WELCOME TO THE

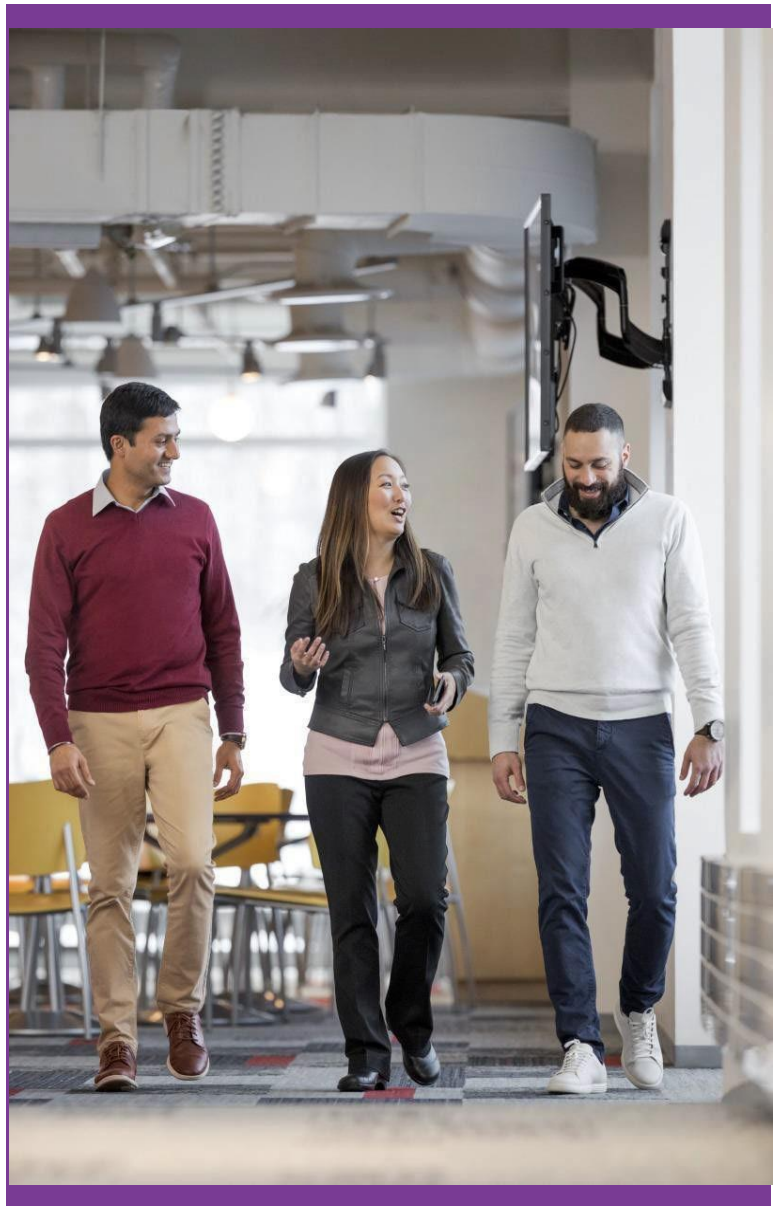
Aetna Better Health Premier Plan MMP

MI LTSS and Waiver Provider Overview

Aetna Better Health Premier Plan MMP Overview for Waiver Providers

TOPICS:

- Member Enrollment & Eligibility
- Provider Roles & Responsibilities
- Claims, Billing & Authorizations
- Secure Provider Portal
- Provider Resources



Member Enrollment & Eligibility

aetna®

Enrollment Qualifications & Service Area

Aetna Better Health Premier Plan Provides benefits to people 21 and over who qualify for both Medicare and Medicaid under the Michigan Department of Health and Human Services (MDHHS) MI Health Link Program

Service Area	Counties
Region 4	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph or Van Buren County
Region 7	Wayne
Region 9	Macomb

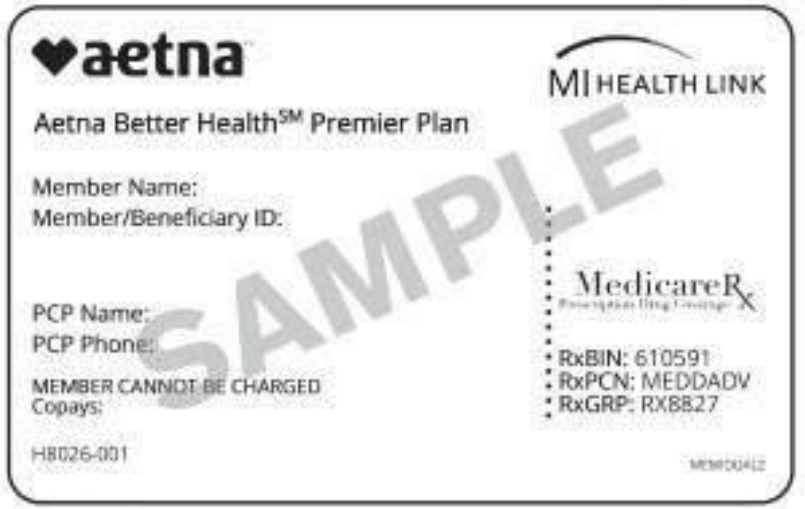
ID Cards & Enrollment

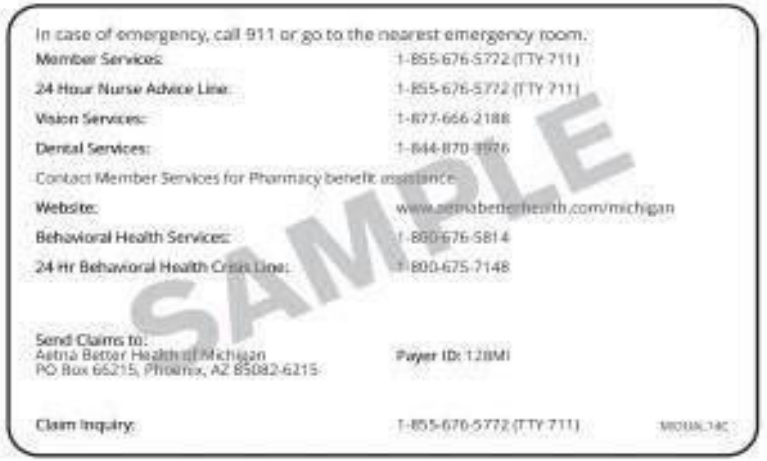
Verifying Member Eligibility:

You can verify member eligibility, PCP assignment, and benefits by:

- Using the State CHAMPS system
  www.michigan.gov/medicaidproviders
- Using the Availity Provider Portal
  https://www.availity.com

- Members have only one ID card for Medicare and Medicaid.
- You will only submit claims directly to Aetna Better Health.
- Do not submit claims directly to Medicare or Medicaid.





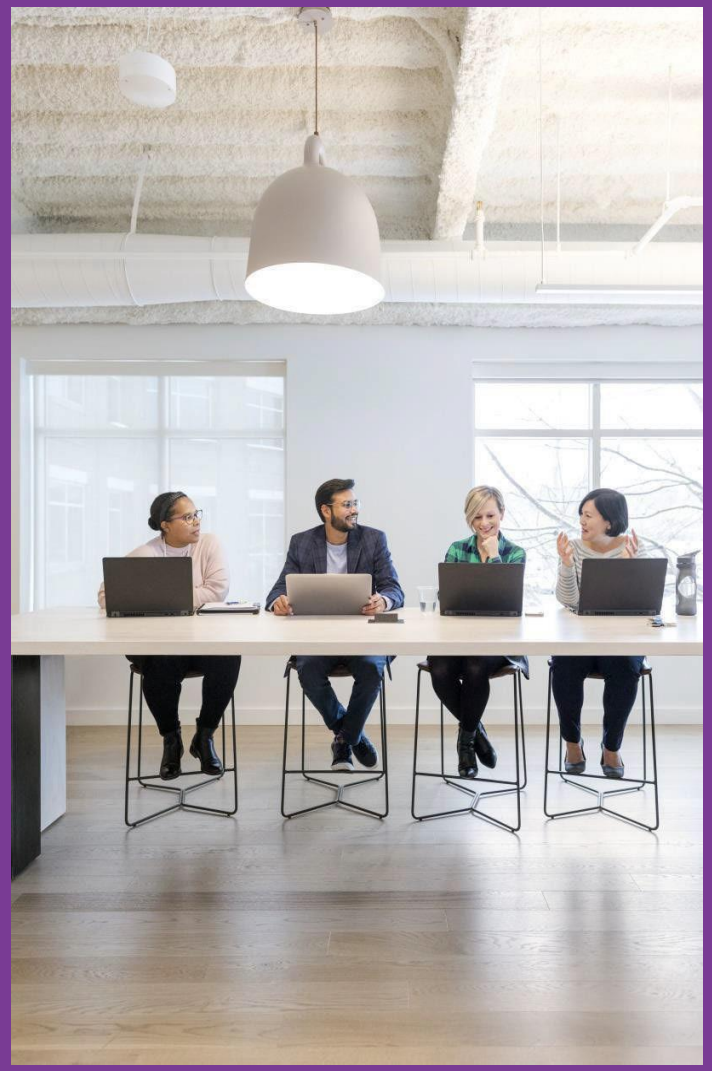
aetna

Provider Roles & Responsibilities

aetna®

Provider Roles & Responsibilities

- Aetna Better Health Premier Plan participating providers are contractually obligated to comply with all guidelines and laws outlined in their Michigan MMP Contract and their Provider Manual.
- The quality of our network and the ability to provide excellent service is dependent on having accurate provider data. Please update us if you have any change of address, telephone number, or other demographic information as soon as possible.



Provider Training Requirements

The State of Michigan requires the following courses to be completed every year.

- Person-Centered Planning
- Introduction to MI Health Link
- Care Coordination
- Critical Incidents
- Cultural Competency
- Disability Awareness
- Self-Determination
- Behavioral Health Consent

You may register and take them here:
Michigan HealthLink required annual training

Aetna Better Health Premier Plan training and information can be found **on our website**.

- Fraud Waste and Abuse
- Provider Newsletter

Claims, Billing & Authorizations

aetna®

Understanding Authorizations

- **Personal Care Services**: A Care Manager will reach out to you directly to provide authorization for a member needing personal care services. Authorizations for personal care services generally last for 6 months.

- **Chore Services:** We will send an email or fax to providers to bid on chore services. Responses are required within 14 days. If your bid is approved, an authorization for chore services will be issued. These authorizations generally last for 12 months.

- **Home Modifications:** We will send an email or fax to providers to bid on home modifications. Responses are required within 14 days. Authorizations are approved for 3 months, but work is expected to be completed as soon as possible (weather permitting and member agreeable).

- Should a member require additional services, and an authorization is nearing its end date, please reach out to the assigned care manager for additional authorization. Please note that authorization dates can not overlap.

Waiver services are only paid if there is a current authorization in place in the name of the rendering provider.
If you have general questions or are unable to reach a care manager directly, you may contact the Michigan Care Management inbox at **MIDualsCMLTSS@aetna.com**
or by fax at **1-866-586-6075**

Tips for Submitting Claims on Paper or Electronically

- Bill only for the procedure codes and diagnosis codes that are included on your authorization. Do not submit an invoice, but please save them in case of a future audit.
- Include your authorization number in Box 23.
- Places of service that are acceptable are 11 (office), 12 (home), or 99 (other).
- It is highly recommended that you obtain an NPI number (National Provider ID number) to ensure seamless billing and faster claims processing and payment. You can sign up for an NPI number **here**. For detailed information about NPI numbers you can learn more **here.**
- An NPI number will make electronic claims easier to submit and speed up payment.
- Please note, that MMP members do not have a copayment and can not be balance billed. Should you have any questions about claims payment, you can reach out to Provider Services for assistance and clarification **1-855-676-5772**.

Additional Resources:

- MI Choice Waiver Program: MI Choice Waiver Program
- Billing and Reimbursement: Billing and Reimbursement
- Electronic Billing: Electronic Billing

Claim Submission

Electronic Claims Submissions:

Both electronic and manual claim submissions are accepted. To assist us in processing and paying claims efficiently, accurately and timely, we encourage Providers to submit claims electronically. Please use Submitter (Payer) ID# **128MI** when submitting electronic or manual claims.

Paper Claims Submission Providers can submit hard copy CM 1500 or UB-04/1450 claims directly to us via mail at the following address:

Aetna Better Health of Michigan
P.O.Box 982963

EL Paso, TX 79998-2963

To facilitate electronic claims submissions, we have developed a business relationship with ECHO Health, Inc. Aetna Better Health of Michigan receives Electronic Data Interchange (EDI) claims directly from this clearinghouse, processes them through pre- import edits to maintain the validity of the data, HIPAA compliance and Member enrollment, and then uploads them into our business application system each business day.

Within twenty-four (24) hours of file receipt, we provide production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

Check Claim Status: You can contact Claims Inquiry/Claims Research Phone:
1-866-316-3784 oryou may use the **Availity Provider Portal.**

EFT/ERA Registration

Aetna Better Health is partnering with ECHO Health, Inc. to introduce the new EFT/ ERA Registration Services (EERS), a better and more streamlined way for our providers to access payment services.

What is EERS?

EERS will offer providers a standardized method of electronic payment and remittance while also expediting the payee enrollment and verification process. Providers will be able to use the ECHO Health, Inc. tool to manage ETF and ERA enrollments with multiple payers on a single platform.

How does it work?

Please complete the ERA/EFT **enrollment form**. Upon submission, paperwork outlining the terms and conditions will be emailed to you directly along with additional instructions for setup. ECHO Health, Inc. supports both NPI and TIN level enrollment. You will be prompted to select the option that you would like to use during the enrollment process. If you need assistance, contact ECHO Health at allpayer@echohealthinc.com or 888.834.3511.

How and when do I enroll?

All Aetna Better Health plans will migrate payee enrollment and verification to EERS. To enroll in EERS, please visit ECHO Health, Inc. **Portal Guide**

EFT (Electronic Funds Transfer) Payments

For faster payment with direct deposit into your bank account, we recommend that you sign up for electronic payments (EFTs) though ECHO Health. This system will allow you to receive payment one of the following ways:

- Virtual credit card (VCC) – virtual one time use credit card.
- ACH/EFT – automatic deposits direct to your bank account. Transaction fees from your bank may apply.
- MPX (Medical Payment Exchange) – paper check replacement option with ability to convert check to VCC or ACH.
- Paper checks by mail.

To check status of your EFT enrollment, contact ECHO customer support at (888)-834-3511

Your bank statement will reflect a payment from Huntington Bank and ECHO as “HNB-ECHO”

What is a “Clean Claim”?

- To best ensure timely and accurate payment of your claim, submit a “clean claim”
- A “clean claim” is defined as one that can be processed without obtaining additional information from the service provider or from a third party.
- This does not include claims submitted by providers under investigation for fraud or abuse or for claims that are under review for medical necessity.
- Clean claims are processed according to the following timeframes:
    - 90% of clean EDI (electronic) claims adjudicated within 30 days of receipt
    - 90% of clean paper claims adjudicated within 90 days of receipt

Corrected Claims & Claim Resubmissions

- Corrected claims require a resubmission code of “7” in Box 22, along with the original claim reference number.
- Failure to submit a corrected claim will result in the claim denying as a duplicate.
- Corrected claims must include all lines from the original claim, not just the line item(s) to be corrected.
- Corrections must be made within 120 days from the date of service.

Timely Filing

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

- New claim submissions – Claims must be filed on a valid claim form within 120 days from the date services were performed, unless there is a contractual exception.

- Claim Resubmission – Claim resubmissions must be filed within 120 days from the date of service. The only exception to this is if a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Please submit any additional documentation that may support a different outcome or decision.

Provider Dispute and Provider Appeal Process

Participating Providers: Participating Providers can submit a Provider Dispute. It is a request to review a denied service. Providers can dispute our decision if service was denied or reduced. Provider disputes must be received via Mail or Availity Web Portal within ninety (90) days of the action taken by Aetna Better Health Premier Plan. The dispute form can be found **here.**

- **Response Time?** Disputes average 30 business days
  Disputes are reviewed by a party not involved in original decision.
  Please go through the dispute process first, before reaching out your assigned Provider Representative for assistance.

Non-Participating Providers: Non-Participating Providers can submit a Provider Appeal. It is a request to review a denied service. Providers can appeal our

Provider Disputes

If you are a Contracted Provider, you may use the Dispute Form found online to have your claim reconsidered. Please fill the form out completely and accurately for proper handling of your Dispute. Disputes can be sent by mail to:

Aetna Better Health of Michigan
Medicaid & Premier Plans
PO BOX 66215
Phoenix, AZ 85082

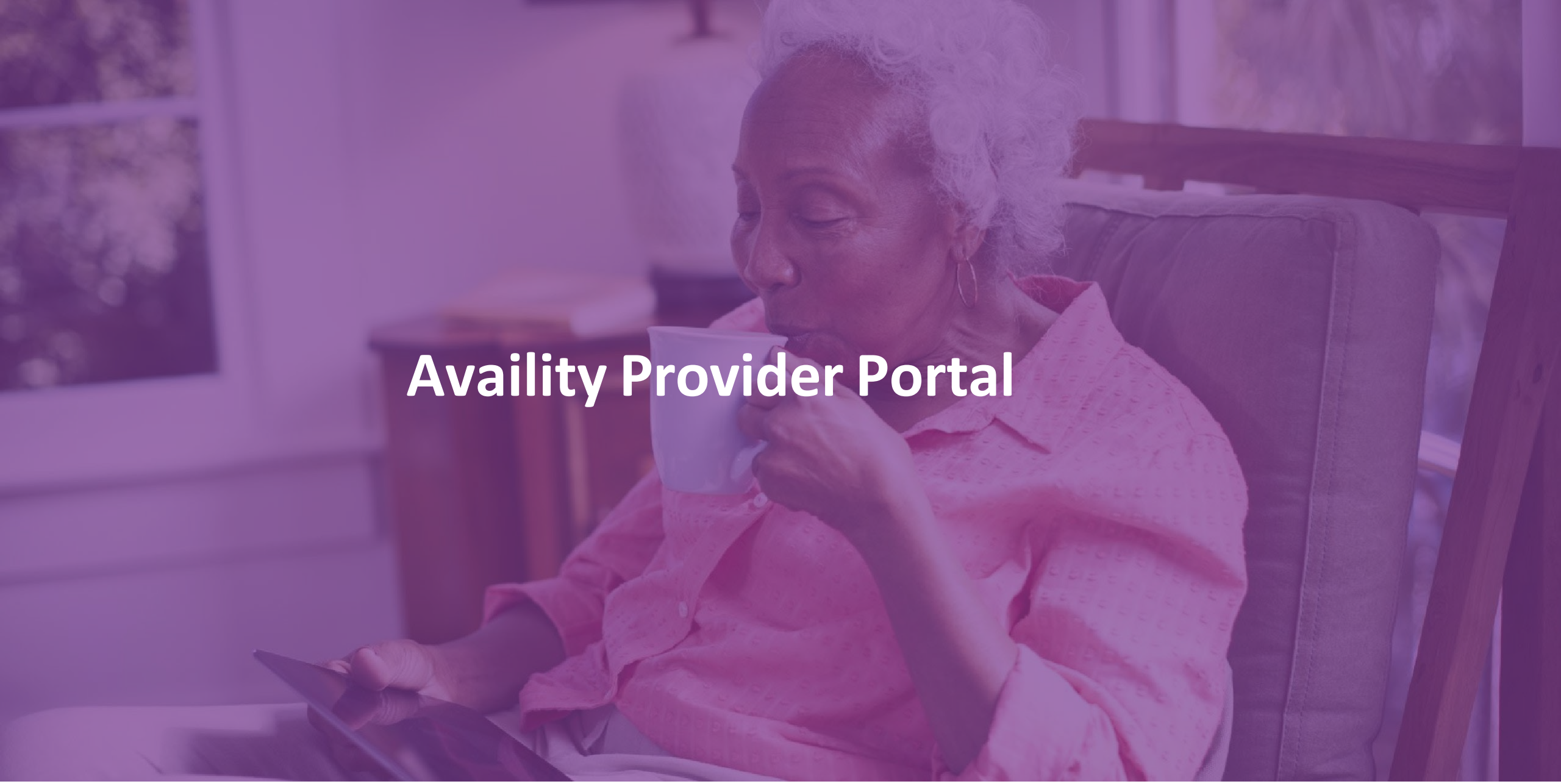
For faster processing, you may also submit a dispute through the Availity Provider Web Portal.

You must select the appropriate reason for your Dispute (Incomplete or missing information may cause Dispute decision to be upheld or returned to Provider) including but not limited to:

- Incorrect Denial of Claim or Claim Line(s)
- Incorrect Denial of Authorization Code or Modifier Issue
- Medical Necessity
- Incorrect Rate Payment

Your Dispute must include:

- The completed form
- Factual or legal basis for appeal statement
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation) or Medicaid references as needed



Availity Provider Portal

aetna®

Availity Secure Provider Portal

- If you are already registered with Availity, you will simply select Aetna Better Health Premier Plan MMP from your list of payers to begin accessing the portal and all the features
- If you are not registered, we recommend that you do so immediately under “Providers” at the link below:
- https://www.availity.com/Essentials-Portal-Registration
- For registration assistance, please call Availity Client Services at **1-800-282-4548** between the hours of 8:00am and 8:00pm Eastern, Monday – Friday (excluding holidays)

The Availity Secure Provider Portal allows providers to:

- Request portal access
- Verify member eligibility
- Check claim status
- File a dispute / submit supporting documentation

Provider Resources

Provider Relations

Our provider Relations staff is available to you Monday - Friday 8 AM - 5 PM to assist you on any facets of your relationship with Aetna Better Health Premier Plan.

You can reach Provider Relations via:

Aetna Better Health Premier Plan Phone Number: **1-855-676-5772**

Email: **COEProviderServices@aetna.com**

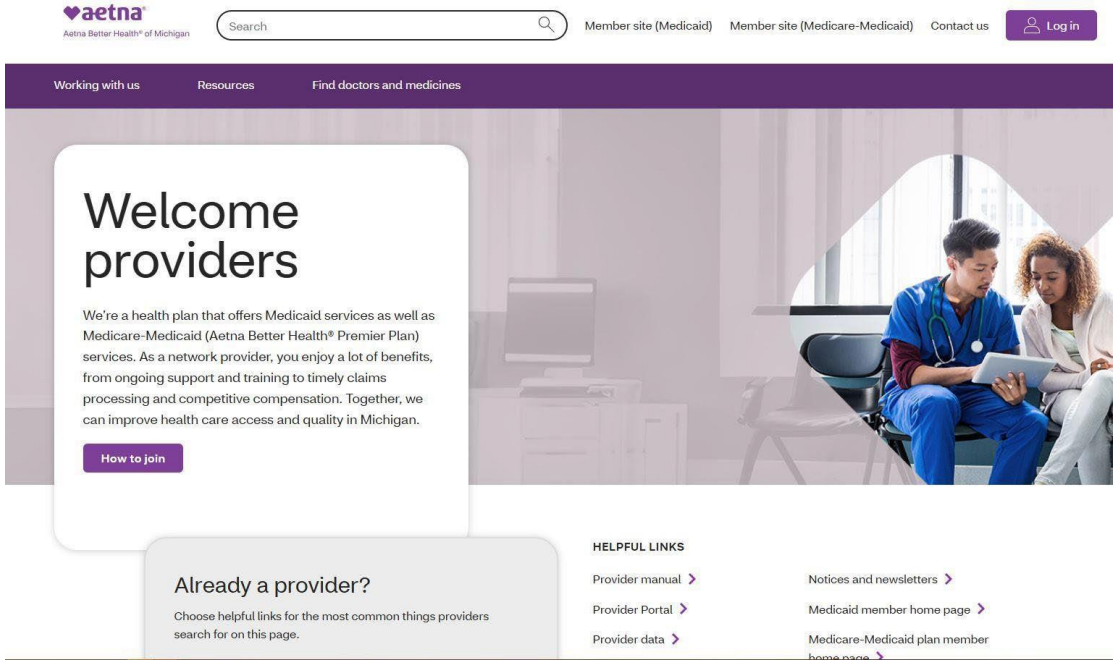
Each participating provider group is also assigned a Provider Relations Liaison who can assist with any escalated claim questions or other concerns.

Visit Our Website

Providers can access the Aetna Better Health Premier Plan website at https://www.aetnabetterhealth.com/michigan/providers/index.html
There you'll find tools and resources to make doing business with us quick and simple.

We've listed a few of the tools and resources found on the "For Providers" tab below:

- Provider Directory
- Provider Manual
- Notifications and Newsletters
- Document Library
- Provider Education

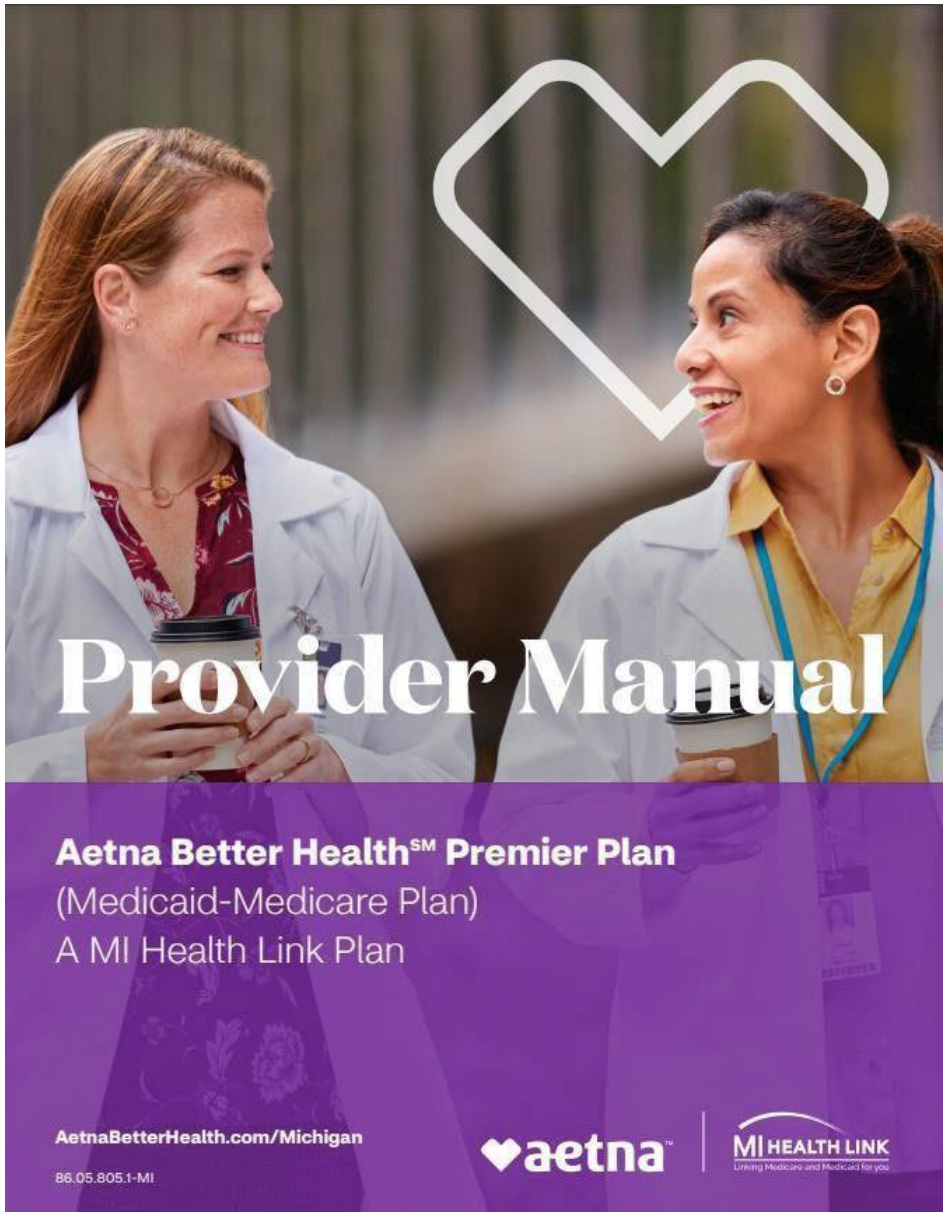


Provider Manual

The provider manual contains plan policies, procedures and benefits. You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available **here** on our website. Please note that the Premier Plan provider manual is different than the Medicaid provider manual.

To request a copy of the provider manual by email, USPS mail or for general questions, simply contact our Provider Relations Department.
Email: COEProviderServices**@Aetna.com**




Thank
You
aetna

Aetna policy statement


aetna®