Providers can submit their claims electronically through a clearinghouse, or on their own portal or via paper by mailing the claim forms to CareSource ATTN: Claims Dept. PO Box 8730 Dayton, OH 45410-8730.

For claims assistance contact Provider Service at 1-866-296-8731.

Providers can contact our BH Rapid Response Team via email at BHProviderServices@MolihcaHealthcare.com. This mailbox will be monitored daily by the provider relations team, who will track all provider reported issues along with status of resolution for operational leadership. Additionally, your trading partner/swinghouse should be available to assist.

Change Healthcare will accept Molina claims through their web portal free of charge at https://office.emdeon.com/vendorfiles/molina.html. While Molina is trying to encourage all providers to submit electronically, paper claims will be accepted in special situations and should be sent to: Molina Healthcare, Inc., PO Box 22712, Long Beach, CA 90801.

Patients are also welcome to call us at 855-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com. Contact OptumInsight at 800-341-6141 to get set up. Online under Tools & Resources there are tutorials under the EDI Education for Electronic Transactions section to assist providers in getting set up - step-by-step.

Contact OptumInsight at 800-220-8325.

25. Who should I contact if I need assistance with claims submission? (Updated 6/7/2018)

Can submit the Form 800-488-0134 or by email at OH_HealthPartnerManager@Aetna.com. This mailbox is monitored daily by the provider relations team, who will track all provider reported issues along with status of resolution for operational leadership. Additionally, your trading partner/swinghouse should be available to assist.

Change Healthcare will accept Molina claims through their web portal free of charge at https://office.emdeon.com/vendorfiles/molina.html. While Molina is trying to encourage all providers to submit electronically, paper claims will be accepted in special situations and should be sent to: Molina Healthcare, Inc., PO Box 22712, Long Beach, CA 90801.

Paramount is adding functionality to their provider web portal to offer a claims submission option starting 5/1/2018. If necessary providers may submit their claims mail at P.O. Box 497 Toledo, Ohio 43607.

You are also welcome to call us at 855-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com. You are also welcome to call us at 855-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com. OH_ProviderServices@Aetna.com.

Providers can contact their BH Rapid Response Team via email at BHProviderServices@MolihcaHealthcare.com. This mailbox will be monitored daily by the provider relations team, who will track all provider reported issues along with status of resolution for operational leadership.

Contact OptumInsight at 800-341-6141 to get set up. Online under Tools & Resources there are tutorials under the EDI Education for Electronic Transactions section to assist providers in getting set up - step-by-step.

Contact OptumInsight at 800-220-8325.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Who should I contact if I do not get a response within 24-48 hours?</td>
<td>You can contact your Provider Services Liaison at 959-299-7278 or <a href="mailto:KilincA@AETNA.com">KilincA@AETNA.com</a>. Contact your Provider Network Specialist or call Provider Services at 1-866-296-8731 and ask for the Rapid Response Team. During the BH Re-Design/Carve-in transition period, CMHC Providers can also initiate contact with CareSource’s BH Re-design/Carve-in Rapid Response Team by telephone: 855-708-4866 or by email: <a href="mailto:OhioBHInfo@caresource.com">OhioBHInfo@caresource.com</a>. Messages will be returned within 24 business hours. You can contact Emily Higgins, our Director of Behavioral Health at <a href="mailto:Emily.Higgins@MolinaHealthCare.com">Emily.Higgins@MolinaHealthCare.com</a>. You can contact our Provider Inquiry department by 419-887-2564 or 1-888-891-2564 or by email: <a href="mailto:PHCBehavioralHealthTesting@ProMedica.org">PHCBehavioralHealthTesting@ProMedica.org</a>. You can contact Tracy Board or Tracy.izzard‐<a href="mailto:everett@optum.com">everett@optum.com</a> or for more rapid response <a href="mailto:OhioNetworkManagement@Optum.com">OhioNetworkManagement@Optum.com</a>.</td>
</tr>
</tbody>
</table>
30. What are common denial reasons and how can I prevent them?

Common denial reasons include eligibility issues, duplicate claims, incorrect/incomplete claims coding and lack of authorization. If you need assistance please contact Provider Services.

Common Denials include: No authorization - please review the Covered Services and Authorization Guidelines at www.cenpatico.com in the MyCare Resources section. Duplicate Submission - if you need to submit a corrected claim, please indicate as such on the claim. No EDI from Primary Payer, please include the Medicare providers EDI when submitting the Medicaid claim.

Examples of Common Rejections:
- Duplicate Claim, Place of Service not typical, member not eligible, member terminated, typical daily frequency exceeded, invalid modifier, non-specific diagnosis code, date of service is prior to the member’s effective date.
- Common Denials due to duplicate claims, no enrollment on date of service, invalid practitioner modifiers or missing practitioner NPI, missing authorization, or the date of service is prior to the member’s effective date.

Molina recommends utilizing EDI reports made with paper checks or available on the ProviderNet website to get detail on denial reasons in order to identify common denials for your organization.

Common reasons for denial and ways to prevent are as follows:
- Incomplete or missing member ID, date of birth
- No NPI on the claim or NPI is in the incorrect field of the claim
- Invalid or missing HCPC/CPT examples (i.e. submitting claims with codes that are not covered services, required data elements are missing such as number of units)
- Provider information is missing/incorrect (i.e. provider information has not been completely entered on the claim form or place of service)
- Prior Authorization Required (i.e. no authorization received for those services which an authorization is required)

Some of the common denial reasons are incorrect/incomplete claims coding including:
- Incomplete or missing diagnosis
- Invalid or missing HCPC/CPT examples (i.e. submitting claims with codes that are not covered services, required data elements are missing such as number of units)
- Provider information is missing/incorrect (i.e. provider information has not been completely entered on the claim form or place of service)
- Prior Authorization Required (i.e. no authorization received for those services which an authorization is required)

31. How do I check the status of my claims?

You can check the status of a claim through the Buckeye Secure Web Portal or call Provider Services at 1-800-488-0134 Monday – Friday 8am – 6pm. You can check claim status online via the CareSource portal 24/7 or call Provider Services at 1-800-488-0134 Monday – Friday 8am – 6pm.

These trading partners/clearinghouses also allow you to perform 276/277 transactions to check on claims status:
- Availity
- Change Healthcare
- Experian Health
- Healthcare.gov
- Molina
- Multiplan
- Optum
- Reliant
- ReliaHealth
- University Health
- Availity
- Change Healthcare
- Experian Health
- Multiplan
- Molina
- Optum
- Reliant
- ReliaHealth
- University Health

The provider can register to use the Paramount Portal to view all their member and claim detail. Also providers can contact Provider Inquiry 419-487-2564 or 1-888-891-2564.

32. How do I submit a corrected claim?

You can file a corrected paper claim by completing a new claim form and marking the new claim form as a corrected claim. Be sure to mark “Corrected Claim” or “Re-submission” on the envelope. Send corrected claims to: Aetna Better Health of Ohio P.O. Box 64205 Toledo, OH 43606-9974

You can also submit a corrected electronic claim through your WebConnect if you use our clearinghouse for claim submissions. If you use another vendor or clearinghouse please contact your vendor to find out how to refile a corrected claim. You are always welcome to call us at 1-800-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com.

Correct the claim and resubmit through the Buckeye Web Portal, submit a corrected claim by EDI or submitting a paper claim.

Providers have 303 calendar days from the date of service or discharge to submit a corrected claim.

The provider can register to use the Paramount Portal to view all their member and claim detail. Also providers can contact Provider Inquiry 419-487-2564 or 1-888-891-2564.

To go to www.uhcminline.com

33. How can I check the status of my claims?

You can check the claim status at any time by logging into your WebConnect or Secure Provider Portal. And you are always welcome to call us at 1-800-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com.

You can check status of a claim on the Buckeye Secure Web Portal or call Provider Services at 1-800-488-0134 Monday – Friday 8am – 6pm. You can check claim status online via the CareSource portal 24/7 or call Provider Services at 1-800-488-0134 Monday – Friday 8am – 6pm.

These trading partners/clearinghouses also allow you to perform 276/277 transactions to check on claims status:
- Availity
- Change Healthcare
- Experian Health
- Multiplan
- Molina
- Optum
- Reliant
- ReliaHealth
- University Health

You can file a corrected paper claim by completing a new claim form and marking the new claim form as a corrected claim. Be sure to mark “Corrected Claim” or “Re-submission” on the envelope. Send corrected claims to: Aetna Better Health of Ohio P.O. Box 64205 Toledo, OH 43606-9974

You can also submit a corrected electronic claim through your WebConnect if you use our clearinghouse for claim submissions. If you use another vendor or clearinghouse please contact your vendor to find out how to refile a corrected claim. You are always welcome to call us at 1-800-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com.

Correct the claim and resubmit through the Buckeye Web Portal, submit a corrected claim by EDI or submitting a paper claim.

Providers have 303 calendar days from the date of service or discharge to submit a corrected claim.

You can also submit a corrected electronic claim through your WebConnect if you use our clearinghouse for claim submissions. If you use another vendor or clearinghouse please contact your vendor to find out how to refile a corrected claim. You are always welcome to call us at 1-800-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com.
Ohio Medicaid Billing Rules

23. How will the MCOs accept claims for dually licensed practitioners?

Updated 6/7/2018

If a claim is submitted with a practitioner NPI in the rendering field, but the practitioner is ‘unknown’ meaning there is no ODM enrollment and/or affiliation with the agency in the MTS system, UHC will pay the claim for the time being to allow for all applications to be processed by ODM. UHC will also contact the agency to inform them that all rendering practitioners need to be enrolled in MITS and affiliated with the billing agency to prevent future denial of claims.

24. Coordination of Benefits: Are you following the ODM policy guidance regarding eligible providers when services are provided to dual eligible or individuals with commercial insurance?

Yes. Aetna Better Health of Ohio is following the ODM policy guidance regarding eligible providers when services are provided to dual eligible or individuals with commercial insurance.

Yes, BHP follows the requirement from ODM policy guidance.

Yes, Molina’s claim system is configured to recognize Medicare eligible practitioners using either the practitioner’s NPI or a practitioner modifier when billed as a dually licensed practitioner so that claims for Medicare covered services provided by a Medicare practitioner are billed against a Medicare patient’s Medicare benefit. Claims for services not covered by Medicare or not billable to a third party payor will not deny or pend for a primary explanation of benefits.

25. After July 1, will the practitioner "U" modifiers be required on claims for dually licensed practitioners?

Updated 6/12/2018

Most practitioner "O" modifiers will be optional for providers submitting claims to Aetna except for the following two situations: 1. They are not covered by Medicare and are not eligible/covered/submitted to Medicare will be processed without denying the primary ODM. If a member has other coverage, non-Medicare, possibly commercial coverage, then an EOP will be required.

Buckeye will not deny the claim as long as the provider is enrolled with ODM and is licensed to provide the service and if the claim was billed correctly per billing rules.

Practitioner "O" modifiers will be optional for providers submitting claims to CareSource, except for dually licensed practitioners using either the practitioner’s NPI or a practitioner modifier when billed as a dually licensed practitioner so that claims for Medicare covered services provided by a Medicare practitioner are billed against a Medicare patient’s Medicare benefit. Claims for services not covered by Medicare or not billable to a third party payor will not deny or pend for a primary explanation of benefits.

Practitioner "U" modifiers will be optional for providers submitting claims to Molina, except for dually licensed practitioners using either the practitioner’s NPI or a practitioner modifier when billed as a dually licensed practitioner so that claims for Medicare covered services provided by a Medicare practitioner are billed against a Medicare patient’s Medicare benefit. Claims for services not covered by Medicare or not billable to a third party payor will not deny or pend for a primary explanation of benefits.

In July 1, 2018, Practitioner "U" modifiers will not be required for providers submitting claims for commercial coverage. The NPI information is required for all claims submitted to Molina in order to process appropriately.

EHIC will require providers submitting claims to include both the NPI and U modifiers.
37. Dual licensure billing: When a RN/LPN is billing under their secondary license (e.g., LSW, LPC) will a claim require the “ordering” NPI in order for the claim to process properly?

Aetna will not require the ordering NPI on the claims when the rendering RN/LPN provider is billing under a secondary license such as LPC or LSW.

Yes, the claim will require the ordering NPI to process.

Providers who have a dual license must identify on the claim which license the service was provided under. Providers will be loaded and configured in our system with the dual licensure logic in the agreement will pay the claim correctly based upon the dual licensure modifier identified on the claim. The dual licensure modifier will determine which rate the claim will pay based on the specialty/license (e.g., Registered Nurse (RN) vs. Licensed Independent Social Worker (LISW)) that is entered on the claim.

All nursing services require an ordering practitioner on a claim. Under the dually licensed provisions, someone enrolled as a nurse, with a second non-nurse license, any service under the second license do not require an ordering practitioner.

Molina will not require an ordering NPI on the claim when the practitioner is operating under their secondary non-RN/LPN licensure (e.g., LSW, LPC).

38. After July 1, will a supervisor be required to be reported on a claim when billing HCPCS codes?

No, the claim will ignore supervisor.

The Molina claims system will ignore the supervisor reported on any claims with HCPCS codes.

The supervising NPI information must be on the claim for those dependent providers (where applicable) - ODMPer the Behavioral Health Provider Manual

39. Will each MCO recognize the NCCI modifiers that override Procedure-to-Procedure edits when the services performed on the same day are separate and distinct?

Yes, Aetna Better health of Ohio updates our claims system quarterly to be compliant with federal NCCI rules, which includes any NCCI-associated modifiers.

Buckeye is currently implementing the NCCI edits to our CBH claims system to be compliant with federal NCCI rules, which includes any NCCI-associated modifiers.

Yes, CareSource's claims system is compliant with regular NCCI updates.

Yes, Molina updates our claims system quarterly to be compliant with federal NCCI rules, which includes any NCCI-associated modifiers.

Yes, Paramount will recognize the NCCI modifiers. If a claim were to deny/pend, it would be because Paramount needs to further review the supporting documentation the provider has submitted.

Yes, updates our claims system quarterly to be compliant with federal NCCI rules, which includes any NCCI-associated modifiers.

40. How will each MCO handle outpatient services billed on the day of admission or discharge for SUD Residential?

CMHC provider can submit a claim appeal/dispute form to Aetna along with supporting information.

Buckeye will follow the standard clinical review process and will follow standard appeal process for the SUD Residential services upon admission/discharge date that are outlined within Behavioral Health redesign.

Reference: HOW TO SUBMIT APPEALS - You can submit appeals through the Provider Portal, by letter or writing using the NavigateClinical/Claim Appeal Form.

The Molina claims reconsideration process will be available to providers who receive denials for outpatient services billed on the day of admission or discharge from a SUD Residential program.

Paramount will follow the standard medical/clinical review process and will follow standard appeal process for the SUD Residential services upon admission/discharge date that are outlined within Behavioral Health redesign. If questions occur around appeal/ denial outcomes, Paramount plans to engage with providers to correct issues that may be present during claims submission or upon Paramount’s review.

United claim appeal/dispute review process will address this.
Managed Care Plans - Prior Authorization Guide

Is there a time limit for prior authorization decisions? The PA Team must respond within 72 hours of receipt of the request for service or your client will be unauthorized. If you will require your own authorization number, please contact the PA Team at: 855‐322‐4079. A PA Team representative will respond within 24 hours. All written appeals must be received by the PA Team via fax with the details of the authorization, including the authorization number for that specific service.

If your client is referred to specialty services, a prior authorization number will be issued at the time of referral. The new Managed Care Plan can be contacted at 855‐322‐4079. Monroe CareSource will notify the provider when/if the authorization is approved.

If you believe the service is an emergency, please contact the PA Team at: 855‐322‐4079. Monroe CareSource will authorize the service without a prior authorization number.

If your client is transferred to another facility, Monroe CareSource will process the transfer so that your client may continue to receive covered services. If your client is moved to another Monroe CareSource network provider, Monroe CareSource will honor the 90‐calendar day standard for authorization. Monroe CareSource will authorize the service for a new period of time when the transfer is from one network provider to another network provider.

What should I do if a client needs to switch health plans? Your client can switch health plans at any time. Follow these steps if your client wishes to switch health plans:

1. Contact the current health plan and request a transfer of care.
2. Complete and submit the new provider enrollment form.
3. Submit any outstanding prior authorization requests.
4. Contact the new health plan to request an authorization for services.

If you need additional assistance, please contact Monroe CareSource at: 855‐322‐4079.

Is a retrospective review possible? Retroactive PA requests are not accepted. Please submit PA requests before services are rendered.

If you require additional assistance, please contact Monroe CareSource at: 855‐322‐4079.
What is your standard appeal process if I want to appeal a denial?

Contracted and Non-contracted providers are advised of their appeal rights on the remittance advice, in the Provider Manual and on our website. The detailed instructions regarding claim appeals/payment disputes can be found at http://www.aetnabetterhealth.com/ohio/providers/, under the Aetna Better Health of Ohio (Medicare-Medicaid) menu, Non Part D Complaints, Coverage, Decisions & Appeals page. The forms are located on the “For Providers” section of our website, under the “Forms” menu. The participating provider dispute forms can be submitted via fax to 1-855-826-3809 or mailed to:

Aetna Better Health of Ohio, a MyCare Ohio plan
Provider Services Department
Attention: Provider Dispute Grievance System Manager
7400 West Campus Road
Mail Code: F494
New Albany, OH 43054

If a Resubmission has been processed and you are still dissatisfied with Cenpatico’s response, you may file an appeal of this decision by writing to the address listed below. Note: Appeals must be filed in writing. Place APPEAL within your request. In order for CBH to consider the appeal, it must be received in writing within 60 days of the date on the EOP which contains the denial of payment that is being appealed unless otherwise stated in your contract. If you do not receive a response to your written appeal within 90 days, you may request reconsideration:

CareSource
Attn: Provider Appeals
P.O. Box 2008
Dayton Ohio 45401-2008
Fax: 937-531-2398

If the provider has any questions regarding the Appeal Process, they should contact Provider Inquiry as they can provide the appropriate information for all providers (par and non-par)

To file an appeal, send it to UnitedHealthcare Community Plan of Ohio at the following address:

UnitedHealthcare Community Plan of Ohio
Appeals and Grievances Department
PO Box 31364
Salt Lake City, UT 84131
Fax Number for Appeal: 1-877-886-8120

Provider need to file an appeal by sending the appropriate form to the address of the following points:

Mailing Address
Medicare Provider Services
PO Box 392
Cincinnati, OH 45201-3920

Fax Number
Provider Inquiries Line
(877) 201-4100

Provider Relations Manager
Phone: 419-887-2564
Toll Free: 1-888-891-2564
# Managed Care Plan - Pharmacy Information

## 1. What is the Primary contact at the MCP for regular pharmacy questions?

Contact Aetna Better Health of Ohio Toll-free Plan number: 1-855-364-0974 and choose either Member services or Provider Services for routine or regular questions.

Contact Buckeye Health Plan at Toll-free Plan number: 1-866-246-4258 for Member services or (866) 296-4731 for Provider Services for routine or regular questions. For any escalated issues/questions, please reach out to Karen Lenz-Winterhalter: KWINTERHALTER@CENTENE.COM.

Contact CareSource Pharmacy help line at 1-800-488-0134. For Member Services questions, you can call 937-224-3300 or the phone number on the members ID card. Fax PA request to 1-866-930-0019 for 24 hour Turn Around Time.

For member issues that need resolved or PA, please use our pharmacy fax line: 844-256-2025. Any faxed PA requests should be answered under 24 hours. Providers can also call 800-891-2520 if they need immediate help.

For routine PA requests, please use our pharmacy fax line: 800-961-5160. Providers can email us at MHOPharmacyDepartment@MolinaHealthCare.Com for help with member specific issues.

Contact Buckeye Health Plan at Toll-free Plan number: 1-866-246-4258 for Member services or (866) 296-4731 for Provider Services for routine or regular questions. For any escalated issues/questions, please reach out to Karen Lenz-Winterhalter: KWINTERHALTER@CENTENE.COM.

## 2. What is the escalation point at the MCP when resolution is needed or a provider has an urgent issue?

Contact Gina Vergil, Clinical Pharmacy Manager via email at VergilG@AETNA.com.

Provider can send an e-mail to: php@centene.com OR they can reach out to Meera Patel-Zook via e-mail: MZOOK@CENTENE.COM

Provider can send an email to pharmacyrequest@caresource.com

Providers can send an urgent email to MHOPharmacyDepartment@MolinaHealthCare.com for help with any member specific issues during business hours. After hours and on weekends, providers can call the Nurse Advice Line at (888) 275-8750 to get assistance with medical questions including medication fills.

Please send a secure email with the subject of "Urgent Medicaid Need" to PHCPharmHelpDesk@promedica.org

Dr. Linda Post 614-410-7934; Diane McCutcheon at 614-410-7352 or Linda.post@uhc.com or diane.mccutcheon@uhc.com

After hours and on weekends the pharmacists should contact the Optum Pharmacy Helpline for routine medication issues.

## 3. Does the MCP require specialty pharmacy for MAT meds?

No. Aetna Better Health of Ohio does not require Medication Assisted Treatment medications to be filled at a specialty pharmacy. Aetna allows Part D drugs to be filled at any of our network pharmacies.

Specialty pharmacy for Vivitrol Only. No clinical PA is needed.

Other MAT does not require dispensing from specialty pharmacies. However, a clinical PA may be required.

Use of specialty pharmacy is not required for MAT medications. These medications can be obtained from retail pharmacy.

Specialty pharmacy for Vivitrol Only. No clinical PA is needed.

Other MAT does not require dispensing from specialty pharmacies.

Our network list is found here: http://www.paramounthealthcare.com/documents/prescription-drugs/specialty-pharmacy-network.pdf

Specialty pharmacy for Vivitrol Only. No PA is required for the medication. All requests for Vivitrol are handled by an OptumRx/Briova specialty pharmacy location in West Virginia. Briova (West Virginia) - phone: 800-707-8194, fax: 800-707-8217.

Specialty pharmacy for Vivitrol Only. No PA is required for the medication. All requests for Vivitrol are handled by an OptumRx/Briova specialty pharmacy location in West Virginia. Briova (West Virginia) - phone: 800-707-8194, fax: 800-707-8217.

Managed Care Plan – Pharmacy Information

### 4. If a MCP uses specialty pharmacy for MAT medications, what is the process for MAT providers to submit orders (e.g. timing of request, mailing instructions, how to make an urgent request, etc.)?

Not Applicable

Simply call the specialty pharmacy (Aetna health) and ask for their patient’s refill. They will want to give enough notice to allow the pharmacy to fill the medication and mail the order to the provider’s location by the time the medication is needed.

Not applicable

Simply call one of the specialty pharmacies on our network listing (found: http://www.paramounthealthcare.com/documents/prescription-drugs/specialty-pharmacy-network.pdf) and ask for their patient’s refill. Provider will want to give enough notice to allow the pharmacy to fill the medication and mail the order to the provider’s location by the time the medication is needed. Recommended notice: 5 days.

Care providers may order Vivitrol from our OptumRx/Briova Specialty Pharmacy. Briova (West Virginia) - phone: 800-707-8194, fax: 800-707-8217. They will expedite the request as needed.
1. What if a provider requests a mail order from specialty pharmacy and the member doesn’t show for dispensing? Aetna Better Health of Ohio does not allow direct to provider shipping. Aetna does not require MAT medications to be filled at a specialty pharmacy. The medication is shipped to the provider based on appointment information. The expectation would be for the provider to reach out to the member and facilitate any appointments. Not applicable MAT medications are provided as a 30 day supply. Use of specialty pharmacy is not required for MAT medications. These medications can be obtained from retail pharmacy. Not applicable Vivtritol is dispensed to the provider, not the member in most cases. This is for safety reasons and to prevent tampering prior to the appointment. Vivtritol is dispensed to the provider’s office in advance of the member’s scheduled appointment. If the member does not come for their appointment & will not reschedule it, the medication must be destroyed by the provider & can’t be returned to the specialty pharmacy.

2. How should a provider handle a request from the specialty pharmacy to speak with the member prior to shipping medication? Not applicable Vivtritol is dispensed to the provider, not the member in most cases. This is for safety reasons and to prevent tampering prior to the appointment. Not applicable Vivtritol is dispensed to the provider, not the member in most cases. This is for safety reasons and to prevent tampering prior to the appointment. Our specialty pharmacy has verified that they do not require to speak to the member when a provider requests a refill. Only specialty pharmacies other than OptumRx/Briova may make this request. Please use our Optum/Briova Specialty pharmacy.

3. Does the MCP offer a “Buy & Bill” option for providers who want to dispense medication at their clinic? Yes, Aetna Better Health of Ohio offers a “Buy & Bill” option. OhioMHAS certified providers can bill for the administration of medication using the available community alcohol and drug treatment services procedure codes. Yes, Buckey offers a Buy & Bill option which is encouraged. Yes, Molina Healthcare of Ohio offers a “Buy & Bill” option. OhioMHAS certified providers can bill for the administration of medication using the available community alcohol and drug treatment services procedure codes. Yes, it is encouraged for provider-administered medications. Yes, we encourage the provider to buy and bill as a standard medical claim.

4. If a “Buy & Bill” option is available for providers, how does the billing work (e.g., J codes)? OhioMHAS certified providers can bill for the administration of medication using the available community alcohol and drug treatment services procedure codes, including billing to medical with J codes. Providers will have to include the NDC code from the medication package on the claim in order for a claim with J codes to pay. OhioMHAS certified providers can bill for the administration of medication using the available community alcohol and drug treatment services procedure codes, including billing to medical with J codes. Providers will have to include the NDC code from the medication package on the claim in order for a claim with J codes to pay. OhioMHAS certified providers can bill for the administration of medication using the available community alcohol and drug treatment services procedure codes, including billing to medical with J codes. Providers will have to include the NDC code from the medication package on the claim in order for a claim with J codes to pay. OhioMHAS certified providers can bill for the administration of medication using the available community alcohol and drug treatment services procedure codes, including billing to medical with J codes. Providers will have to include the NDC code from the medication package on the claim in order for a claim with J codes to pay. Please see the Ohio Medicaid Opioid Treatment Program provider manual for specific billing instructions using office visit codes and J codes for medication administration. For our Advantage product line we pay providers from the ODM fee schedule. All providers may buy-and-bill Vivtritol by purchasing it from a wholesaler or pharmacy and submitting a 1500 form or electronic equivalent one of the following ways. Online: Go to UnitedHealthcareOnline.com > Claims Payment > Claims Submission Mail: UnitedHealthcare Community Plan, P.O. Box 82072, Kingston, NY 12402
9. Is the MCP willing to allow medication fills at local retail pharmacies that some providers already have established relationships with?

Aetna Better Health of Ohio allows Part D drugs to be filled at any network pharmacy. Unfortunately, not currently for our Medicaid line of business.

Yes, MAT or psychotropic medications can be obtained from local retail pharmacies. Yes for buprenorphine; no for Vivitrol. Changing our specialty network coding would allow non-specialty retail pharmacies to dispense other specialty network drugs and would be a violation of contract with our specialty providers.

Not at this time. We have arranged for all Vivitrol requests to be forwarded to a specific specialty pharmacy location: OptumRx / Briova specialty pharmacy in West Virginia in order to expedite and track these requests.

10. How should providers work with MCPs on local retail pharmacy options if possible (e.g. contracting, single case agreements, prior authorization, etc.)?

The pharmacy would need to contact our Pharmacy Benefit Management organization (CVS Caremark) and ask to be included in our network. Non-Contracted Pharmacies wanting to participate in a Plan Sponsor network (already Credentialled with Caremark) may contact Caremark Network Operations team at 1-888-314-8457, press the option for “Network Enrollment.” For Prior Authorization, contact Toll-Free Health Plan number at 855-364-0974, and follow the prompts for Pharmacy and then Prior Authorization.

If a retail pharmacy would like to be in network, they would need to work through our Pharmacy Benefit Management organization (CVS Caremark) to become part of the network. This will not apply to specialty pharmacies as we work with Aetna Health exclusively.

Not applicable. The pharmacy would need to work with our Pharmacy Benefit Management Organization, Optum Rx.

11. How should a provider route an urgent PA or specialty pharmacy request to avoid treatment disruption?

Providers may call our pharmacy prior authorization department at 855-364-0974 or they can fax their request to us at 855-365-8108 and mark it as urgent.

Complete Prior Authorization form in its entirety (if current authorization is about to end- submit request at least a week prior to end date). On all requests, whether new or renewal, to include supporting documentation i.e. notes, labs. Etc. pertinent to diagnosis and request, provide a good contact person/phone number if additional information is needed from provider. The specialty PA forms can be found at: https://www.buckeyehealthplan.com/providers/pharmacy/prior-auth-specialty.html

Send to the established fax number and contact the primary or escalation person identified.

Send an urgent fax request to 800-961-5160 for help during business hours. After hours and on weekends, providers can call the Molina Nurse Advice Line at (888) 275-8750 to get assistance, including urgent approval for medication fills.

The provider should indicate that this is an emergency request on the standard fax form available on the UnitedHealthcare Community Plan website. There are forms specifically for specialty pharmacies and for Suboxone. The provider can also let the Intake know by calling the pharmacy request number at 800-310-6826.

Providers can call 800-891-2520 if they need immediate help. For member issues that need resolved or PAs, please use our normal pharmacy fax line: 844-256-2025. Any faxed PA requests should be answered under 24 hours.

The pharmacy would need to work with our Pharmacy Benefit Management Organization, Optum Rx.
12. If a member is waiting on medication and decides to pay in cash, how can they get reimbursed?

Members may be reimbursed by the pharmacy at the retail level within a certain timeframe (e.g. 14 days) after the prescription is processed. If it is passed the timeframe and the pharmacy is not able to reimburse the member, the member can submit receipts and payment information to our member services department for reimbursement. If the medication requires prior authorization or is non-formulary status, approval for prior authorization or non-formulary medication would need to be obtained first. Once approval has been made our members can submit their receipts and payment information to our member services department.

Members can submit in writing their request with receipt for consideration to; Buckeye Health Plan 4349 Easton Way Suite 400 Columbus, Ohio 43219 Attn: Member Services. [*Note: Submission of a prior authorization does not guarantee approval. Request still must meet requirements/criteria etc. Authorizations begin date decision is rendered, and not normally backdated.] Also, please keep in mind that our PA turnaround time is 24 hours which is very quick and therefore we would not expect the member or provider to pay cash prior to decision as there is no guarantee on approval.

13. For UDS, when does an MHAS certified SUD provider need to use an MCP network lab? Is Prior Authorization required for UDS after a certain limit? What is the process for requesting a prior authorization for UDS?

Aetna Better Health of Ohio does not require urine drug screen when MAT medications are prescribed for our members. Providers need to follow the specific PA criteria when prescribing MAT medications as applicable. To obtain a list of in-network laboratory medicine providers, please contact us at 1-855-564-0974 or visit our website at http://www.aetnabetterhealth.com/ohio/find-provider. **Buckeye does not require providers to use a network lab for UDS services. Prior authorization is not required for presumptive tests and there is no limit on this service. Outpatient confirmatory/definitive testing requires prior authorization except when performed for children < 6 years of age. Requests for prior authorization will be accepted up to 5 business days after specimen collection. There is no limit on confirmatory testing. The providers need to fill complete the prior authorization forms and fax them to the health plan with all the necessary clinical documentation.

See CareSource's UDT medical and payment policies at https://www.caresource.com/providers/policies/for/additional/current_information_on_UDT. CareSource does not authorize out of network labs to perform UDS. At this time, CareSource does not require prior authorization for UDS, but all UDS must be medically necessary and is subject to retrospective review. Molina requires that all lab services other than CLIA-waived lab codes be performed by a network lab. To obtain a list of in-network laboratory providers, members or IPA providers can contact us at 1-800-643-4168 to get assistance from our Member/Provider contact center. You can also visit our website at https://providersearch.molinahealthcare.com/Provider/ and once you have selected the member's location and type of coverage, select "Other Providers" as the Provider Type and then choose "Laboratories" under More Search Options Specialty. Molina currently does not require PA for UDS, but we do investigate patterns of overutilization through retrospective claims review.

Providers are required to use our network labs for UDS. Please visit http://www.paramounthealthcare.com/ for our PAR provider directory. Paramount allows for 20 dates of service per calendar year for presumptive testing and for definitive testing with applicable code sets only 5 tests within the code set are allowed per date of service. For additional details, please see DRUG TESTING Policy PG00069 posted on our website. Once the limit is reached, Prior Authorization is required. Prior Authorization can be submitted by faxing the request and supporting clinical documentation to Paramount's BH UM department at 567-661-0841 or Toll Free: 844-282-4901.

Molina does not require providers to use a network lab for UDS services. Prior authorization is not required for presumptive tests and there is no limit on this service. Outpatient confirmatory/definitive testing requires prior authorization except when performed for children < 6 years of age. Requests for prior authorization will be accepted up to 5 business days after specimen collection. There is no limit on confirmatory testing. The providers need to fill complete the prior authorization forms and fax them to the health plan with all the necessary clinical documentation.

13. For UDS, when does an MHAS certified SUD provider need to use an MCP network lab? Is Prior Authorization required for UDS after a certain limit? What is the process for requesting a prior authorization for UDS?

Aetna Better Health of Ohio does not require urine drug screen when MAT medications are prescribed for our members. Providers need to follow the specific PA criteria when prescribing MAT medications as applicable. To obtain a list of in-network laboratory medicine providers, please contact us at 1-855-564-0974 or visit our website at http://www.aetnabetterhealth.com/ohio/find-provider. **Buckeye does not require providers to use a network lab for UDS services. Prior authorization is not required for presumptive tests and there is no limit on this service. Outpatient confirmatory/definitive testing requires prior authorization except when performed for children < 6 years of age. Requests for prior authorization will be accepted up to 5 business days after specimen collection. There is no limit on confirmatory testing. The providers need to fill complete the prior authorization forms and fax them to the health plan with all the necessary clinical documentation.

See CareSource’s UDT medical and payment policies at https://www.caresource.com/providers/policies/for/additional/current_information_on_UDT. CareSource does not authorize out of network labs to perform UDS. At this time, CareSource does not require prior authorization for UDS, but all UDS must be medically necessary and is subject to retrospective review. Molina requires that all lab services other than CLIA-waived lab codes be performed by a network lab. To obtain a list of in-network laboratory providers, members or IPA providers can contact us at 1-800-643-4168 to get assistance from our Member/Provider contact center. You can also visit our website at https://providersearch.molinahealthcare.com/Provider/ and once you have selected the member's location and type of coverage, select "Other Providers" as the Provider Type and then choose "Laboratories" under More Search Options Specialty. Molina currently does not require PA for UDS, but we do investigate patterns of overutilization through retrospective claims review.

Providers are required to use our network labs for UDS. Please visit http://www.paramounthealthcare.com/ for our PAR provider directory. Paramount allows for 20 dates of service per calendar year for presumptive testing and for definitive testing with applicable code sets only 5 tests within the code set are allowed per date of service. For additional details, please see DRUG TESTING Policy PG00069 posted on our website. Once the limit is reached, Prior Authorization is required. Prior Authorization can be submitted by faxing the request and supporting clinical documentation to Paramount’s BH UM department at 567-661-0841 or Toll Free: 844-282-4901.
14. If a provider is certified to offer lab services on site but they are not in network with the MCP, what can the provider do to encourage contracting? [e.g. if a provider is CLIA certified]

If a provider has a relationship with a local lab or if a local hospital offers lab services that lab can be used by the provider. The OhioMHAS certified providers use local lab providers that are in network with Aetna.

If a lab provider is not in network with Aetna and like to join Aetna’s network the provider should contact the provider service team and ask for a contract to become a participating provider. The number for Provider services is 1-855-364-0974 option 2.

OhioMHAS certified providers can use local lab providers that are in network with Aetna.

[Added 6/7/2018]

15. Can a CBHC operated lab handle services and billing for other providers who are providing the treatment?

OhioMHAS certified providers can use lab providers that are in network with Aetna.

[Response pending]

[Added 6/7/2018]

16. If a urine drug screen indicates relapse, how should providers communicate with the MCP about it to minimize treatment disruption?

Aetna Better Health of Ohio does not require a urine drug screen when MAT medications are prescribed for our members. However, providers must ensure that the PA criteria is met as applicable when prescribing MAT medications in accordance with Aetna’s pharmacy benefit coverage.

By submitting their request to the PBMs: Enroll Pharmacy Solutions (for Prior Authorizations) OR to the Buckeye Health Plan (appeals). These are handled case-by-case. We ask that the provider add any additional information to the PA or appeal case that would speak to why member relapsed as this helps the clinician make a well informed decision.

Reason should be documented on referral form when submitted. This information will be evaluated depending on the drug.

MoHAs preferred laboratory partners are Quest Diagnostics and LabCorp, but providers may utilize any CLIA-certified laboratory that is currently participating in Molina’s provider network.

C3HC labs can provide services and bill only for members receiving their treatment at that same CBHC.

A non-par lab can submit a complete form via the Paramount website, paramounthealthcare.com It can take up to 40 days to become participating. The ordering provider can request a prior auth at this time as well. All Non-Par labs are required to Prior Auth every lab service.

The provider is welcome to bill for the lab services in lieu of the non-contracted lab. Please note that lab services must be covered under the provider’s contract.

A provider is allowed to use any lab they choose, however a lab must be PA and have the codes included in their agreement to be paid for services.

17. How should providers coordinate MAT medication coverage when a member has a planned surgery and requires pain medication, with the hope of minimizing treatment disruption?

The MAT provider should notify the health plan upon PA request of any planned or previous surgeries where there is/was opioid use for pain control. If a PA has not been submitted, we suggest that provider do that as soon as possible in order to coordinate care.

If an authorization is currently approved for a MAT medication, provider to reach out to PBMs. These are handled case-by-case. We ask that the provider add any additional information to the PA or appeal case that would speak to why member relapsed as this helps the clinician make a well informed decision.

Doctor must document the reason, need, and length of therapy for the medication prescribed.

Doctor must document the reason, need, and length of therapy for the medication prescribed.

The MAT provider should notify the pharmacy of any planned surgeries where there is a need for narcotic pain control. Administration of the MAT medication will be suspended during narcotic treatment but can be reinstated once the MAT provider can verify that narcotic treatment is complete.

Notification of any questions regarding pain medications and surgery can be faxed to us pharmacy fax line: (844-256-2025) and can be kept on patient’s file for reference.

As above.
18. How can a provider request an authorization that provides flexibility in dosing for the intention of tapering the medication down (e.g. to cut down on admin burden if member is ready for tapering)?

Please mark the intentions on the prior authorization form. Proposed titration schedules should be included with the initial Prior Authorization request to be taken into consideration during the review process. We would have to be notified that this is going to occur. We can then double wild card the drug within our PBM system which will allow this action. Please note on the PA request the intention to taper down on dose during the period of administration. It would be helpful to indicate the dose and quantity planned for tapering to allow for dispensing.

Our pharmacy staff should enter authorizations which allow for tapering. If the authorization is not allowing tapering or titration of doses, please either use our normal pharmacy fax line: 844-256-2025. Any faxed PA requests should be answered under 24 hours. Providers can also call 800-891-2520 if they need immediate help for our members.

Suncor does not require the physician to get a new authorization when changing the dose.

19. A member has complex treatment issues and a provider would like additional support from a MCP care manager, how can a provider make a request for this service (e.g. urgent requests for assistance)?

Providers can contact our 24/7 Care Management Call Line at the health plan toll free number: 1-855-364-0974 and select option 5.

Providers can call Buckeye Provider Services (866-296-8731) and ask to be directed to a Care Manager or the Care Management Department.

Provider may make a referral to Care Management via fax at 1-866-206-0610 or phone at 1-800-993-6902. If non-urgent, the provider may also use the Provider Portal.

Providers can contact us at 1-800-442-4188 and request to be transferred to our Care Management program to make a referral. If urgent assistance is needed for an individual member at the time of referral, please let us know.

Specific to referring a member for CM: Monday-Friday 8A-5P, contact the Utilization/Case Management Department at 419-887-2520 or 1-800-891-2520.

After hours: Ask Paramount nurse line number: 1-877-336-1616

Behavioral Care Management can be requested by calling 866-261-7692. Medical Care Management can be requested using the following number: 800-508-2581 or faxing 866-508-2581

20. How should agencies who have on site pharmacies work with the Health Plan to dispense the medication through the on site pharmacy location if possible?

The pharmacy would need to contact our Pharmacy Benefit Management organization (CVS Caremark) and ask to be included in our network. Non-Contracted Pharmacies may enroll by completing and submitting the Pharmacy Pre-Enrollment Questionnaire www.caremark.com/pharminfo and select “Pharmacy Pre-Enrollment Questionnaire.” Pharmacies wanting to participate in a Plan Sponsor network (already Credentialled with Caremark) may contact Caremark Network Operations team at 1-888-314-8457, press the option for “Network Enrollment”. For Prior Authorization, contact Toll-Free Health Plan number at 855-364-0974, and follow the prompts for Pharmacy and then Prior Authorization.

The on-site pharmacy would need to be in Buckeye Pharmacy Network. Members are eligible to get medication filled at any eligible Network Pharmacy. For Specialty Medications, they would need to go through Aetna Health (Medicaid product only). If the pharmacy is not part of our network, they would need to work through our Pharmacy Benefit Management organization-Enovo Pharmacy Solutions.

The on-site pharmacy would need to be in CareSource Pharmacy Network. Members are eligible to get medication filled at any eligible Network Pharmacy.

The on-site pharmacy would need to work through our Pharmacy Benefit Management organization (CVS Caremark) to become part of the network. Non-Contracted Pharmacies may enroll by completing and submitting the “Pharmacy Pre-Enrollment Questionnaire” www.caremark.com/pharminfo and select “Pharmacy Pre-Enrollment Questionnaire.”

For member issues that need resolved or handled, please use our normal pharmacy fax line: 844-256-2025. Any faxed PA requests should be answered under 24 hours. Providers can also call 800-891-2520 if they need immediate help. Depending on the medication needed, we can facilitate a one-time authorization depending on the need.

UHC does not require the physician to get a new authorization when changing the dose.

21. How should a provider handle coverage when prescribers for particular members are out of the office? (e.g. order ahead when prescriber is in office, note MD coverage on the PA request, etc.)

Note MD coverage on PA request. The authorization is specific to the member and the drug only, not the prescriber.

They can request a PA ahead of time and make note of it on the PA form. Otherwise, the on call MD can request a PA for the member as the PA is specific to the member and the not the provider.

All applicable state and federal laws must be followed. Covering physician may fax PA request for member and document that they are covering for active physician. Covering Physician must be a qualified prescriber (X-DEA).

Please note prescriber coverage on the PA request if concerned about any lapses in medication. However, pharmacy authorizations are specific to the member and the drug only, not the prescriber.

They can call Paramount ahead (if need is known ahead of time), or the dispensing pharmacy can request a 72-hour supply override from CVS until the office can contact Paramount PA line above.

Members are not locked in to a single prescriber and prescriptions from another physician/provider or support staff will be honored at the pharmacy. The covering physician/prescribers or supporting staff may also request or submit authorizations on behalf of the prescribing physician. For injectable medications, the request would need to be done under the network physician's name.

Providers can call Buckeye Provider Services (866-296-8731) and ask to be directed to a Care Manager or the Care Management Department.

UHC does not require the physician to get a new authorization when changing the dose.
22. Does the Health Plan have a PA exemption program for providers that meet certain criteria and if so, how can a provider request this status?

No, we do not have a PA exemption program in place yet.

CareSource offers a Buprenorphine Gold Carding Program. Eligible providers are identified through internal data analytics reviews.

The Health Plan has the ability to apply exemptions for certain providers or types of providers, and these would be considered on a case-by-case basis through the MHD Pharmacy team. However, FDA edits, quantity limits, and prescribing requirements still apply. We feel that the great majority of PA requests are handled expeditiously so there is not a need for an exemption program.

No, Paramount does not have a PA exemption program in place as of today.

The Health Plan has the ability to apply exemptions for certain providers or types of providers, similar to the anti-psychotic exemption program. However, FDA edits, quantity limits, and prescribing requirements will still apply. Exceptions to the PA process will also depend on the type of patient, practice locations, and whether or not the prescriber is part of a Medicaid pilot program or drug court. A provider is welcome to contact the Health Plan if they are interested in having an exemption.

23. What are your PA requirements for buprenorphine products (e.g. Suboxone, Subutex, Bunavail, generic buprenorphine) [PA for pharmacy vs. office administration]

The PA requirements for buprenorphine products can be found on our website under “Prior Authorization Criteria” at the following link:
https://www.aetnabetterhealth.com/ohio/providers/premier/partd

The Health Plan has the ability to apply exemptions for certain providers or types of providers, similar to the anti-psychotic exemption program. We feel that the great majority of PA requests are handled expeditiously so there is not a need for an exemption program.

Buprenorphine/naloxone (Suboxone) film:

- A. Diagnosis of opioid dependence;
- B. Age ≥ 16 years;
- C. Prescriber has an “X” DEA number (DATA2000 waiver);
- D. Member will participate in drug abuse counseling program while on therapy;
- E. Random urine drug screens will be obtained while on therapy;
- F. Prescribed dose of Suboxone film does not exceed 24 mg per day and health plan approved daily quantity limit.

At PA requirements for MAT are the same.

PA requirements through the pharmacy benefit for these products include adherence to FDA approved use (for treatment of opioid dependence), a urine screen to confirm the patient is not using opioids or illegal substances and is taking the medication as prescribed, attestation that the patient is receiving behavioral health treatment for addiction (or has successfully completed recommended treatment), and the prescriber has an X-waivered DEA license/number. Subutex is the only product in this category that does not require PA at this time through pharmacy. There is no PA requirement for medications administered during office visits.

Buprenorphine + naloxone combinations only require:

1. Prescribed for addiction, not used for pain management
2. Within FDA approved doses
3. Regular urine checks and urine screenings
4. Progress and Plan of care submission
5. Aberrant behavior addressed via documentation
6. Member continues to go to support group or separate counseling

24. If a prescriber has a preference for certain types of dosing (e.g. strips vs. tabs) how can they request that?

The prescriber can prescribe the preferred agent available on our formulary. If the preferred product is not on our formulary please file a prior authorization.

Prescribers will need to indicate on the PA request if they would prefer for a member to use a particular agent. The request must document medical necessity, such as prior use or intolerance of other agents.

On the PA request form, document the preferred dosing form prior to faxing in your PA request.

Prescribers will need to indicate on the PA request if they would prefer for a member to use a particular agent. The request must document medical necessity, such as prior use or intolerance of other agents.

We do not currently have a preferred product, but we ask generics to be used when possible.

Prescribers will need to submit a PA if they choose to use a non-preferred medication. They may request pharmacy drugs or submit PA by calling 800-310-6826, or faxing to 866-940-7328. The request must document medical necessity, such as prior use or intolerance of the preferred agents.

25. What contact at the Health Plan should providers exchange information with regarding prescribers?

Providers should contact Alet Kilinc, Director of Behavioral Health at KilincA@AETNA.com.

Provider Services can be reached at 937-224-8300 option 2

Provider Services can be reached at 937-224-8300 option 2

Provider Services can be reached at 937-224-8300 option 2

Provider Services can be reached at 937-224-8300 option 2

Provider Relations can be reached at (419) 887-2535, or Toll Free (800) 891-2542

Please contact the Molina Behavioral Health team by emailing us at OHCareBehavioralReferrals@MolinaHealthCares.com or by calling our Behavioral Health Liaison Shirley Johnson directly at 1-800-357-0146 ext. 216309.

Please contact the Molina Behavioral Health team by emailing us at OHCareBehavioralReferrals@MolinaHealthCares.com or by calling our Behavioral Health Liaison Shirley Johnson directly at 1-800-357-0146 ext. 216309.

Provider Relations can be reached at (419) 887-2535, or Toll Free (800) 891-2542

Please contact the Molina Behavioral Health team by emailing us at OHCareBehavioralReferrals@MolinaHealthCares.com or by calling our Behavioral Health Liaison Shirley Johnson directly at 1-800-357-0146 ext. 216309.

Provider Relations can be reached at (419) 887-2535, or Toll Free (800) 891-2542

Please contact the Molina Behavioral Health team by emailing us at OHCareBehavioralReferrals@MolinaHealthCares.com or by calling our Behavioral Health Liaison Shirley Johnson directly at 1-800-357-0146 ext. 216309.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Does the Health Plan cover naloxone for emergency use? If so, how should providers request this on the behalf of the member?</td>
<td>Yes</td>
<td>Yes, we do cover naloxone products such as naloxone injection, Evzio, and Narcan at the pharmacy without a prior authorization required. The provider should write a prescription for the member.</td>
</tr>
<tr>
<td>27. Does the Health Plan have any additional options for prescribers to access Narcan kits in bulk through Pharmacy?</td>
<td>No</td>
<td>No, Aetna Better Health of Ohio does not have an option for a prescriber to bill us for bulk narcan kits. Narcan kits can be prescribed for individual members.</td>
</tr>
</tbody>
</table>