MANAGED CARE – BEHAVIORAL HEALTH CONTACTS & RESOURCES

Updated 10/31/2018

*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.

AETNA BETTER HEALTH

Provider Contracting:
Matt Koblens
KoblensM@AETNA.com

Provider Relations:
Rick Welch
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
Christy.L.Wilson@centene.com
Phone: 866-246-4356 ext. 24291

Provider Relations:
Amy Daggett or Charlene McCarthy
BehavioralHealth@centene.com
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

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:
Ellen Landingham
(614) 557-3041
MHOBHProviderTeam@molinahealthcare.com

Provider Relations:
Valerie Brandt
(855) 322-4079
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

Provider Relations:
David Bishop
David.Bishop@Promedica.org

Director of Behavioral Health:
Hy Kisin, Ph.D.
Hy.Kisin@Promedica.org

Authorizations: (800) 891-2520

Provider Manual:
http://www.paramounthealthcare.com/provider-documents

UNITED HEALTHCARE

Provider Contracting and Provider Relations:
Amanda Fling: Amanda.fling@optum
for prompt response: OhioNetworkManagement@Optum.com

Director of Behavioral Health:
Tracey Izzard
Tracey.izzard-everett@optum.com

Authorizations: 866-261-7692 or www.uhconline.com
Provider Manual:
http://www.uhccommunityplan.com/health-professionals/oh.html

Managed Care Plans - Operations Guide

	aetna	buckeye health plan	CareSource	MOLINA HEALTHCARE	PARAMOUNT ADVANTAGE Affiliate of ProMedica	UnitedHealthcare COMMUNITY & STATE
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)?	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 1-800-642-4168 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.	Specific to referring a member for CM: Mon-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. Please indicate if this request is urgent at the time of referral
2. What transportation vendor do you use and what is the standard benefit for your members?	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 recieve 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 trannsports per calendar year, medical or non-medical with no mileage restrictions	Buckeye utilizes Access2Care for Wheelchair and ambulatory trips. Contact Access2Care at: Medicaid 866-246-4358; MyCare Ohio: 866-549-8289. 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 trips per calendar year. Medically necessary trips by wheelchair van 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 & Southeast Medicaid region receive 30 round trip or 60 one-way trips	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 CDJFS redetermination appointments .	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.	Paramount Advantage 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.	UnitedHealthcare Community Plan utilizes Medical Transportation Management (MTM) to arrange or provide our non-emergency transportation services (NET). Our benefit for our Medicaid health plan members is 30 one way trips per calendar year or 15 round trips per calendar year. If a health care service requires a member to travel more than 29 miles one way to receive that service, then transportation is provided as part of the member's benefit and does not count toward the limits noted above.
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 1-866-799-4395 at least 3 days before your appointment for assistance. Transportation assistance for urgent and same-day reservation is available 24/7/365. Call Where's My Ride at 866-799-4405 for reservation confirmations and will-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: 1-866-246-4358; Member Services: MyCare Ohio: 1-866-549-8289; 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 or 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.	Members access the transportation benefit by contacting CareSource Transportation Services at 1-800-488-0134, TTY for the hearing impaired: 1-800-750-0750 or 711. The transportation options for members include bus passes and mileage reimbursement as well as standard taxi service. When members call to arrange transportation, they are asked if they would be interested in mileage reimbursement or 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 can contact 866-282-4836 for assistance. Members must call at least 2 business days (48 hrs) before an appointment. If they need to cancel a ride that is scheduled, members need to call to let us know 24 hours before the appointment. The transportation representative will determine the best ride option: • An Access2Care or Lyft vehicle will arrive at the member's home to pick them up. • The member may be sent passes for bus transportation if he/she lives within 1/2 mile of a bus stop and the appointment is less than 1/2 mile from a bus stop. • The member may be eligible for a gas voucher to pay them back for gas used to drive to an appointment. Members are eligible for this benefit if it is scheduled in advance of your appointments.	To schedule transportation members may call 866-837-9817 (M-F/8:30-a.m.-5 p.m.). 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 toward 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 CDJFS 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 notate that the member will be accompanied by another person/people. Names and relationship to the member will have to be provided for any additional riders. Member 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/developmentally delayed, or under the age of 18; escort not permitted otherwise. The escort can be the member's parent, legal guardian, caregiver, case worker, or an employee of the transportation provider. · If an attendant/escort is medically necessary to accompany the Member to medical appointment, member may take one medical provider (HHA, IP, nurse, SNTA) and personal (family) member. · LogistiCare allows up to two children (up to age 16 years) to accompany their parent on a space available basis, at no additional charge. Parents need to provide their own car seat or booster seat.	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 at the time of the transportation request. One additional passenger allowed, unless 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.	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. *Authorized additional rider information MUST be provided by the member when scheduling transportation or 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 mobililty needs. Accomodation 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 authorized representative.
5. What outcomes will MCOs be monitoring for members receiving behavioral health services? [Added 6/7/2018]	Aetna Better Health of Ohio is measured through HEDIS measures developed by our accrediting body NCQA and CMS Core measures. Please see the MyCare Ohio Provider Agreement (the Two-Way 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.	Buckeye 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.	At this time, CareSource and the other Medicaid Managed Care plans are 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. Additionally, certain ODM/OhioMHAS sponsored programs may have outcomes components associated with them, such as CPC, BH Care Coordination, SIM/Episodes of Care.	Medicaid Managed Care plans are 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.	Medicaid Managed Care plans are 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.	Medicaid Managed Care plans are 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.

Medicaid and MyCare Ohio - Billing Information

	aetna	buckeye health plan	CareSource	MOLINA HEALTHCARE	PARAMOUNT ADVANTAGE Affiliate of ProMedica	UnitedHealthcare COMMUNITY & STATE
Contracting and Credentialing						
1. Can I bill a Managed Care Plan without being contracted?	Non-Participating providers may submit claims to Aetna for services they rendered to MyCare members during the transition of care. However, after the transition period, non-participating providers will need an authorization for services in order for claims to pay.	Non-Participating providers may submit claims to Buckeye during the transition of care period. After the Transition of Care timeframe, an authorization will be needed for all services in order for claims to pay appropriately.	Yes, non-contracted providers can bill and submit claims as long as their information is loaded into the CareSource claims systems. If not, a Non Par 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/ohio-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-contracted providers will need an authorization for services in order for the claims to pay.	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. As a non-participating provider, behavioral health services following the transition period will require an authorization in order for claims to pay. 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.	Yes, providers without a contract can bill the health plan through the transition period. UHC will required basic information to excute 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 1-855-364-0974, 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.	Go to https://www.buckeyehealthplan.com/providers/become-a-provider.html or call 800-224-1991. Answer the prompts, you will be asked a series of questions to guide the contract process. You can find contact information for our contracting team on the "Plan Contacts" tab.	Go to: https://www.caresource.com/providers/join-our-network/ and complete the New Health Partner Contract Form. In the "Contract Code" section, please be sure to enter "BH" in this field and please indicate if that particular location provides AOD Services, in addition to Mental Health, by simply typing "AOD" in the notes section. For questions about credentialing, call CareSource at 1-800-488-0134 and follow the prompts to be directed to one of our Credentialing staff. Please have the following documents ready: • a Standardized Credentialing Form Part B or CAQH number • NPI number • Malpractice Insurance Face Sheet • DEA Certificate (current) if applicable You can find contact information for our contracting team on the "Plan Contacts" tab.	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.	Providers can access our website at: http://www.paramounthealthcare.com/network provider. Complete the 'Network Participation Request Form', save it and email it, along with a W9, to PHCProvider.Contracting@ProMedica.org; or, call 1-800-462-3589 and ask for Contracting.	Individual providers and facilities should go to providerexpress.com, click on "our network" and then click on "join our network." Ohio MHAS certified CMHC's and/or AOD providers should email OhioNetworkManagement@Optum.com. Recruitment mailings have been sent to all agencies asking them to complete an informational form and/or email their interest to OhioNetworkManagement@Optum.com 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_ProviderServices@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.	Any service agreement questions can be addressed through our Contracting Team at 866-246-4356 ext.24291.	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 aresa 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. Will the date of signature on the contract have to coincide with claims submission? Behavioral health services provided by CMHC and SUD providers to Molina's Medicaid members will continue to be billed to ODM until the behavioral health carve-in goes into effect.	Any service agreements are handled through credentialing / contracting which will be coordinated via Provider relations which can be reached at 419-887-2535 or 1-800-891-2542	We don't get questions specifically about the contract. Questions we do get frequently include: (1) how do we get the process started? (2) how long does it take? (3) what specifically do you need from me? To respond Optum/UHC has developed an Agency Readiness document that is available to all CHBCs going through the contracting and setup process.
4. How can I check my contracting status? [Updated 6/13/2018]	Call us at 1-855-364-0974, Option 2, then Option 5 or you can email us at OH_Contracting@Aetna.com. Please provide the provider's name, TIN and NPI. We will respond in 3-5 business days.	Contact our Contracting Team at 866-246-4356 ext. 24291 or you may email our Contract Director,Christy L. Wilson at Christy.L.Wilson@centene.com or Clinical Director Laura Paynter at lpaynter@centene.com All contracting requests can also be submitted via email at buckeyerequests@centene.com.	Email: contract.implement@caresource.com or call Provider Services at 1-800-488-0134. 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: 855-708-4840 or by email: OhioBHInfo@caresource.com.	Providers can contact Provider Services at (855) 322-4079 or reach out to their assigned contract manager at MHOBHProviderTeam@MolinaHealthCare.com to check on their status. If they haven't received a response they can contact Emily Higgins, our Director of Behavioral Health at emily.higgins@molinahealthcare.com	Providers can request contract status information by emailing PHCProvider.Contracting@ProMedica.org or by calling 1-800-462-3589 and asking for Contracting.	You may call the National Provider Services line at 877-614-0484 to receive an update on your contracting status. Or, email ohionetworkmanagement@optum.com to inquire
5. How long does it take to complete the contracting & credentialing process? What is your process for credentialing community behavioral health providers? [Updated 7/11/2018]	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 to process when we are in receipt of a signed contract and all appropriate credentialing documents. If contracting as a CBHC facility, Aetna will not require credentialing of practitioners within the agency but MITS registration is still required for all practitioner types. Aetna 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 Aetna's practitioner roster template by sending us an email at OH_BH_Redesign@AETNA.com.	Ohio Medicaid and MyCare 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 to process upon receipt of a signed contract and all appropriate credentialing 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.	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 group, CareSource will not require credentialing of practitioners within the agency, but MITS registration will still be required for all applicable rendering practitioners. If rendering practitioners are not all registered with MITS and affiliated with a CBHC, it will take additional time to load this data in our claims system to ensure claims will process correctly. CareSource is enouraging CBHCs to submit rosters of their rendering providers. Additional information about CBHC rostering for BH Carve-in can be found on our website at: https://www.caresource.com/providers/ohio/ohio-providers/patient-care/behavioral-health-carve-in/	Ohio Medicaid and MyCare 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 to process upon receipt of a signed contract and all appropriate credentialing documents. If contracting as a CBHC facility, Molina will not require credentialing of practitioners within the agency but MITS registration is still required for all practitioner types. Molina is encouraging agencies to submit a roster of practitioners using the Molina "BH Provider Form" posted on our website at http://www.molinahealthcare.com/providers/oh/medicaid/forms/Pages/fuf.aspx to ensure we have all practitioner information in our system while MITS registration is being processed. Agencies that need to update us on practitioner information should use this template rather than the Molina Provider Information Form since we are credentialing agencies at the facility level.	As part of the contracting process, Paramount credentials all provider types (physician, group, facility). For Behavioral Health providers, a roster is completed by the provider and returned with the contract. This roster is utilized by our credentialing staff in their efforts to credential all essential personnel. Paramount also follows guidelines form the National Committee for Quality Assurance (NCQA) 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, Paramount will not require credentialing of practitioners within the agency but MITS registration is still required for all practitioner types. We are requiring agencies to submit a roster of practitioners to ensure we have all practitioner information in our system while MITS registration is being processed.	As part of the contracting process Ohio Medicaid Plans must credential all provider types (physician, group, facility) in accordance with OAC rule 5160-26-05, and must ensure that providers have met all applicable credentialing criteria before they can be listed as a panel provider. Ohio plans must also follow guidelines from the National Committee for Quality Assurance (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, United will not require credentialing of practitioners within the agency but MITS registration is still required for all practitioner types. We are encouraging agencies to submit a roster of practitioners to ensure we have all practitioner information in our system while MITS registration is being processed.

6. What will an organization need to do to obtain a trading partner agreement with your plan? [Updated 6/7/2018]	Providers are not required to obtain a trading partner agreement (TPA) or business associate agreement (BAA) with our clearinghouse in order to submit claims to Aetna Better Health of Ohio.	We are not requiring any specifics pertaining to a trading partner agreement but trading partners will need to supply basic information in order to test claims within our Ramp Manager application.	CareSource accepts electronic claims from Clearinghouses/Trading Partners. Although we have direct connections to specific Clearinghouses/Trading Partners, provider can submit claims through any Clearinghouses/Trading Partner they wish. In addition, Avality offers free claims submissions. Providers can submit electronic claims, one at a time and free of charge on our provider portal. Which ever method is choosen, a Trading Partner Agreement (TPA) is not relevant.	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.	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 PHCECShelpdesk@ProMedica.org	We accept alll clearing houses. Provider contract / manual includes language, tems, 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.
7. How can I register for your Provider Portal? Is your Web Portal Service available for all providers or does my agency have to be completely contracted, credentialed, and fully loaded with all practitioner data in your claims system to use portal functions? [Added 6/11/2018]	Contracted (Participating) providers have several options to register for Aetna's Secure Provider Portal: • Call us at 1-855-364-0974, Option 2, then Option 5. • Email us at OH_ProviderServices@Aetna.com. • Complete the Paper Registration Form located at www.aetnabetterhealth.com/ohio/providers/portal. 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. Only Contracted providers can register for Aetna's Secure Web Portal and use portal functions.	All prpviders may register to utilize our Provider Portal by going to https://www.buckeyehealthplan.com/login. Beging by answering the question "I am " by using the drop down box, continue by answring various questions regarding your practice to create an account. Please Note: To register for our Provider Portal your provider information must be in our system. If you have any questions please reach out to our Provider Services team who will walk you thorugh the registration process. Provider Services: 1-866-296-8731	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 a 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 1-800-488-0134 to obtain their ID for portal registration.	All providers are able to register for the Molina Provider Portal regardless of contracting status. Visit http://www.molinahealthcare.com/providers/oh/duals/Pages/home.aspx and click on "Register" in the Provider Services Portal section. You will need your organization's TAX ID and a Molina Provider Identification number. A Provider ID can be obtained by contacting Provider Services at (855) 322-4079 or by emailing BHProviderServices@MolinaHealthCare.com. In order to submit claims on the Molina Portal with all rendering practitioners available for claims submission, Molina will need all practitioner data loaded in our claims system. Please notify us when you submit a roster if you plan to use the Molina Portal for claims entry so that your agency roster can be prioritized for loading. Agencies who submit a roster of their practitioners will receive confirmation when all of their practitioners are loaded and available on the Molina Portal.	Go to www.myparamount.org 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 MyParamount.org or by calling our Provider Inquiry department at 1-888-891-2564.	Go to www.uhconline.com. Under User ID and password, click "new user." You will need your Tax ID to register. In order to access the portal and all of its features, including claims submission, you will need a fully executed contract and have gone through the credentialing process to be considered a participaing provider in network (PAR). We can accept paper claims and/or EDI claims for non par or those still working through the credentialing process. Please contact:ohionetworkmanagment@optum.com with any questions or to inquire about your contract/credentialing status.
8. How can I check client eligibility? Are providers able to submit 270/271 eligibility files to your plan directly or to your clearinghouse to obtain the plan member ID? Will User Acceptance Testing (UAT) be required for 270/271 transactions by your clearinghouse? [Updated 6/7/2018]	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.	To verify eligiblity you can call Customer Service at 1-800-224-1991 or check on the Buckeye Secure Web Portal, https://www.buckeyehealthplan.com/login.html .	Providers can continue to utilize the MITS portal, as well as the CareSource portal or Call Us at 1-800-488-0134. 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/OH/User/Register.aspx. You can refer to the Portal Registration Training Module for step-by-step instructions at https://www.caresource.com/wp-content/uploads/Provider_Portal_Registration/1_Provider_Portal_Registration.htm 270/271 exchange must be verified with your clearinghouse if using one. CareSource clearinghouses that support 270/271 exchanges include the following: Alveo, Availity, ChangeHealthcare, Dorado Systems, Experian Health, RelayHealth, and TransUnion. CareSource does not require UAT, but new providers may want to check with their trading partner/clearinghouse to verifiy 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.	MITS portal will help identify and validate eligibility also Paramount's Member Services department can confirm eligibility specific dates and other eligibility related inquiries at 1-800-462-3589 or 1-888-740-5670 Providers are able to transmit 270/271 eligibility files with Paramount directly or through a clearinghouse. Providers must provide the member's first and last name and date of birth to receive Paramount's member ID in 271 Response. Each individual clearinghouse will have to notify the provider if they (the clearinghouse) requires user acceptance testing or not.	MITS portal. You may also contact Member Services at 877-542-9236 to verify specific dates of eligibility. Please contact:ohionetworkmanagment@optum.com with any questions or to inquire about your contract/credentialing status.
Claims Submission						

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. Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare, using 837 file format. Please use Submitter ID #50023 when submitting electronic claims.	You can submit claims electronically either on the Buckeye Web Portal or through an EDI Vendor. Payor ID is 68068. For information on submitting claims electronically contact Centene EDI Department PH: 1.800.225.2573 ext: 6075525 or via e-mail at: EDIBA@centene.com Payor ID 68069 Visit www.buckeyehealthplan.com Click Provider Home/Resources/ Electronic Transactions (EDI)	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 use 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 (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.emdeon.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 recent check number to register. Clearinghouse option: Molina provides an EDI companion guide, a Webconnect guide, and FAQ located under the EDI/ERA/EFT tab located on the Molina Website at www.MolinaHealthCare.com For EDI questions providers can call 1-866-409-2935 or email directly at EDI.Claims@MolinaHealthCare.com Molina Healthcare's payor ID is 20149	Providers can obtain information relating to electronic claims submission by calling 1-855-803-6777 or by email at phcecshelpdesk@promedica.org. Or by visiting http://www.paramounthealthcare.com/frequently-asked-questions. This information is available on www.paramounthealthcare.com under electronic submissions	You can sign-up and/or submit claims electronically either on the uhconline.com portal free of charge or through any EDI vendor. For assistance in learning about the UHC portal registration process, please select "Getting Started" on the home page in order walk through a tutorial that demonstrates the new registration set-up process. Contact phone numbers are also listed in this section. 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.
10. What clearinghouses do you use for processing inbound claims?	Aetna Better Health of Ohio 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: - Aleveo - Availity - 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.	Please find all Clearinghouse information on the following webpage: http://www.paramounthealthcare.com/body.cfm?id=726	We are able to work with any clearinghouse.
11. What NPI do I submit on a claim header and at the service line? Will you require a roster of agency practitioners for claims system configuration?	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.	You should bill the supervising, ordering, or rendering Provider in box 17 of the claim header dependent on the services billing. In box 24J would be the rendering and the agency NPI in box 33. A roster of agency practictioners for claims systems configuration will be needed/requested.	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 organizations 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.	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. 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. 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.
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 service.	Please submit your organization's tax ID number that you use on your W-9 form, placed in box 25 of the CMS 1500 claim form.	Please use the Tax ID of the billing provider/agency.	Please use the Tax ID of the rendering provider/agency.	Please use the Tax ID of the rendering provider/agency.

13. What Member ID should I submit on a claim? [Updated 7/25/2018]	Providers should use the Member ID# on the member's Aetna MyCare ID card which is the same as the member's Medicaid ID number.	Providers should use the Member ID # that is on their ID card. To verify member ID the provider may also use our Web Portal.	The CareSource member ID must be submitted on all claims. This is the only member ID that will be accepted by CareSource. You can locate the member ID on the member's card or on our provider portal at: https://providerportal.caresource.com/OH/User/Login.aspx?ReturnUrl=/OH/default.aspx	Providers should use the Member ID# on the member's ID card. If the consumer is enrolled in MyCare, this will be the member's Medicare ID number. If the member is covered by Molina for Medicaid only, this will be the member's Medicaid ID number.	Paramount Member ID# can be found on their individual member ID card.	UHC will accept the UHC member ID # from the insurance card or the Medicaid ID # on the claim.
14. 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 Medicaid 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 an 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 Medicaid 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 Medicaid 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 service you would need to indicate the member's Medicaid plan (CareSource) as the primary payer on the claim.	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 Medicaid 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 an COB from the primary payer.
15. When Medicaid is the secondary payer, is the electronic COB information from the 837 sufficient to process and pay the claim or is additional documentation, such as the Explanation of Benefits (EOB) required 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 EOB 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 Payer 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).

16. How can I do some testing with your plan on claims submission - what is your testing protocol? Who should I contact if I am having trouble with submitting test files through your clearinghouse? How long will testing be available with your plan in 2018? [Updated 6/7/2018]	Aetna Better Health of Ohio concluded its testing for BH Redesign on December 15, 2017 and implemented the behavioral health resdeign services on January 1, 2018. Providers do not need to test with Aetna and can submit claims for services rendered to Aetna's members now. Please email Aetna's Rapid Response Team at OH_BH_Redesign@aetna.com if you need assistance with submitting your claims to Aetna.	For claims format testing, providers, clearinghouses, and vendors can submit an 837 electronic claim file to Centene's Ramp Manager application. Most clearinghouses are already registered with Ramp Manager but if you are not, you can create an account at https://sites.edifecs.com/index.jsp?centene. Upon completion of registering your account you will need to confirm your profile and accept the trading partner agreement. The system will them walk you through the testing process as you will be routed to the Centene Edifecs Homepage where you can submit 837 test files. Upload your testing files as outlined on the Testing Validation Wizard. Once returning to the claims testing screen, an error report will be available for viewing if claims did not pass edit criteria. Once you have completed the process, please send us an email notification to ediba@centene.com letting us know what agency/provider you are representing and what type of files you uploaded and tested.	Contact CareSource to coordinate testing of claims submission: julie.curtis@caresource.com; extension 937-531-3402 to set up an intake call. Testing requires 1) the confirmation of Clearinghouse connection through to CareSource for EDI file exchange and 2) processing of claims through to payment / Explanation of Payment (EOP) or denial. Test coordination will be conducted to confirm which services and codes will be submitted by the provider and confirm the appropriate test indicator within the 837 CareSource has proactively conducted outreach to our trading partners/clearinghouses to help them understand the priority and necessity for their support. We have also escalated to help them understand the effort needed when providers contact us with this concern. Please contact our Rapid Response Team if you need any assistance with testing through one of our clearinghouses. We will continue to support test submissions through July 1 and post July 1 as needed, but we ask you to submit your test files sooner to allow	Testing scenarios should reflect the current scope of services being offered in your practice today: - Scenarios must align with current HIPAA billing guidance and standards - Practitioners used for testing should be linked in MITS and affiliated with the group practice - Scenarios will be provided in the guidance documents and can be used although testing should not be limited to these test cases - For test claims use dates of services in 2018 and current active Molina member information 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 BHProviderServices@MolinaHealthcare.com mailbox for assistance with testing, including assistance needed for testing through our clearinghouse Change Healthcare. Testing will remain open until 10/31/2018.	Providers will complete an intake form that provides the appropriate information. Providers will be required to contact the ECS Coordinator at Paramount to work through the testing process. ECS Coordinator can be reached at 419-887-2739 Please send an email to PHCBehavioralHealthTesting@ProMedica.org Our rapid response team can assist any provider or provider groups through the testing process. Also, providers can reach out Provider Inquiry Department 419-887-2574 or our 24/7/365 call center 419-887-2557 where the inquiries and coordination of testing process can be triaged. Our Behavioral Health Claims Testing Request form has the entire structure of the testing requirements regarding details around test files, testing process and results/reporting.	After attending an instructional webinar, providers interested in testing should complete and return a "Claims Test Template" to OhioNetworkManagement@Optum.com Test claims should: bill only with assigned dates of service assigned, use test members provided, ensure all required fields are populated on claims, electronic 837p/837i submissions require field ISA15 populated with "T", use payer ID 87726. Paper claim (CMS1500/UB-04) submissions require hand writing or typing "TEST CLAIM" at the very top of the claim, and should be sent via secure email to the Network Manager. Once the electronic claim file is received: (1) a 999 file level report indicates whether file was accepted or not, (2) HIPAA validation performed and if claim errors surface, a 277CA is returned that provides reasons why the claim has errors. This information is supplied to the clearinghouse. Contact for general questions regarding testing process: Nanna Horton, Network Manager: OhioNetworkManagement@Optum.com Testing will be open until 6/30/18.
17. Is there a time limit for filing a claim, and what is the date you use to determine a claim is beyond the timely filing limit? [Updated 6/7/2018]	Non-contracted providers have 365 days from the date of service so long as the date of service is within the transition of care period. Contracted providers need to follow the terms of the contract for filing a claim. If there is primary coverage, Aetna will use the date of the Explanation of Benefit from the primary insurer to determine a claim is beyond the timely filing limit.	365 days from the date of service or discharge.	Within 365 days of date of service or discharge. CareSource will honor the 90-calendar day 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, 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, timely filing rules will realign with Molina standard contracts - refer to the timely filing requirements found in your Provider Agreement. The standard timely filing limit is 120 days.	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, provider has 60 days to appeal, unless the providers agreement states otherwise.	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.
18. How should I handle claims rejected or unable to process through the plan's clearinghouse 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 redetermination of claims that are submitted after timely filing deadline, providers would need to submit an appeal to the health plan.	If the date of service is great than 365 days of the receipt date the claims will be denied. Providers are sent 277u rejects reports, through their clearinghouse, the following day after a claim rejects to ensure they have ample time to correct and resubmit any claims. Additionally, claim status is available through our provider portal or call center. These trading partners/clearinghouses also allow provider to perfomr 276/277 transactions to check on claims status: - Availity - Change Helathcare - Experian Health - RelayHealth	Molina will allow 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 reconsideration form on the Molina website at http://www.molinahealthcare.com/providers/oh/duals/forms/Pages/fuf.aspx . If you have any problems receiving technical assistance from Molina's clearinghouse Change Healthcare or concerns about a claim reconsideration request you submitted, please contact BHProviderServices@MolinaHealthcare.com or the Director of Behavioral Health Emily Higgins at Emily.Higgins@MolinaHealthCare.com.	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.	For any timely filing issues, resubmit the claim with any of the following as valid proof of timely filing: The following are considered valid proof of timely filing (POTF) attachments: • UnitedHealth Group correspondence (data entry send back letter) • Computer-generated activity page/print screen listing the date the claim was submitted to UHC/Community & State • Other insurance carrier denial/rejection EOB/PRA • Billing statement indicating the date in which they became aware the member had coverage with our health plan • Electronic claims-acceptance report which must include either of the following: o Universal EDI acceptance code A1:19 coding and an acceptance date within the timely filing period. Combination of a version of the words "accepted by payer"; "acknowledged by payer" or "received by United Healthcare".

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?	Aetna 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 OH_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 redetermination of claims that are submitted after timely filing deadline, providers would need to submit an appeal to the health plan.	In general, if the date of service is greater than 365 days has elapsed since the Date of Service on the claim, the claim(s) will be denied. If CareSource determines they incorrectly denied claims due to an inaccurate billing configuration in their system, they will adjust the claims accordingly and the provider will not have to resubmit the claims. If a provider believes CareSource is denying or paying the incorrect amount on a claim or multiple claims they should submit a provider appeal to CareSource.] There is an exception to the 365 timely filing limit for coordination of benefit claims for which the provider submits the primary carrier EOB within 90 days of the date issued for CareSource to consider payment as secondary (tertiary, etc.). This is in accordance with the DRA (Deficit Reduction Act).	Molina will allow special consideration for denials that result from Molina system configuration issues. For any denied claims that fall after the timely filing limit, please use the reconsideration form on the Molina website at http://www.molinahealthcare.com/providers/oh/duals/forms/Pages/fuf.aspx. If you have any concerns about configuration issues or about a claim reconsideration request you submitted, please contact BHProviderServices@Molinahealthcare.com or the Director of Behavioral Health Emily Higgins at Emily.Higgins@MolinaHealthCare.com.	Providers can reach out Provider Inquiry Department 419-887-2574 or our 24/7/365 call center 419-887-2557 where the inquiries and coordination of testing process can be triaged. If necessary provider should submit their claim/s via mail to POB 497 Toledo, Ohio 43697.	If it is a corrected claim, the provider would follow the corrected claim process. Must be submitted 60 days from paid date for in-network providers and 180 days from paid date for out of network providers.
20. How should I handle denials due to Medicaid eligibility or MCO enrollment errors in MITS when the dates of service are beyond the timely filing limit? What are the timelines that I need to follow for reconsideration?	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 MITS 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 OH_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 redetermination of claims that are submitted after timely filing deadline, providers would need to submit an appeal to the health plan.	In general, if the date of service is greater than 365 days since the Date of Service on the claim, the claim(s) will be denied. In order to have reconsideration of claims that are submitted after timely filing deadline, providers would need to submit a providerappeal to CareSource.	Contracted providers typically have 120 days from the date of the original remittance advice to submit a reconsideration request. Providers should use our standard reconsideration/appeal process outlined below.	Providers can reach out Provider Inquiry Department 419-887-2574 or our 24/7/365 call center 419-887-2557 where the inquiries and coordination of testing process can be triaged. If necessary provider should submit their claim/s via mail to POB 497 Toledo, Ohio 43697.	Please call UHC Community Plan Ohio Provider Services at 800-600-9007 for assistance.
21. How do I get set up for Electronic Funds Transfer (EFT) instead of receiving paper checks by mail? [Updated 10/2/2018]	Providers can submit Electronic Funds Transfer Form to be set up for EFT. The form can be obtained at the following link: https://www.aetnabetterhealth.com/ohio/assets/pdf/OHEFTform2017.pdf You are also welcome to call us at 1-855-364-0974, 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.buckeyehealthplan.com/providers/resources/electronic-transactions/payspan.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, InstaMed.InstaMed 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 215-789-3682, or call CareSource Provider Services at 1-855-202-1058.	Enrollment for EFT Registration is through the Change Healthcare ProviderNet at https://providernet.adminisource.com and is offered as a free service. Providers will need a check number from a Molina claim payment to register. Additional registration instructions can be found on Molina's website http://www.MolinaHealthcare.com/OhioProviders Providers who would like assistance with EFT registration including obtaining a check number for registration can contact our Rapid Response Team at BHProviderServices@MolinaHealthCare.com	The instructions to sign up for Virtual Credit Card (VCC), Paper Checks, or Electronic Funds Transfer (EFT) can be found on the Explanation of Payment (EOP) with both a phone number and web address as RedCard and VPAY facilitates the Payment process for providers with Paramount. Contact Change RedCard/VPay at Phone: 1-877-836-7586 Email: support@vpayusa.com	Providers can go to www.uhconline.com, Tools & Resources and select EDI Education for Electronics 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.aetnabetterhealth.com/ohio/assets/pdf/OH_ERAForm_050415.pdf. You are also welcome to call us at 1-855-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com and we will send you the ERA form at your request.	To register for ERA please use the following link: https://www.buckeyehealthplan.com/providers/resources/electronic-transactions/payspan.html	Be sure to be set up for EFT first. Complete the Electronic Remittance Advice Routing form available at: https://www.caresource.com/documents/instamed-order-form-for-payer-payments/	To register for ERA (835), please go to https://providernet.adminisource.com. For assistance with receiving 835/ERAs: 1-866-409-2935 or email directly at EDI.eraeft@MolinaHealthcare.com	The instructions to sign up for ERA can be found on the Explanation of Payment (EOP) with both a phone number and web address as Change Healthcare facilitates the ERA process during the EFT set-up processor providers with Paramount. Contact Change Healthcare at 1-877-271-0054 or 1-866-506-2830	Go to www.uhconline.com or 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 contact for technical EDI questions including trading partner setup and information about 837 file format? [Updated 6/7/2018]	Call us at 1-855-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com	Contact your EDI Vendor or the Centene EDI Department at 1-800-225-2573, ext 60725525 or fax at 1-866-266-6985.	Start by reaching out to your clearinghouse. 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: 855-708-4840 or by email: OhioBHInfo@caresource.com.	For 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 419-887-2739. Or contact our ECS coordinator 419-887-2739 If necessary also contact Change Healthcare at 1-866-506-2830	Contact Optum Insight at 800-210-8315.

24. What are my options for claims submission if I am having technical problems with EDI submission?	Aetna accepts claims in electronic or paper format. Send paper claims to: Aetna Better Health of Ohio P.O. Box 64205 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-resources.html	Providers can submit their claims electronically through a clearinghouse, on our provider provider or via paper by mailing the claim forms to CareSource ATTN: Claims Dept. P.O. Box 8730 Dayton, OH 45401-8730	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 our provider web portal to offer a claims submission option starting 5/1/2018. If necessary providers may submit their claims via mail at P.O. Box 497 Toledo, Ohio 43697 Also, Paramount will have an electronic claims submission portal as of July 1, 2018. Please call Provider Inquiry 419-887-2574 to register for the provider portal and begin to prepare submitting claims through the portal as of July 1, 2018.	Providers have the option to submit paper claims, claims through our portal, or through any EDI vendor.
25. Who should I contact if I need assistance with claims submission? [Updated 6/7/2018]	Providers can contact our BH Rapid Response Team at OH_BH_Redesign@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. Providers can also call us at 1-855-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com. OhioMHAS certified providers can also contact your Single Point of Contact or Regional Provider Services Liaison.	For claims assistance contact Provider Service at 1-866-296-8731.	Please call Provider Services 1-800-488-0134 or your Health Partner Manager. Additionally, your trading partner/clearinghouse should be able to assist. 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: 855-708-4840 or by email: OhioBHInfo@caresource.com.	Providers can contact our BH Rapid Response Team via email at BHProviderServices@MolinaHealthCare.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.	Advantage Provider Inquiry Phone: 419-887-2574 Toll Free: 1-855-522-9076 Toll Free Fax:1-855-448-4705 Rapid Response Team Contact Information: Email Name: PHCBehavioralHealthTesting@ProMedica.org 24/7365 Help: 419-887-2557	Ohio providers who need assistance with eligibility, benefits or who need to report claim issues may do so by calling into the UHC Community Plan Customer Service Center via an IVR (Integrated Voice Response) line at TFN 1-800-600-9007, Option 4 (Ohio) (MyCare: Hrs. 8AM-6PM EST, Mon. – Fri. / Medicaid: Hrs. 8AM-5PM EST, Mon. – Fri.). Provider Information is also available 24x7 online via the provider's secure account.
26. Who should I contact if I do not get a response within 24-48 hours?	You can contact your Provider Services Liaison or Afet Kilinc, Director, Behavioral Health at 959-299-7278 or KilincA@AETNA.com.	Contact your Prvoider Network Specailist 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: 855-708-4840 or by email: OhioBHInfo@caresource.com. Messages will be returned within 24-business hours or Terry Jones, Director of BH for Ohio at terry.jones@caresource.com or (614) 318-3483.	You can contact Emily Higgins, our Director of Behavioral Health at Emily.Higgins@MolinaHealthCare.com.	Please contact our Provider Inquiry department via 419-887-2564 or 1-888-891-2564 or You can contact our Rapid Response Team via email PHCBehavioralHealthTesting@ProMedica.org	You can contact Tracey Izzard tracey.izzard-everett@optum.com or for more rapid response OhioNetworkManagement@Optum.com
Reconciliation						
27. How often does each MCO cut checks or process EFT payments and on which day of the week? [Updated 6/7/2018]	Aetna Better Health of Ohio currently processes check runs twice a week on Wednesdays and Fridays.	Buckeye processes check runs twice a week on Tuesday & Fridays	Weekly, on Friday.	Molina currently processes check runs once a week, but will be increasing check runs to daily by July 1st 2018 to ensure fast payment through the managed care transition.	Paramount currently processes check runs once a week but is in the process of increasing check runs/payments to multiple times a week and will be implemented by July 1, 2018.	Payments are processed daily-Wednesday through Sunday
28. How can I obtain an Explanation of Payment (EOP)?	Remittance advices are sent with payment or providers may sign up to receive Electronic Remittance Advice notices.	EOP's can be viewed on the Buckeye secure web portal or call Provider Services and reqeust an EOP 1 -866-296-8731	Hard copy EOPs are sent with a check (for claims submitted as paper), but the electronic copy is the ERA (835) file, which can be accessed from the clearinghouse portal. PDFs can also be accessed from our provider portal. Note, 277Us are not EOPs. Providers can also view the 835 through the CareSource Provider Portal.	EOPs are mailed with paper checks, but are also available to view and download on the ProviderNet website. The EOP PDF will remain online on the ProviderNet site for up to 12 months after original payment. Note: If you are currently receiving EFT payments you have login credentials to the ProviderNet website.	Paramount coordinates claims payable weekly with Change Healthcare. Change Healthcare sends EOPs and all forms of payment on a weekly basis. EOPs are sent out automatically with all forms of payment. All providers should use the provider portal on our website www.paramounthealthcare.com/providers or providers should work with their clearinghouse to set up the EOP.	277Us are done upon receipt of the claim - they are obtained in the same manner in which we receive the claim or electronically through the vendor. Rejection information is handled in the same manner. Upon payment, providers will need to look for the EOP. The ability to get electronic EOP's exists through UHConline. The EOP will be on the bank portal and is linked to UHConline.
29. How long does it take to process my claims?	In accordance with 42 C.F.R. § 447.46, Ohio MyCare Plans must process ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.	In accordance with 42 C.F.R. § 447.46, Ohio MyCare and Medicaid Plans must process ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.	In accordance with 42 C.F.R. § 447.46, Ohio MyCare and Medicaid Plans must process ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.	In accordance with 42 C.F.R. § 447.46, Ohio MyCare and Medicaid Plans must process ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.	In accordance with 42 C.F.R. § 447.46, Ohio Medicaid Plans must process ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.	In accordance with 42 C.F.R. § 447.46, Ohio MyCare and Medicaid Plans must process ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.

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 EOP from Primary Payor, please include the Medicare providers EOP 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, nonspecific diagnosis code, date of service is prior to the member's effective date.	Common Denials are due to duplicate claims, no plan 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 EOP reports mailed 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 your claim status at any time by logging into your WebConnect or Secure Provider Portal. And you are always welcome to call us at 1-855-364-0974, 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 Service at 1 - 866-296-8731.	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 provider to perform 276/277 transactions to check on claims status: - Availity - Change Healthcare - Experian Health - RelayHealth	You can check the status of a claim is through the Molina WebPortal. However, providers who need additional assistance can contact the Provider Relations team at (855) 322-4079.	The provider can register to use the Paramount Portal to view all their member and claim detail Also providers can contact Provider Inquiry 419-887-2564 or 1-888-891-2564	Go to www.uhconline.com
32. How do I submit a corrected claim? [Updated 10/17/2018]	You can file a corrected paper claim by completing a new claim form and marking the claim form as a corrected claim. Be sure to mark "Corrected Claim" or "Resubmission" on the envelope. Send corrected claims to: Aetna Better Health of Ohio P.O. Box 64205 Phoenix, AZ 85082 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 1-855-364-0974, Option 2, then Option 5 or email us at OH_ProviderServices@Aetna.com. Detailed information about corrected claims can be found on page 161 in the Aetna Better Health of Ohio Provider Manual at https://www.aetnabetterhealth.com/ohio/providers/manual	Correct the claim and resubmit through the Buckeye Web Portal, submit a corrected claim by using EDI or submitting a paper claim. Providers can log into our website at www.buckeyehealthplan.com/providers/login to acess the claim submission option and process for reversing the claim and payment.	Providers have 365 calendar days from the date of service or discharge to submit a corrected claim. You can submit a corrected claim in one of three (3) ways: 1. Electronic submission (837P) using your current clearinghouse (CareSource payer ID # 31114) 2. Electronic submission via the portal - see recent network notifications regarding electronic submission of coordination of benefit claims and corrected claims. 3. Paper submission by using the industry standard CMS1500 claims form to the address below. Please note: The paper corrected claim should be marked or stamped "corrected" and the previous claim number should be added. CareSource ATTN: Claims Department P.O. Box 8730 Dayton, OH 45401-8730 For information on how to submit Corrected Claims please see the Network Notification from 7/22/2015, located here: https://www.caresource.com/documents/new-requirements-for-corrected-claims-submissions/	Detailed information about the correction process for electronic (portal or EDI) claims can be found on page 22 in the Molina Provider Manual which can be found on the website at https://www.molinahealthcare.com/providers/oh/medicaid/manual/PDF/oh-combined-provider-manual.pdf You will need to include the original claim number on the corrected claim, which can be found on the remittance advice or paper Explanation of Payment. Paper corrections will need the corrected claim form found at http://www.molinahealthcare.com/providers/oh/duals/forms/Pages/fuf.aspx. Please place a 7 or 8 in box 21 of the CMS 1500 claim form and send the paper claim to: Molina Healthcare, Inc. PO Box 22712 Long Beach, CA 90801	Paper adjustments: Paramount P.O. Box 497, Toledo, OH 43697-0497 (current form attached) Electronic Adjustments: Professional- use the correct freq. code of 7 or 8 and for UB- use the correct Type of bill ending in 5, 7 or 8. The Claim Adjustment Form and information about electronic adjustments can be found at https://www.paramounthealthcare.com/provider-documents. Claims submitted through the MyParamount portal may have adjustments aslo submitted through the MyParamount portal.	• Go to www.uhconline.com, OptumCloud, or submit via paper to UHC Community Plan of Ohio, P.O. Box 31364, Salt Lake City, UT 84131-0364. • For electronic professional claims the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes: • "7" – REPLACEMENT (Replacement of Prior Claim) • "8" – VOID (Void/Cancel of Prior Claim) For information on how to submit corrected claims Providers can go to the claims tip page and click on Claims Problems Resolution. There is also a guided tour documentation that goes into details on submitting corrected claims. https://www.providerexpress.com/content/ope-provexpr/us/en/admin-resources/claim-tips.html.html

33. When a provider identifies either a billing error or identifies a payback is necessary through their internal QI process, what is the process for reversing the claim and payment? [Updated 10/24/2018]	To initiate a Reconsideration, Participating providers should submit a Dispute and provide any supporting doucumentation along with our Dispute form and a copy of the claim with an explanation of the overpayment. Non-participating providers should follow our Appeal process. Both forms can be found at our website under 'For Providers' link at https://www.aetnabetterhealth.com/ohio/providers/forms	When information on the claim is being modified, providers can submit a corrected claim or submit the correction through the Buckeye claims portal. Buckeye will process the resubmitted claim and recover the original payment if needed, or adjust the claims if it is corrected through the portal. For claims where it is a billing error requiring a full take-back, BHP can either adjust the claims and offset future payments, or a refund can be sent with supporting documentation including impacted claim(s). Providers can log into our website at www.buckeyehealthplan.com/providers/login to acess the claim submission option and process for reversing the claim and payment.	The CareSource Claim Recovery Request Form has been created to help ensure timely and accurate reprocessing, and is available to download from CareSource.com at http://workspace.caresource.corp/sites/mktg/Products/OH-SP-0137%20Claim%20Recovery%20Refund%20Check%20Form.pdf. Please submit a separate Claim Recovery Request Form for each refund check and include the appropriate required documentation for each submission. Please view this network notification (https://www.caresource.com/documents/oh-sp-0138_new-address-for-refund-checks/) for more information.	Claim reversals can be handled by voiding the initial claim submitted or through the claims correction process on the portal as outlined below, or as above in #32 for EDI claims. Please note: claims can only be voided if you are still within the timely filing timeframe (180 days) but claims can be corrected up to 365 days after initial submission. 1. Provider Portal Submission • Go to http://Provider.MolinaHealthcare.com. • Log in with your username and password. • Select “Create a professional claim” from the left menu. • Select the radio button for the correct claim option. • Enter the ID number of the claim you want to correct. • Make corrections and add supporting documents or an explanation of benefits (EOB). • Submit your claim.	Paramount requests adjustments to be processed using the electronic 837P. A frequency code of 7 indicates a replacement for an original claim, and a frequency code of 8 indicates a void of a previous claim. The electronic adjustment claim must also include the original claim number in the appropriate loop. A paper adjustment must be accompanied by a paper adjustment request form. We do not expect a provider to submit an unsolicited refund to us unless requested. Please reference question #32 for additional submission detals.	**Billing Errors:** see instructions for correcting claims as listed above in #32. **Paybacks:** the UHC Preferred Method is for provider to do nothing, our claims system audits claims and recognizes overpayments and all identified overpayments will be recouped in further payments. The other option would be for provider to contact ARO recovery services @ 800-727-6735.
Ohio Medicaid Billing Rules						
34. How will the MCOs accept claims for dually licensed practitioners? [Updated 6/7/2018]	Aetna will follow Behavioral Health Redesign FFS guidelines regarding dually licensed provider billing instructions (1-26-18 MITS BITS).	Buckeye will follow Behavioral Health Redesign FFS guidelines regarding dually licensed provider billing instructions (1-26-18 MITS BITS).	CareSource will follow Behavioral Health Redesign FFS guidelines regarding dually licensed provider billing instructions (1-26-18 MITS BITS).	Molina will follow Behavioral Health Redesign FFS guidelines regarding dually licensed provider billing instructions (1-26-18 MITS BITS).	Paramount will follow Behavioral Health Redesign FFS guidelines regarding dually licensed provider billing instructions (1-26-18 MITS BITS).	UHC will follow Behavioral Health Redesign FFS guidelines regarding dually licensed provider billing instructions (1-26-18 MITS BITS).
35. If a practitioner's enrollment application is still "in process" with the MITS system, what options are available to submit claims to an MCP after 7/1 while the ODM application process continues? [Added 6/27/2018]	If the rendering field of the claim is blank or includes the billing agency NPI, claims will be denied and Aetna will contact the provider to inform them of the denial reason and requirements needed to process claims starting July 1 (e.g. rendering practitioner needs to obtain a NPI, enroll in MITS and affiliate themselves in MITS with the billing agency). 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 MITS system Aetna will pay the claim for the time being to allow for all applications to be processed by ODM. Aetna 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.	If the rendering field of the claim is blank or includes the billing agency NPI, claims will be denied and Buckeye will contact the provider to inform them of the denial reason and requirements needed to process claims starting July 1 (e.g. rendering practitioner needs to obtain a NPI, enroll in MITS and affiliate themselves in MITS with the billing agency). 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 MITS system Buckeye will pay the claim for the time being to allow for all applications to be processed by ODM. Buckeye 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.	If the rendering field of the claim is blank or includes the billing agency NPI, claims will be denied and CareSource will contact the provider to inform them of the denial reason and requirements needed to process claims starting July 1 (e.g. rendering practitioner needs to obtain a NPI, enroll in MITS and affiliate themselves in MITS with the billing agency). 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 MITS system CareSource will pay the claim for the time being to allow for all applications to be processed by ODM. CareSource 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.	If the rendering field of the claim is blank or includes the billing agency NPI, claims will be denied and Molina will contact the provider to inform them of the denial reason and requirements needed to process claims starting July 1 (e.g. rendering practitioner needs to obtain a NPI, enroll in MITS and affiliate themselves in MITS with the billing agency). 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 MITS system Molina will pay the claim for the time being to allow for all applications to be processed by ODM. Molina 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.	If the rendering field of the claim is blank or includes the billing agency NPI, claims will be denied and Paramount will contact the provider to inform them of the denial reason and requirements needed to process claims starting July 1 (e.g. rendering practitioner needs to obtain a NPI, enroll in MITS and affiliate themselves in MITS with the billing agency). 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 MITS system Paramount will pay the claim for the time being to allow for all applications to be processed by ODM. Paramount 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.	If the rendering field of the claim is blank or includes the billing agency NPI, claims will be denied and United will contact the provider to inform them of the denial reason and requirements needed to process claims starting July 1 (e.g. rendering practitioner needs to obtain a NPI, enroll in MITS and affiliate themselves in MITS with the billing agency). 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 MITS system United will pay the claim for the time being to allow for all applications to be processed by ODM. United 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.

36. 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/Medicaid as defined on Slide 52 & 56 from the BH Redesign 501 training (http://bh.medicaid.ohio.gov/Portals/0/Providers/BH%20Redesign_Webinar_V2_501_12052017.pdf) and as defined in the Final Services Billable to Medicare and Commercial Insurance IT resource document? [Added 6/20/2018]	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 coverage.	Yes, BHP follows the requirement from ODM policy guidance.	Third Party Liability (TPL) bypass services and providers, identified by ODM, which are not eligible/covered/submitted to Medicare will be processed without denying for the primary EOB. However, if a member has other coverage, non-Medicare, possibly commerical coverage, then an EOP would be required.	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 member's Medicare benefit. Claims for services not covered by Medicare or not billable to a third party payer will not deny or pend for a primary explanation of benefits.	Paramount follows the current ODM policy guidance regarding eligible providers providers when services are provided to dual eligible or individuals with commercial insurance coverage.	UHC is following ODM policy guidance regarding eligible providers for Medicare participation and Third Party Liability for Commercial Insurance.
37. After July 1, will the practitioner "U" modifiers be required on claims (HM, HN, HO, UK)? [Updated 7/11/2018]	Most practitioner "U" modifiers will be optional for providers submitting claims to Aetna except for in the following two situations: 1. Dually licensed practitioners that are billing under their secondary license; 2. Practitioner types with multiple educational levels (e.g., HM, HO, HN) that are billing for specific service codes for which the rates are set based on the rendering provider's educational level.	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 "U" modifiers will be optional for providers submitting claims to CareSource, except for dually licensed practitioners that are billing under their secondary licensure.	Practitioner "U" modifiers will be optional for providers submitting claims to Molina, except for dually licensed practitioners that are billing under their secondary licensure.	U modifiers (excluding UK) should only be billed when the rendering practitioner is billing under their secondary licensure because they are dually licensed. Modifiers HM (High School, Associates), HN (Bachelors), HO (Masters) and UK (3+ years' experience) are always required.	UHC will require providers submitting claims to include both the NPI and U modifiers
38. 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? [Updated 6/7/2018]	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.	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).	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.	UHC 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).
39. After July 1, will a supervisor be required to be reported on a claim when billing HCPCS codes? [Updated 6/7/2018]	Claim will ignore supervisor	Claim will ignore supervisor	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) - ODM Per the Behavioral Health Provider Manual	Claim will ignore supervisor
40. 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? [Updated 6/7/2018]	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 curently 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.
41. How will each MCO handle outpatient services billed on the day of admission or discharge for SUD residential? [Updated 6/7/2018]	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 our Provider Portal, by fax or in 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

	aetna	buckeye health plan	CareSource	MOLINA HEALTHCARE	PARAMOUNT ADVANTAGE Affiliate of ProMedica	UnitedHealthcare COMMUNITY & STATE
1. Do I need to obtain prior authorization in order to submit claims?	Aetna Better Health of Ohio will honor any prior authorizations that providers currently have on file for services delivered to our members during the Transition of Care. Providers should contact Aetna to obtain a prior authorization when existing authorizations expire or if new services are provided to the member. Non-participating providers will need to obtain prior authorization for any service after the transition of care period while participating providers will only need to obtain prior authorization for intensive services. The Prior Authorization form can be located on our website at: http://www.aetnabetterhealth.com/ohio/providers/forms	Network providers will need to obtain authorization for services determined by ODM to have a PA requirement by completing an Outpatient Treatment Request (OTR). This can be done electronically through the Cenpatico Secure Web Portal. The provider can fax a paper copy to 866-694-3649. The OTR can be found at www.cenpatico.com/providers/ohio/mycare resources or http://www.bh.medicaid.ohio.gov/manuals Non-contracted (non-PAR) providers will need to obtain prior authroization for any service after the continuity of care period. We will accept PA requests for new services (ACT, IHBT, SUD Partial Hosp) 30 days prior to implementation.	Regardless of par status, prior authorizations (PA) are only required for inpatient services and intensive outpatient services beyond 30 visits. Prior authorizations are annualized. For the most current list of those services requiring PA visit the quick reference link at https://www.caresource.com/providers/ohio/caresource-mycare-ohio/quick-reference/ CareSource will honor the 90-calendar day 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.	Network providers will need to obtain authorization for services determined by ODM to have a PA requirement - we will accept PA requests for new services (ACT, IHBT, SUD Partial Hospitalization) 30 days prior to implementation. Non-contracted ("non-PAR") providers will need to obtain prior authorization for any service after the continuity of care period (authorization of assessment and crisis services can be obtained after the service is performed). Single Case agreements may be necessary when an eligible Molina member needs to receive services from a provider who is not contracted. Providers should indicate why the client preferred to receive a service at their facility (distance, continuity of care, specialty service, etc.), and a Molina Medical Director will review to determine if the service is medically necessary.	Contracted providers will only need to obtain a prior authorization for a few specific intensive services (e.g. ACT, IHBT, SUD Partial Hopitalization) and for services beyond the annual benefit limit (e.g. Psych Testing, Psychiatric Diagnostic Evals, etc). Non-contracted providers will need to obtain a prior authorization for any services after the transition of care period. For the most current prior authorization information, please visit our webpage at: http://www.paramounthealthcare.com/priorauth	Most services do not require a prior authorization. Services that require a prior authorization can be obtained by calling the Behavioral Health Prior Authorization line at 866-261-7692 or go to uhconline.com. Please refer to the provider handbook for specific services requiring prior authorization.
2. What authorization number needs to be on a claim starting 7/1? Will the MCPs use the same authorization number as FFS or issue a new authorization number of their own? If you will require your own authorization number, how will this be conveyed to the provider to put on the claim? [Added 6/20/2018]	Aetna Better Health of Ohio will create a new prior authorization number in our system and will share it with the provider via fax and/or phone. Providers will need to use the authorization number provided by Aetna Better Health of Ohio when submitting claims to us.	Buckeye Community Health Plan will be assigning a new authorization number unique to the plan. When an authorization is created, the provider receives an authorization letter via fax with the details of the authorization, including the authorization number for their records.	A CareSource authorization number will need to be on the claim. CareSource will issue a CareSource authorization number from our clinical system which populates its own unique authorization number during the prior authorization process. CareSource's UM will fax the authorization number, dates of service, and number of units/hours/days authorized to the provider.	The Molina authorization number needs to be on the claim starting July 1 to process correctly. Molina UM staff load FFS authorizations into our claims system and do outreach to provide the Molina authorization number by fax to providers who received approval from FFS. If you haven't yet received a new authorization number, providers can contact the Molina UM team at (855)322-4079 by phone or (866) 449-6843 by fax to obtain a new authorization number for claims. Providing a copy of the Kepro approval can help to expedite this process (see MITS BITS dated 7/13/2018).	Paramount will enter the authorization information into our clinical system which will create a unique authorization number for every authorized service. The Paramount authorization number will need to be on the claim. Paramount's UM team will fax the authorization number, dates of service, and number of units/hours/days authorized to the provider.	The provider will submit the claim without an authorization number. As long as the claim contains the same service codes and dates of service that were on the original auth, it will be matched and paid by our claims team. A new authorization letter is generated when Optum creates the transitional auth. The provider does not need the auth number on the claim. As long as the claim contains the same service codes and dates of service that were on the original auth, it will be matched and paid by our claims team.
3. Where do I find what services require PA?	You can check if your procedure code needs to be preauthorized by checking our code lookup tool, ProPAT. ProPAT is available to you through the Secure Provider Portal, if you are registered, at www.aetnabetterhealth.com/ohio/providers/portal.	Go to www.cenpatico.com/providers/ohio/MyCare Resources.	BH benefit grids and service guides can be found under "Resources" at: https://www.caresource.com/providers/ohio/ohio-providers/patient-care/behavioral-health/	Providers can find the services that require PA under "PA Code List - Medicaid/Marketplace" at: http://www.molinahealthcare.com/providers/oh/medicaid/Pages/home.aspx	Go to: http://www.paramounthealthcare.com/documents/provider/Prior-Authorization-List.pdf	In the UHC Provider Administrative Manual which can be found at www.uhccommunityplan.com.
4. How is a PA obtained?	There are several options: • Call 1-855-364-0974, Option 2, then Option 4; • Complete the Prior Authorization Form located on our website at: http://www.aetnabetterhealth.com/ohio/providers/forms; • You may submit a request through your Secure Provider Portal account located at www.aetnabetterhealth.com/ohio/providers/portal.	For IP admissions, PHP, and detoxification providers must contact Cenpatico's Utilization Management Department at 800-224-1991 for authorization. Requests for lower levels of care (ECT, Psychological or Neuropsychological testing, Outpatient services, IOP/Day Tx.) submit electronically on the Cenpatico Secure Web Portal, or complete a request form that can be found at www.cenpatico.com/proivders/ohio/mycarere sources. The form can be faxed to 877-725-7751. All out of network providers require authorization for all services.	Online @ CareSource.com through the Provider Portal option; Email: mmauth@caresource.com; Fax: 1-888-752-0012; Mail: CareSource P.O. Box 1307, Dayton, OH 45401-1307 or Call: 1-800-488-0134 CareSource will also accept the Universal BH Service Prior Authorization Form developed by the Ohio Association of Health Plans.	To request a PA, providers will need to fax the Behavioral Health Prior Authorization Form to (866) 449-6843 along with any supporting clinical notes and evaluations. The form can be found at http://www.molinahealthcare.com/providers/oh/duals/forms/Pages/fuf.aspx. A reference guide for providers filling out the Behavioral Health Prior Auth Form can be found at http://www.molinahealthcare.com/providers/oh/marketplace/forms/PDF/pa-reference-guide.pdf	To request a PA, providers will need to fax the standardized Behavioral Health Prior Authorization form to 567-661-0841 or 844-282-4901 including any supporting clinical documentation. Effective January 1, 2018 providers will be able to submit their PA requests via Paramount's portal as per Senate Bill 129.	Most services do not require a prior authorization. Services that require a prior authorization can be obtained by calling the Behavioral Health Prior Authorization line at 866-261-7692 or go to uhconline.com. OAHP has developed a standardized PA form to use. However, if providers prefer to call us and give us the information verbally rather than completing a form, that would be our preference as we have found in other markets this is less time consuming and more conducive to obtaining the actual information needed.

5. Where can I find information on the medical review process such as medical necessity criteria that you use for making decisions? [Added 6/7/2018]	Please see the Aetna Better Health of Ohio Provider Manual posted on our website at https://www.aetnabetterhealth.com/ohio for information on medical necessity guidelines that are used for authorization decisions. Aetna adheres to ASAM guidelines for SUD services.	Please see the Medically Necessity Criteria posted on our website at www.buckeyehealthplan.com for information on medical necessity guidelines that are used for authorization decisions. For SUD services, Buckeye adheres to ASAM guidelines based on the requested level of care.	Milliman Care Guidelines, OAC rules, and ASAM criteria are used during the prior authorization review process. These are available to any provider or member upon request. CareSource internally developed clinical policies may be found on our website at: https://www.caresource.com/providers/ohio/ohio-providers/medical-policies/	OAC rules and Medicare Local Coverage Determinations are typically the first level of criteria used when reviewing requests, if applicable. Please see the Molina Provider Manual posted on our website at www.MolinaHealthcare.com for information on medical necessity guidelines that are used for authorization decisions. Molina adheres to ASAM guidelines for SUD services.	Paramount abides by OAC rules for Medical Necessity determinations. InterQual and ASAM are utilized as guidelines for clinical decision making related to level of care determiniations for mental health and substance use disorder services respectively. Please refer to Paramount's Provider Manual posted on our website Paramounthealthcare.com for additional information.	https://www.providerexpress.com/content/ope provexpr/us/en/clinical-resources.html
6. How many days of intensive services will be approved at a time (e.g. ACT, IHBT)? [Added 6/7/2018]	Per OAC rule 5160-27-04 the maxium amount of ACT service that can be approved at one time is 48 units for 12 months. Per OAC rule 5160-27-05 the maximum number of hours of IHBT service that can be approved at one time is 72 hours.	The maximum amount of ACT services that can be approved at one time is 12 months. The maximum number of hours of IHBT service that can be approved at one time for 3 months is 72 hours. Buckeye may approve a shorter time frame than the above for ACT or IHBT if medical necessity is not met.	CareSource considers the number of hours/units being requested by the provider and the OAHC. Per OAC rule 5160-27-04 the maxium amount of ACT service that can be approved at one time is 12 months. Per OAC rule 5160-27-05 the maximum number of hours of IHBT service that can be approved at one time is 72 hours. In the event of a concern about the member continuing to meet medical necessity for a service, CareSource may approve a shorter time frame than the above.	Per OAC rule 5160-27-04 the maximum amount of ACT service that can be approved at one time is 12 months. Per OAC rule 5160-27-05 the maximum number of hours of IHBT service that can be approved at one time is 72 hours. In the event of a concern about the member continuing to meet medical necessity for a service, Molina may approve a shorter time frame than the above.	Per OAC rule 5160-27-04 the maximum amount of ACT service that can be approved at one time is 12 months. Per OAC rule 5160-27-05 the maximum number of hours of IHBT service that can be approved at one time is 72 hours. In the event of a concern about the member continuing to meet medical necessity criteria for a service, Paramount may approve a shorter time frame and request more frequent clinical updates than above.	Per OAC rule 5160-27-04 the maximum amount of ACT service that can be approved at one time is 12 months . Per OAC rule 5160-27-05 the maximum number of hours of IHBT service that can be approved at one time is 72 hours.
7. What should I do if a client switches from one managed care plan to another in the middle of a treatment episode that required authorization? [Added 6/7/2018]	You may need to obtain authorization from the new Managed Care plan. Aetna will allow a retrospective PA request to the start date of coverage in the event of coverage changes.	You may need to obtain authroization from the new managed care organization. At Buckeye, we allow you to submit a retrospective PA request to the start date of coverage as long as medically necessity criteria are met. Retrospective authorization review requests can be faxed to 1-866-714-7991, secure email at appeals@cenpatico.com, or mail to 12515-8 Research Blvd., Suite 400 | Austin, Texas 78759.	CareSource wants to ensure the member's care for acute or chronic, medical or behavioral health conditions have uninterrupted medically necessary care from their providers. Regardless of the provider's participation status, CareSource will accept the current services provided by his/her provider for a 30 day time period. A new prior authorization would need to be submitted to CareSource by the provider. At CareSource we would allow you to submit a retrospective PA request to the start date of coverage with us and as long as it meets Medical Necessity criteria and hasn't exceeded the time to request the PA (180 days for CareSource) it would be approved.	You may need to obtain authorization from the new Managed Care plan. Molina will allow a retrospective PA request to the start date of coverage in the event of coverage changes. ODM and the Managed Care Plans are collaboratively working on a project to transmit data files including authorization data between managed care plans when members change coverage. This project is anticipated to be complete by January 1, 2019.	You may need to obtain authorization from the new Managed Care plan. Paramount will allow a retrospective PA request to the start date of coverage in the event of coverage changes when the request is made within 14 days of notification of enrollment at Paramount.	There is a 180-day Transition of Care, Continuity of Care Period and Authorization Waiver Period. The health plan shall provide continuation of care for services the lesser of (1) ninety (180) calendar days, or (2) until the member has transferred, without disruption of care, to an in-network provider
8. If provider does not receive a response on a PA request, who can they contact?	Aetna Better Health PA Team at: 855-364-0974, option 4, option 2	Customer Service department at 800-224-1991	Provider Services 1-800-488-0134	Providers can call the Molina UM department at 855-322-4079.	Providers can call the Behavioral Health Utilization Management team at 419-887-2520 or 800-891-2520.	Please contact the PA line at 866-261-7692 or the UHC Community Plan Ohio Provider Services line at 800-600-9007.
9. How long does it take to get a decision on a PA request? [Updated 7/11/2018]	For standard prior authorization decisions, Ohio MyCare Plans are required to provide notice to the provider and member as expeditiously as the member's health condition requires, but no later than 10 calendar days following receipt of the request for service. Urgent prior authorization decisions are made within 48 hours of receipt of request for service. Please specify if you believe the request is urgent. If we do not receive enough clinical information with the initial request, it will take additional time to get a decision if we have to wait for additional information from the provider.	For standard prior authorization decisions, Ohio Medicaid and MyCare Plans are required to provide notice to the provider and member as expeditiously as the member's health condition requires, but no later than 10 calendar days following receipt of the request for service. Urgent prior authorization decisions are made within 48 hours of receipt of request for service. Please specify if you believe the request is urgent. If we do not receive enough clinical information with the initial request, it will take additional time to get a decision if we have to wait for additional information from the provider.	For standard prior authorization decisions, Ohio Medicaid and MyCare Plans are required to provide notice to the provider and member as expeditiously as the member's health condition requires, but no later than 10 calendar days following receipt of the request for service. Urgent prior authorization decisions are made within 48 hours of receipt of request for service. Please specify if you believe the request is urgent. If we do not receive enough clinical information with the initial request, it will take additional time to get a decision if we have to wait for additional information from the provider.	For standard prior authorization decisions, Ohio Medicaid and MyCare Plans are required to provide notice to the provider and member as expeditiously as the member's health condition requires, but no later than 10 calendar days following receipt of the request for service. Urgent prior authorization decisions are made within 48 hours of receipt of request for service. Please specify on the Prior Authorization Form if you believe the request is urgent, including marking any requests for ACT, IHBT or SUD Partial Hospitalization services as urgent in order to expedite within 48 hours of receipt. If we do not receive enough clinical information with the initial request, it will take additional time to get a decision if we have to wait for additional information from the provider.	For a standard (non-urgent) prior authorization request, Medicaid Managed Care Plans are required to provide notice to the provider and member as expeditiously as the member's health condition requires, but no later than 10 calendar days following receipt of the request. Urgent prior authorization decisions are made within 48 hours of receipt of request. Please specify if you believe the request is urgent. If we do not receive enough clinical information with the initial request, it will take additional time to get a decision if we have to wait for additional information from the provider.	For standard prior authorization decisions, Ohio Medicaid and MyCare Plans are required to provide notice to the provider and member as expeditiously as the member's health condition requires, but no later than 10 calendar days following receipt of the request for service. Urgent prior authorization decisions are made within 48 hours of receipt of request for service. Please specify if you believe the request is urgent. If we do not receive enough clinical information with the initial request, it will take additional time to get a decision if we have to wait for additional information from the provider.

10. How can a provider appeal a PA denial?	The appeal process is explained in the Notice of Action as well as in the Provider Manual at www.aetnabetterhealth.com/ohio/providers/portal	IP, PHP and detox denials for not meeting MNC, can be appealed immediately by telephone. The physician reviewer will respond within 24 hours. All written appeals may be faxed to 866-714-7991 or mailed to: Cenpatico Appeals 12515-8 Research Blvd. Ste 400, Austin TX 78759. Please refer to the Cenpatico Provider Manual at www.cenpatico.com.	Providers can submit appeals online, via fax, or in writing as follows, Provider Portal: https://providerportal.caresource.com/OH/ Fax: 937-531-2398 Writing: CareSource Attn: Provider Appeals – Clinical P.O. Box 2008 Dayton, OH 45401-2008	Providers can contact the number that is listed on the denial notification and request a peer review with a Medical Director. Additionally, providers can get more information about the appeal process in the Molina Provider Manual which can be accessed at: http://www.molinahealthcare.com/providers/oh/medicaid/manual/PDF/oh-combined-provider-manual.pdf	Providers are offered a peer to peer support at the time of notification of the denial. The peer to peer information & appeal information is included in the letter that is sent. Providers can appeal per fax or US mail. Mailing Address Paramount Health Care P.O. Box 928 Toledo, OH 43697-0928 Fax Number Provider Inquiry Fax-Line 419-887-2014	Electronically, go to www.uhconline.com to appeal. Appeals may also be submitted in writing to UHC Community Plan of Ohio, P.O. Box 31364, Salt Lake City, UT. 84131-0364.
11. 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 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, Provider Grievance System: Complaints, grievances & appeals tab. The forms are located on the "For Providers" section of our website, under the "Forms" menu. The participating provider dispute form 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 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 a written appeal within 45 days for Medicaid specific patients, or are not satisfied with the response you receive, you may appeal within 60 days of the HMO's final decision: Cenpatico Appeals PO Box 6000 Farmington, MO 63640-3809	Appeals can be submitted in writing or through the provider portal. Provider Portal: https//providerportal.caresource.com/OH/ Under the provider portal, click on the "Claims Appeals" tab on the left. Writing: Use the Provider Claim Appeal Request Form" located on our website. Please include: Patient Name, CareSource Member ID number, Provider Name and ID number, the code and reason why the determination should be reconsidered. If you are submitting timely filing appeal, you must send proof of original receipt of the appeal by fax or electronic data Information (EDI) for reconsideration. If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination. CareSource Attn: Provider Appeals P.O. Box 2008 Dayton Ohio 45401-2008 Fax: 937-531-2398	Molina will consider retroactive authorization requests in some hardship situations, please contact us. The claim reconsideration/appeal form and instructions can be found at the following link: http://www.molinahealthcare.com/members/oh/en-US/PDF/Duals/claim-reconsideration-request-form.pdf The form can be submitted via fax to: (800) 499-3406 or mailed to: Molina Healthcare of Ohio Attn: Provider Services PO Box 349020 Columbus, Ohio 43234-9020	Standard appeal process must be submitted in writing. Providers need to file an appeal by sending the appropriate form to the either of the following contact points: Mailing Address Paramount Health Care P.O. Box 928 Toledo, OH 43697-0928 Fax Number Provider Inquiry Fax-Line 1-877-2014 If the provider has any questions regarding the Appeal Process, they should directly contact Provider Inquiry as they can provide the appropriate information for all providers (par and non-par) Provider Relations Phone: Phone: 419-887-2564 Toll Free: 1-888-891-2564	To file an appeal, send it to UnitedHealthcare Community Plan of Ohio at the following address: UnitedHealthcare Community Plan Appeals and Grievances Department PO Box 31364 Salt Lake City, UT 84131 Fax Number for Appeal: 1-877-886-8120
12. What is the process for ending an approved prior authorization for IHBT, ACT or SUD Residential and/or initiating disenrollment from this service when a client is no longer requiring that level of services? [Updated 8/1/2018]	To end an existing authorization and initiate disenrollment from IHBT, ACT or SUD Residential Treatment, the provider should contact the Aetna Better Health PA team at 855-364-0974, option 4, then option 2 by phone, or 855-734-9393 by fax. Please include the following information: Member Name, Medicaid ID number, Date of Birth, Authorization Number and the end date of the program. After Aetna Better Health PA team receives the notification, the end date for the SUD residential, ACT, or IHBT authorization is updated and the member is dis-enrolled from the service.	The process for ending an authorization prior to its initially requested end date consists of the member or the member's guardian calling the Customer Service department at 800-224-1991 and requesting for an active authorization to be closed or cancelled. The provider has three business days to make notification of disenrollment of these services.	Providers are to notify the CareSource UM department by phone, fax, or email within 3 business days (per the Ohio Admin Code 5160-27-04 (H) (5) http://codes.ohio.gov/oac/5160-27-04v1) of the disenrollment of SUD residential, ACT, or IHBT. A member or member's guardian may call CareSource member services or the CareSource UM department to notify CareSource of the disenrollment. After CareSource UM receives the notification, the SUD residential, ACT, or IHBT authorization is end dated in our system to reflect the disenrollment date, which will then allow a member to receive the full range of BH services.	An end date is given to every authorization in the Molina UM system for the timeframe approved. Providers must request additional days or units if needed for these services, but otherwise the member will be automatically disenrolled from these services on the end date of the authorization. If a member is disenrolled from the program prior to the amount of days approved the provider should contact the Molina UM team at (855)322-4079 by phone or (866) 449-6843 by fax to notify us of the end date of the program.	An end date is given to every authorization in the Paramount UM system for the timeframe approved. Providers must request additional days or units if needed for these services, but otherwise the member will be automatically disenrolled from these services on the end date of the authorization. If a member is disenrolled from the program prior to the amount of days approved the provider should contact the Paramount UM team at (800) 891-2520 by phone or (844) 282-4901 by fax to notify us of the end date of the program.	The preferred method would be to call 866-261-7692. The information we need includes: Member Name ID number Date of birth Authorization number

Managed Care Plan - Pharmacy Information

	aetna	buckeye health plan	CareSource	MOLINA HEALTHCARE	PARAMOUNT ADVANTAGE Affiliate of ProMedica	UnitedHealthcare COMMUNITY & STATE
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: 1-866-246-4358 for Member services or (866) 296-8731 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 option 1 or the phone number on the members ID card. Fax PA request to 1-866-930-0019 for 24 hour Turn Around Time.	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.	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. Providers can also call 800-891-2520 if they need immediate help.	Please use our regular pharmacy line at 800-310-6826 or contact Janine Kudla at jkudla@uhc.com, 517-852-0842, or Jeanne Cavanaugh at 248-331-4277.
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: bhp_rph@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 614-410-7924; 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.	No	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.
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 (Acaria 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	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.
5. 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 infromation. The expectation would be for the provider to reach out to the member and faciliate 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.	Vivitrol is dispensed to the provider, not the member in most cases. This is for safety reasons and to prevent tampering prior to the appointment.	Vivitrol is shipped 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.

6. How should a provider handle a request from the specialty pharmacy to speak with the member prior to shipping medication?	Not applicable	Vivtrol is dispensed to the provider, not the member in most cases. This is for safety reasons and to prevent tampering prior to the appointment.	In the case of shipping a medication this would depend on the Specialty Pharmacy's policies. Standard practice is for the pharmacy to schedule with the member. In the case of the provider it would be ok to provide the contact information.	Although specialty pharmacy is not required, providers can communicate with our local pharmacy team at MHOPharmacyDepartment@MolinaHealthCare.com if there is any concern about our specialty pharmacy requiring direct verification with members.	Vivtrol is the only drug required to be dispensed by the specialty pharmacy. Vivitrol 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.
7. Does the MCP offer a "Buy & Bill" option for providers who want to dispense medication at their clinic? (e.g. Opioid Treatment Program)	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, Caresource 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, 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.
8. 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 Vivitrol 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 buisness.	Yes	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 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 Credentialed with Caremark) may contact Caremark Network Operations team at 1-480-314-8457, 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 retail pharmacy would like to be in network, they would need to work through our Pharmacy Benefit Managerment organziation (Envolve Pharmacy Solutions) to become part of the network. This will not apply to specialty pharmacies as we work with Acaria Health exclusively.	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.	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. Non-Contracted Pharmacies may enroll by completing and submitting the "Pharmacy Pre-Enrollment Questionnaire" www.caremark.com/pharminfo and select "Pharmacy Pre-Enrollment Questionnaire."	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.	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 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**
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.	Members may be reimbursed by the retail pharmacy within the allotted timeframe(e.g.7-28 days depending upon CVS/Caremark network pharmacy). PA turnaround is 24 hours therefore we would not recommend cash pay prior to PA approval being completed. If the member wishes to take the risk and self pay, they would have to submit a direct claim to CVS/Caremark, our PBM. CVS/Caremark information is on the back of the members ID card.	The member should contact Member Services to inquire about reimbursement. Member Services will work with the pharmacy that dispensed the medication to have the refund issued back to the member (via pick up at pharmacy). This scenario is only for situations in which there was an eligibly issue at time prescription was paid for that has been fixed, or if there is an approved PA on file for the medication when needed. If there is no approved PA on file and the member chooses to pay for medication before the PA is approved, Molina will not reimburse the member unless the PA is approved the same day the member paid out-of-pocket. Member Services can facilitate reimbursements at the pharmacy for 90 days post pick up. After 90 days, members must complete the Direct Member Reimbursement Form and send it, along w/receipts, to CVS/Caremark.	All member payment issues can be routed through our Member Services Department.	We do not reimburse members for obtaining pharmaceuticals without authorization. This is particularly important with members who are purposely locked in to a pharmacy as part of the state Coordinated Services Program.
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? [Updated 6/7/2018]	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 1-855-364-0974 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 authorizaton 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 MAT providers can contact us at 1-800-642-4168 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 PG0069 posted on our website. Once the limit is reached, Prior Authorizatiton 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.	The member or the sample can be sent to one of the contracted labs listed on the UnitedHealthcare Community Plan website. No prior authorization is required for a urine drug screen.

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 can MHAS certified providers use these options? [Added 6/7/2018]	If a lab provider is not in network with Aetna and likes 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.	If a lab provider is not in network and is interested in becoming contracted, they can visit our website at www.buckeyehealthplan.com, click on the Providers tab, click the Ohio tab and the Join Our Network tab is located at the top of the page. Our provider services team is also available at 1-866-296-8731 or via email at ohiocontracting@centene.com.	A non-par lab can submit a contract request at any time via https://www.caresource.com/providers/join-our-network/ utilizing the New Health Partner Contract Form. Requests for lab contracts are evaluated against network need on a case-by-case basis. CareSource does not authorize out of network labs to perform UDS.	Any providers who have CLIA certification to perform laboratory services who would like to inquire about becoming part of our network should contact us. A request to become a participating provider in the Molina network can be found on our website at: http://www.molinahealthcare.com/providers/oh/duals/forms/Pages/fuf.aspx Molina's 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.	A non-par lab can submit a completed form via the Paramount website, paramounthealthcare.com It can take up to 90 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 chose, however a lab must be PAR and have the codes included in their agreement to be paid for services.
15. Can a CBHC operated lab handle services and billing for other providers who are providing the treatment? [Added 6/7/2018]	OhioMHAS certified providers can use lab providers that are in network with Aetna.	[Response pending]	In-network labs are not limited to providing services ordered by providers affiliated with their organization exclusively.	Molina's 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 including those operated by a CBHC provider.	CBHC labs can provide services and bill only for members receiving their treatment at that same CBHC.	Yes, as long as the codes are covered and are contracted. Please note; this applies to the Behavioral Health lab codes covered under the Behavioral Health Redesign. Any codes outside of the BH redesign code set must be performed by a PAR lab.
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 urine drug screen when MAT medications are prescribed for our members. However, providers need to insure 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 PBM - Envolve 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 document on referral form when submitted. This information will be evaluated depending on the drug.	The MAT provider should document that they are aware of the relapse and how he/she plans to work with the member through the relapse. This information will be evaluated to determine the safety of approving additional medication, and the Pharmacy team may approve shorter time frames of the medication for a period to ensure safety.	Relapse and instruction to the patient would need to be clearly documented in any PA request.	The provider should include this information when calling or faxing in the prior authorization form for Suboxone or Subutex.
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. The MAT provider would need to justify why the member received an opioid concurrently with the MAT therapy upon renewal of the MAT PA.	If an authorization is currently approved for a MAT medication, provider to reach out to PBM or health plan prior to surgery. If a PA has not been submitted, we suggest that provider do that as soon as possible in order to coordinate care etc.	Doctor must doucument 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 in to 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.	UHC does not require the physician to get a new authorization when changing the dose.

19. 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)?	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 1-800-642-4168 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.	Specific to referring a member for CM: Mon-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 Credentialed with Caremark) may contact Caremark Network Operations team at 1-480-314-8457, 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 Buckey Pharmacy Network. Members are eligible to get medication filled at any eligible Network Pharmacy. For Specialty Medications, they would need to go through Acaria Health (Medicaid product only). If the pharmacy is not part of our network, they would need to work through our Pharmacy Benefit Management organization- Envolve 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 PAs, 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.	1. Pharmacy benefit coverage billed (through the pharmacy claims system) requires the pharmacy to be contracted in our retail or 340B network. 2. If a clinic dispenses the medication, they should submit a claim using the buy and bill directions in the grid above.
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 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 provider 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.
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.	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 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 MHO 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 to: https://www.aetnabetterhealth.com/ohio/providers/premier/partd	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.	All PA requirements for MAT are the same. PA requests should be faxed to 1-866-930-0019.	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 opiods 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 OARRs checks and urine screenings 4. Progress and Plan of care submission 5. Abberent behavior addressed via documentation 6. Member continues to go to support group or separate counseling	PA requirements for these products include FDA approved use (for treatment of opioid dependence), the patient is not using opioids, the physician/prescriber documents the patient is receiving substance abuse treatment/rehabilitation services, and the prescriber has an X-waivered DEA license/number. The Subutex PA requirements include intolerance to naloxone or documentation the patient is pregnant. Providers must use the UnitedHealthcare Community Plan preferred agents; use of non-preferred medications requires a prior authorization. UHC preferred Narcotic Antagonists: • buprenorphine (SUBUTEX) generic PA, QL • buprenorphine/naloxone (SUBOXONE) brand 2 mg and 8 mg film only, PA, QL
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 prefered 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 Afet Kilinc, Director of Behavioral Health at KilincA@AETNA.com.	Providers can call Buckeye Provider Services (866-296-8731) and ask to be directed to a Care Manager or the Care Management Department.	Provider Services can be reached at 937-224-3300 option 2	Please contact the Molina Behavioral Health team by emailing us at OHBehavioralHealthReferrals@MolinaHealthCare.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	Tracey Izzard-Everrett, Executive Director : tracey.izzard-everett@optum.com; (614) 410-7592
26. Does the Health Plan cover naloxone for emergency use? If so, how should providers request this on the behalf of the member?	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.	Yes, we cover naloxone products such as naloxole injection and Narcan Nasal spray without a PA. There are quantity limits for these products.	Narcan Nasal Spray is available without a PA. The prescriber can send a prescription to the any network pharmacy for the member.	Naloxone does not require Prior Authorization in order to obtain a dose for emergency use. Prescribers can write a script for the generic injectible naloxone or Narcan nasal spray. Members can fill these scripts at any retail pharmacy.	Narcan Nasal Spray is available without PA. Any network pharmacy can dispense to our members with a valid prescription.	Generic naloxone vials are covered as preferred with no PA, of up to 4 vials every 180 days. Pharmacies may dispense atomizer for prescriptions of inhalation actuation of the vials, and can submit atomizer as administration fee.
27. Does the Health Plan have any additional options for prescribers to access Narcan kits in bulk through Pharmacy?	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 prescriibed for individual members.	Narcan is on the BHP Drug List: Narcan Liquid 4MG/0.1ml Brand 2/60 days. Providers can Buy and Bill if they need it in bulk and have it ready in their office.	No, we cover Naloxone products without a PA requirement for all members.	Prescribers can write a script for up to two doses of the generic injectible naloxone or Narcan nasal spray for individual members to have on hand. Otherwise, providers can use the buy and bill option.	We encourage providers who wish to make these available to purchase through a contracted supplier and store/dispense according to Ohio law.	No, not at this time.