Aetna Better Health® of Pennsylvania
2000 Market Street, Suite 850
Philadelphia, PA 19103

aetna®

Notice Date: October 23, 2017

AETNA BETTER HEALTH® OF PENNSYLVANIA
AETNA BETTER HEALTH® KIDS

FAQs ABOUT PROVIDER PROMISe ID ENROLLMENT, REVALIDATION AND ORDERING, REFERRING, PRESCRIBING (ORP) ENROLLMENT PROCESSES

We realize that the PROMISe ID Enrollment and Revalidation processes, and the Ordering Referring and Prescribing provider enrollment process can be confusing and that you may have many unanswered questions about these processes. While our Provider Relations team is always available to answer your questions, we thought it may also be helpul to provide you, our valued providers, with a list of FAQ's regarding the new enrollment/revalidation and Ordering, Referring and Prescribing requirements.

Reminder for MA Providers:
August 28, 2017 - All **MA** providers must comply with the state-mandated requirements to **enroll** and **revalidate** their **PROMISe ID and all active and current service locations** every five years. Providers who do not complete the revalidation process every five years may have their MA provider record disenrolled, contract terminated and their claims denied.

January 1, 2018 – Aetna Better Health will deny claims submitted without an ordering, referring or prescribing provider or with a non-enrolled ordering, referring or prescribing provider.

Reminder for CHIP Providers:
January 1, 2018 - All **CHIP** providers must comply with the state-mandated requirements to **enroll** and **revalidate** their **PROMISe ID and all active and current service locations** every five years. Providers who do not complete the revalidation process every five years may have their CHIP provider record disenrolled, contract terminated and their claims denied.

January 1, 2018 – Aetna Better Health will deny claims submitted without an ordering, referring or prescribing provider or with a non-enrolled ordering, referring or prescribing provider.

If you have questions regarding this requirement notice please call Aetna Better Health Provider Relations at **1-866-638-1232, option 3, then 5.**

Sincerely, Aetna Better Health Provider Relations

	Question	DHS Response
1	What is the average turnaround time for processing PROMISe ID applications?	Average application processing time is 7-14 days for a “clean” application. However, it may take longer if the application is incomplete or needs to be reviewed by other offices.
2	Will DHS retroactively date providers who miss the revalidation cut off?	DHS does not have a bulletin or written guidance to support a retro policy; however, DHS has an unwritten policy that they will retro the effective date of the enrollment 60 days from the date they receive the application, if the provider requests it. If a longer date is requested, DHS would seek approval from the Deputy Secretary.
3	When Medicaid is the secondary payer, do the requirements for enrollment still apply?	For the ORP requirement: Federal law requires prescriptions for drugs or orders for services paid for by the Medical Assistance program to be written by health care providers who are enrolled in the Medical Assistance program. The MA program cannot pay for drugs or services that are prescribed or ordered by health care providers not enrolled in the program. This applies to secondary claims as well.
4	If a provider is part of a FQHC group are they bound to have Promise ID for member assignment?	Enrollment of providers who are employed by FQHCs or other clinics is to ensure compliance with the ACA requirement for providers who order, refer or prescribe services to MA recipients . Yes, an FQHC provider will need a PROMISE ID.
5	What are the exceptions or guidelines where members are traveling out of state and need access to ER or Pharmacy providers.	Out-of-network providers under single case agreements are not network providers and, therefore, are **not** subject to § 438.602(b). Emergency room physicians are only subject to § 438.602(b) to the extent that they meet the definition of a network provider in § 438.2. Consistent with § 438.114(c)(1)(i), managed care plans and states must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract. **Additionally per § 431.52 - Payments for services furnished out of State**. **(b) Payment for services**. A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State, and any of the following conditions is met: **(1)** Medical services are needed because of a medical emergency; **(2)** Medical services are needed and the beneficiary's health would be endangered if he were required to travel to his State of residence; **(3)** The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; (4) It is general practice for beneficiaries in a particular locality to use medical resources in another State.

6	Can non – par/non-enrolled providers bill MA members directly?	Per PA Code 1101.63a sec C, a provider may bill a MA recipient for a noncompensable service or item if the **recipient is told before the service is rendered that the program does not cover it**.
7	Regarding care that is ordered or delivered by a non-validated provider; what member responsibility would be involved? If the provider is not willing to enroll in MA will the provider be permitted to balance bill?	55 PA Code §1101.63(a) states that a provider may bill a MA recipient for a noncompensable service or item if the **recipient is told before the service is rendered that the program does not cover it**.
8	Will authorizations that are in place for non-MA participating prescribers beyond the ORP deadline still be honored?	No. DHS' expectation is that all ORP providers will enroll in MA. If not, the MCO will work with members to transition them to an in-network enrolled provider as we get closer to the implementation of the ORP requirement.
9	Can large Pharmacy chains register as a large group, or does every site need to apply with DHS?	Pharmacies are required to enroll every address (site) where services are provided and subsequently reported on claims submitted for compensation.
10	What is the definition of an "unenrolled provider?"	If the provider is enrolled as ORP ONLY and does not provide services to MA recipients, in order to be considered actively enrolled there needs to be at least one active service location enrolled in PROMISe, otherwise the provider would be considered to be unenrolled. If the ORP provider also provides services to MA recipients, he/she must be enrolled at every site in which they provide services. The provider cannot see MA recipients at a closed location. If there are no active service locations then the provider would be considered to be unenrolled.
11	What is the process to prevent members from being billed from providers who are not enrolled and their claims are denied?	Per PA Code 1101.63a sec C, a provider may bill a MA recipient for a noncompensable service or item if the **recipient is told before the service is rendered that the program does not cover it.**
12	How are DHS/CMS addressing members having the ability to go to any ER and/or Family Planning facilities? By law, members are not restricted; they can go anywhere to receive care.	ER will require the Attending provider be enrolled. Family Planning only requires the Prescriber to be enrolled for any medication prescribed.
13	What are the medical and pharmacy exception processes?	There is not an exception process.
14	What is the process for handling Medicare, Family Planning, ER and Ob-gyn providers as members are allowed to see any provider? Are Medicare providers required to enroll?	Family Planning and OB-GYN only requires Prescriber be enrolled for any medication prescribed. ER will require the Attending Provider to be enrolled. Medicare Providers are required to also be enrolled in Medical Assistance if the are a Prescribing or Ordering provider.
15	If a provider submits a UB and an NPI is listed in fields 77, 78 and 79, is DHS expecting the provider to have a valid, active MAID number for the NPIs reported?	For UB claims, only Attending will be required even if the other fields are populated except for Outpatient Drug claims. Either field 78 or 79 should have a DN (Referring) with an NPI that crosswalks to a valid MAID number. If it is not populated, the Attending will be used as the Prescriber.

16	On a UB, a provider can send DN (referring provider), DX (ordering provider) and DQ (supervising provider) in field 17. Do we need to validate if the DQ (supervising provider) has a valid MAID?	The Attending Provider on the UB must have a valid MAID. For Outpatient Drug claims, the DN (Referring) must also have a valid MAID.
17	When the hard edit is implemented by 1/1/18, what are the retroactive eligibility timeframes?	DHS does not have a bulletin or written guidance to support a retro policy; however, DHS has an unwritten policy that they will retro the effective date of the enrollment 60 days from the date they receive the application, if the provider requests it. If a longer date is requested, DHS would seek approval from the Deputy Secretary.