Provider Manual

Provider Experience Department: 1-855-242-0802

AetnaBetterHealth.com/Louisiana

Aetna Better Health® of Louisiana

LA-19-12-01
Revised 03-15-2021

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PROVIDER MANUAL REVISION LOG

Status (New or Addition)	Topic	Summary	Location	Effective Date
New	Legal Compliance	Describes prohibited acts and legal compliance mandated by the settlement of class action lawsuits.	CHAPTER 22: Legal Compliance	3/5/2021
Addition	New Louisiana Medicaid Provider Enrollment Portal	Effective April 2021, Louisiana Medicaid is launching a new portal to screen and enroll Medicaid providers.	APPENDIX A: Program Updates	4/1/2021
Addition	Provider Enrollment	All potential and existing ABHLA providers must enroll in new the Louisiana Medicaid Portal.	CHAPTER 4: Provider Enrollment, Responsibilities, & Important Information	4/1/2021
Addition	Extended Home Health	Listed EHH and IN coverage/benefit and limitations in Covered and Non-Covered Services table.	CHAPTER 5: Covered and Non-Covered Services	3/5/2021
Addition	Rate Modifiers for Extended Home Health	Added list of rate modifiers for Extended Home Health.	CHAPTER 15: Encounters, Billing, and Claims	3/4/2021

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Welcome

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

Aetna Medicaid and Schaller Anderson

Aetna expanded its Medicaid services in 2007, when it purchased Schaller Anderson, an Arizona-based, nationally recognized health care management company with more than two decades of Medicaid experience.

When Schaller Anderson was formed in 1986, Medicaid managed care was a new concept that had not been tried anywhere else in the country on the scale that the state had adopted. Schaller Anderson's founders were key visionaries in the development of the Arizona Health Care Cost Containment System (AHCCCS). The program soon became a model for states moving into Medicaid managed care.

About Aetna Better Health of Louisiana

Aetna Medicaid has been a leader in Medicaid managed care since 1986 and currently serves almost 3 million individuals in 16 states. An Aetna Medicaid affiliate has recently been awarded a contract in Louisiana to operate a Medicaid program. Aetna Medicaid affiliates currently own administer or support Medicaid programs in Arizona, California, Florida, Illinois, Kansas, Kentucky, Louisiana, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia and West Virginia.

Aetna Medicaid has more than 30 years' experience in managing the care of the most medically vulnerable, using innovative approaches to achieve successful health care results.

Experience and Innovation

We have more than 30 years' experience in managing the care of the most medically vulnerable. We use innovative approaches to achieve both successful health care results and maximum cost outcomes.

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

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

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

Meeting the Promise of Managed Care

Our state partners choose us because of our expertise in effectively managing integrated health models for Medicaid that provides quality service while saving costs. The members we serve know that everything we do begins with the people who use our services – we care about their status, their quality of life, the environmental conditions in which they live and their behavioral health risks. Aetna Medicaid has developed and implemented programs that integrate prevention, wellness, disease management and care coordination.

We have particular expertise in successfully serving children with special health care needs, children in foster care, persons with developmental and physical disabilities, women with high-risk pregnancies, and people with behavioral health issues.

Aetna Medicaid distinguishes itself by:

- More than 30 years' experience managing the care and costs of the Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP) and Aged, Blind and Disabled (ABD) (both physical and behavioral) populations
- More than 30 years' experience managing the care and costs of the developmentally disabled population, including over 9,000 members served today through the Mercy Care Plan in Arizona
- 20 years' experience managing the care and costs of children and youth in foster care or other alternative living arrangements
- Operation of a number of capitated managed care plans
- Participation on the Center for Health Care Strategies (CHCS) Advisory Committee, as well as specific programs and grants, since CHCS' inception in 1995
- Local approach – recruiting and hiring staff in the communities we serve

About the Louisiana Medicaid Managed Care Program

The Louisiana Bureau of Health Services Financing, an agency under the Louisiana Department of Health (LDH) administers the state-and federally-funded Healthy Louisiana Medicaid program for certain groups of low- to moderate-income adults and children.

About the Medicaid Managed Care Program

Aetna Better Health of Louisiana was chosen by LDH to be one of the Healthy Louisiana Plan to arrange for care and services by specialists, hospitals, and providers including member engagement, which includes outreach and education functions, grievances, and appeals.

Providers may locate specialists, hospitals, and other providers for member care by referring to the provider directory online at **AetnaBetterHealth.com/Louisiana**.

Aetna Better Health of Louisiana is offered statewide.

Region
Description: Associated Parishes (Counties)

Gulf	Capital	South Central	North
Ascension	East Baton Rouge	Acadia	Bienville
Assumption	East Feliciana	Allen	Bossier
Jefferson	Iberville	Avoyelles	Caddo
Lafourche	Livingston	Beauregard	Caldwell
Orleans	Pointe Coupee	Calcasieu	Claiborne
Plaquemines	St. Helena	Cameron	DeSoto
St. Bernard	St. Tammany	Catahoula	East Carroll
St. Charles	Tangipahoa	Concordia	Franklin
St. James	Washington	Evangeline	Jackson
St. John	West Baton Rouge	Grant	Lincoln
St. Mary	West Feliciana	Iberia	Madison
Terrebonne		Jefferson Davis	Morehouse
		Lafayette	Natchitoches
		LaSalle	Ouachita
		Rapides	Red River
		St. Landry	Richland
		St. Martin	Sabine
		Vermilion	Tensas
		Vernon	Union
		Winn	Webster
			West Carroll

Disclaimer
Providers are contractually obligated to adhere to and comply with all terms of the plan and your Aetna Better Health of Louisiana Provider Agreement, including all requirements described in this Manual, in addition to all federal and state regulations governing a provider. While this Manual contains basic information about Aetna Better Health of Louisiana, LDH requires that providers fully understand and apply LDH requirements when administering covered services. Please refer to **www.LDH.la.gov/** for further information on LDH.

Aetna Better Health of Louisiana Policies and Procedures
Our comprehensive and robust policies and procedures are in place throughout our entire Health Plan to verify all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and required updates are made as needed.

Eligibility
To be eligible for Louisiana Medicaid, a person must meet a categorical eligibility requirement, including but not limited to:

- Children under nineteen (19) years of age including those who are eligible under Section 1931 poverty-level related groups and optional groups of older children in the following categories:
  - TANF - Individuals and families receiving cash assistance through FITAP (Families in Temporary Need of Assistance)
  - CHAMP-Child Program
  - Deemed Eligible Child Program
  - Youth Aging Out of Foster Care. Children under age 21 who were in foster care and already covered by Medicaid on their 18th birthday, but have aged out of foster care.
  - Former Foster Care Children. Members aged 18 -26 who had Medicaid and were in foster care on their 18th birthday.

    - Regular Medically Needy Program
    - LaCHIP Program
    - Children who are eligible for Medicaid due to blindness or disability
    - Children receiving foster care or adoption assistance, in foster care, or in an out of home placement
    - Children with Special Health Care Needs
- Parents and Caretaker Relatives eligible under Section 1931 of the Social Security Act including:
    - Parents and Caretaker Relatives Program
    - TANF (FITAP) Program
    - Regular Medically Needy Program
- Pregnant Women - Individuals whose basis of eligibility is pregnancy, who are eligible only for pregnancy related services [42 CFR§440.210(2)] including:
    - LaMOMS (CHAMP-Pregnant Women)
    - LaCHIP Phase IV Program
- Breast and Cervical Cancer (BCC) Program
- Aged, Blind and Disabled Adults (ABD) – Individuals who do not meet any of the conditions for mandatory enrollment in a managed care organization for specialized behavioral health only.
- Continued Medicaid Program
- Individuals receiving Tuberculosis (TB) related services through the TB Infected Individual Program

Mandatory Populations for Behavioral Health Only

Some people who are eligible for behavioral health services only must pick a Healthy Louisiana plan. These members will only get specialized behavioral health services from us. The mandatory populations include:

- Individuals residing in Nursing Facilities (NF)
- Individuals under the age of 21 residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)

Mandatory Populations for Behavioral Health and Non-Emergent Medical Transportation services only

Members who receive both Medicaid and Medicare (Medicaid dual eligible) must pick a Healthy Louisiana plan. This does not include those members who reside in a nursing facility or ICF/DD. Medicaid dual eligible are only able to receive behavioral health and NEMT services from us.

Voluntary opt-in populations

Members who must enroll in a Healthy Louisiana plan for behavioral health and non-emergency medical transportation (NEMT) services can choose to also enroll for their other covered Medicaid services. Members can change their mind and return to legacy Medicaid for other covered Medicaid services at any time, but members will have to stay with your Healthy Louisiana Plan for behavioral health and NEMT services. If a member chooses to leave Healthy Louisiana for other Medicaid services, they have to wait until the next annual open enrollment to enroll again.

This applies to members who are in one of these groups:

- Members who do not have Medicare and who receive services through any of the following 1915(c) Home and Community-Based Waivers:
    - Adult Day Health Care (ADHC) - Direct care in a licensed adult day health care facility for those individuals who would otherwise require nursing facility services;
    - New Opportunities Waiver (NOW) – Services to individuals who would otherwise require ICF/DD services
    - Children's Choice (CC) - Supplemental support services to disabled children under age 18 on the NOW waiver registry
    - Residential Options Waiver (ROW) – Services to individuals living in the community who would otherwise require ICF/DD services
    - Supports Waiver – Services to individuals 18 years and older with mental retardation or a developmental disability which manifested prior to age 22

    - Community Choices Waiver (CCW) – Services to persons aged 65 and older or, persons with adult-onset disabilities age 22 or older, who would otherwise require nursing facility services
- Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' (OCDD's) Request for Services Registry who are Chisholm Class Members.

Excluded populations

Individuals in an "excluded population" may not enroll in the Healthy Louisiana Program. "Excluded populations include:

- Adults aged 21 and older residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete "managed care" type benefit combining medical, social and long-term care services
- Individuals with a limited eligibility period including:
    - Spend-down Medically Needy Program – An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to 3 months)
    - Emergency Services Only - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements
    - Greater New Orleans Community Health Connection (GNOCHC) Program.

Choosing a PCP:

- Members need to pick a PCP that is in the Plan provider network.
- Each eligible family member does not have to have the same PCP.
- If a member does not pick a PCP, we will pick one for the member.
- Providers must verify eligibility each and every visit by the member.

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services.

When a member first enrolls in our Plan, the Enrollment Broker will help them pick a health plan with whom their PCP participates. We will do our best to make sure they get to keep that PCP they chose. Sometimes we cannot assign the member to the PCP they pick. When this happens, we will pick a PCP for the member. The PCP's name and phone number will be on the member's ID card. The member can call us at any time to change PCPs. We might pick a PCP for the member if:

- They didn't pick a PCP when they enrolled
- The PCP they picked isn't taking new members
- The PCP they picked only sees certain members, such as pediatricians who only see children.

If we have to pick a PCP for the member, we will try to find the PCP that is close to member and best fits their needs. We look for:

- The member's recent PCP
- The member's family member's PCP
- The member's zip code
- The member's age

PCP auto assignment methodology and algorithm used for members that do not make a PCP selection

Aetna Better Health uses an auto assigned PCP logic which includes:

- First search for previous enrollment and PCP assignments history, to initiate re-assignment
- Geographic region (zip code) search applied first

- Age/Gender restrictions then applied based on incoming beneficiary information
- Providers with open panels matching geo/age/gender identified
- Assignment made

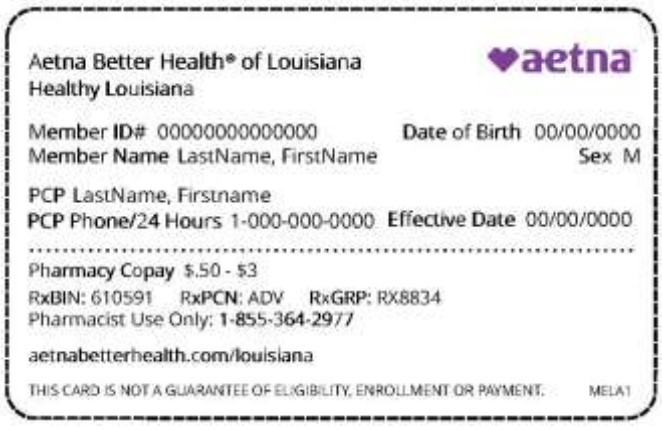
Quarterly Member Reassignment
Aetna Better Health of Louisiana, on a quarterly basis, will conduct a claims analysis using no less than 12 months and no more than 18 months of claims data and will prospectively attribute members to primary care providers where care is being delivered.

A provider shall have 15 business days to review changes made to their roster prior to any changes being made via the Aetna Better Health of Louisiana Medicaid Web Portal. If a Provider chooses to dispute any member assignments, they are encouraged to email the LA Provider Relations department at LAProvider@aetna.com or call 1-855-242-0802. To successfully dispute any re-assignment, the provider must show documentation (medical record, proof of billed claim, etc. for at least one DOS) that they have seen the enrollee(s) within the claims analysis 12 to 18 month look back period. A provider may not request member re-assignment due to a lack of engagement per the terms of the provider agreement or for any discriminatory practices against the member or plan.

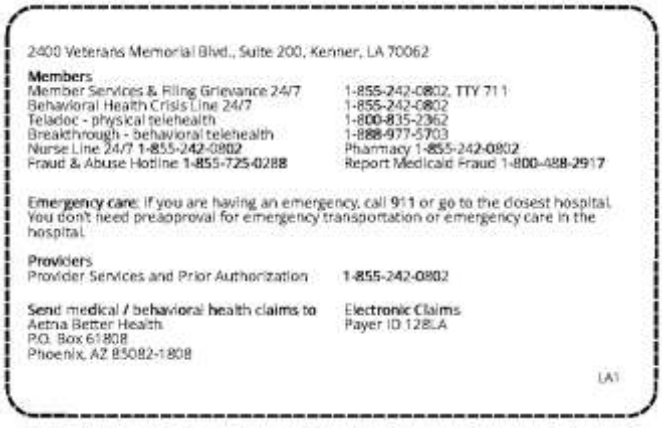
ID Card
Members should present their ID card at the time of service.
The member ID card contains the following information:

- Member Name
- Member ID Number
- Date of Birth of Member
- Member's Gender
- PCP Name
- PCP Phone Number
- Effective Date of Eligibility
- Claims address
- Emergency Contact Information for Member
- Health Plan Name
- Aetna Better Health of Louisiana's Website
- Carrier Group Number
- RX Bin Number
- RX PCN Number
- RX Group Number
- CVS Caremark Number (For Pharmacists use only)

Sample ID Card
Front:



Back:



Model of Care

Integrated Care Management

Aetna Better Health of Louisiana's Integrated Care Management (ICM) Program uses a Bio-Psycho-Social (BPS) model to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time. We use evidence-based practices to identify members at highest risk of not doing well over the next twelve (12) months, and offer them intensive care management services built upon a collaborative relationship with a single clinical Case Manager, their caregivers and their Primary Care Provider (PCP). This relationship continues throughout the care management engagement. We offer members who are at lower risk supportive care management services. These include standard clinical care management and service coordination and support. Disease management is part of all care management services that we offer. Aetna Better Health also accepts referrals (by mail, fax, phone, email) for care management from practitioners, providers, members, caregivers, health information lines, facility discharge planners, and plan staff such as those from Member Services, Care Management and Utilization Management.

The ICM Interventions and Services are detailed below:

ICM Interventions and Services	
ICM Service Level	**Care Management Interventions**
Intensive: Complex Case Management and Chronic Condition Management (Disease Management)	• Outreach/Enrollment • Welcome letter • Face to face visits • PCP notification of enrollment, education about the program and services and how they can best support their patient[1] • Encouraging members to communicate with their care and service providers • Comprehensive bio-psychosocial assessment including behavioral health and substance abuse screening • Condition specific assessments for physical and behavioral health • Case Formulation/Synthesis (summary of the member's story) • Integrated plan of care and service plans (if member is LTSS eligible) • Chronic condition management • Care Planning • Member education and coaching to self-manage their conditions and issues • Monthly (minimum) care plan updates based on progress toward goals • Member contacts as clinically indicated and face to face if indicated • Complex care coordination with both internal and the member's multi-disciplinary care team which includes the member's identified support system • Case rounds • Integrated care team meetings (duals & LTSS) • Annual newsletter for primary chronic condition • Krames educational sheets

ICM Interventions and Services	
ICM Service Level	**Care Management Interventions**
Supportive: Supportive Standard Care Management and Chronic Condition Management (Disease Management)	• Outreach/Enrollment • Welcome letter • Face to face visits optional • PCP notification of enrollment, education about the program and services and how they can best support their patient • Condition specific assessments for conditions of focus • Bio-psychosocial care plan which includes activities for chronic conditions and service plans • Chronic condition management • Coaching on the management of conditions and issues and self-care • Encouraging members to communicate with their care and service providers • Education on disease process, self-management skills, and adherence to recommended testing and treatment • Quarterly (minimum) care plan updates • Member contacts as clinically indicated • Care team coordination • Case rounds • Integrated care team meetings (duals & LTSS) • Bi-annual newsletter for primary chronic condition • Krames educational sheets
Population Health Monitoring, follow up and education for low risk members	• Low/No Risk pregnant members: Quarterly screening to identify risk factors • Dually enrolled Medicare-Medicaid: Annual HRQ, low risk care plans, Krames materials • Welcome letter and bi-annual newsletter for low risk chronic condition management • Special populations: monitoring/tracking per state requirements • PCP notification of enrollment, education about the program and services and how they can best support their patient • Not applicable for LTSS

About this Provider Manual

This Provider Manual service as a resource and outlines operations for Aetna Better Health of Louisiana's Healthy Louisiana program. Through the Provider Manual, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health of Louisiana. Medical, dental, and other procedures are clearly denoted within the Manual.

Aetna Better Health of Louisiana is updated and made available to providers via the Aetna Better Health website at **AetnaBetterHealth.com/Louisiana**. Aetna Better Health of Louisiana annually notifies all new and existing participating providers in writing that the Provider Manual is available on the website. The Aetna Better Health of Louisiana Provider Manual is available in hard copy form or on CD-ROM at no charge by contacting our Provider

Experience Department at **1-855-242-0802**. Otherwise, for your convenience Aetna Better Health of Louisiana will make the Provider Manual available on our website at **AetnaBetterHealth.com/Louisiana**.

This manual is intended to be used as an extension of the Participating Health Provider Agreement, a communication tool and reference guide for providers and their office staff.

For the purpose of this manual, "provider" refers to practitioners (licensed health care professionals who provide health care services) and providers (institutions or organizations that provide services) that have agreed to provide Covered Services to health plan members pursuant to a Participating Health Provider Agreement ("contract").

About Patient-Centered Medical Homes (PCMH)

A Patient-Centered Medical Home (PCMH), also referred to as a "health care home", is an approach to providing comprehensive, high-quality, individualized primary care services where the focus is to achieve optimal health outcomes. The PCMH features a personal care clinician who partners with each member, their family, and other caregivers to coordinate aspects of the member's health care needs across care settings using evidence-based care strategies that are consistent with the member's values and stage in life. If you are interested in becoming a PCMH, please contact us at **1-855-242-0802**.

Providers who have additional questions can refer to the following phone numbers:

Important Contacts	Phone Number	FAX	Hours and Days of Operation (excluding State holidays)
Aetna Better Health of Louisiana	**1-855-242-0802** (follow the prompts in order to reach the appropriate departments) Provider Experience Department Member Services Department (Eligibility Verifications, education, grievances) **AetnaBetterHealth.com/Louisiana**	Individual departments are listed below	7 AM-7 PM CT Monday-Friday 7 AM-7 PM CT Monday-Friday 24 hours / 7 days per week Members have access to Services for Hearing Impaired (TTY) Louisiana Relay Services for Hearing-Impaired Members – Toll-Free **1-800-846-5277**
Aetna Better Health of Louisiana – Care Management	**1-855-242-0802**	Individual departments are listed below	
Aetna Better Health of Louisiana Prior Authorization Department	See Program Numbers Above and Follow the Prompts	Individual departments are listed below	24 hours / 7 days per week
Aetna Better Health of Louisiana Compliance Hotline (Reporting Fraud, Waste or Abuse) Providers may remain anonymous.	**1-855-725-0288**	N/A	24 hours / 7 days per week through Voice Mail inbox
Aetna Better Health of Louisiana Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse) Providers may remain anonymous.	**1-800-338-6361**	N/A	24 hours / 7 days per week Providers have access to Member Services staff and UM staff during normal business hours as well as after hours. Should our staff need to initiate or return a call regarding UM issues, staff will identify themselves by name, title and organization name

Aetna Better Health of Louisiana Department Fax Numbers	Fax Number
Member Services	**1-855-853-4936**
Provider Experience	**1-844-521-9775**
Provider Claim Disputes	**1-860-607-7657**
Care Management	**1-866-776-2813**
Medical Prior Authorization	**1-844-227-9205**

Community Resource	**Contact Information**
Louisiana Tobacco Quitline	**1-800-QUIT-NOW** (**1-800-784-8669**) TTY **1-866-228-4327** Website**: http://quitwithusla.org/**

Contractors	**Phone Number**	**Facsimile**	**Hours and Days of Operation (excluding State holidays)**
Interpreter Services Language interpretation services, including sign language, special services for the hearing impaired.	Please contact Member Services at **1-855-242-0802** (for more information on how to schedule these services in advance of an appointment)	N/A	24 hours / 7 days per week
Superior Vision - Vision Vendor	**1-800-879-6901**	N/A	8 AM-5 PM CT Monday-Friday
DentaQuest	**1-844-234-9834**	N/A	7 AM-7 PM CT Monday-Friday
Lab – Quest Diagnostics (Preferred Lab) **www.questdiagnostics.com/home.html**	Please visit the website for additional information.	Please visit the website for additional information.	Please visit the website for additional information.
Durable Medical Equipment- DME	Please see our online provider search tool for details surrounding DME providers. **AetnaBetterHealth.com/Louisiana**	N/A	N/A
Radiology- N/A Aetna Better Health of Louisiana currently does not use third-party vendors for radiology authorizations. Please contact our health plan directly at **1-855-242-0802** and follow the prompts for more information.	N/A	N/A	N/A

CVS Caremark – Pharmacy Vendor For prior authorizations, pharmacies will call our health plan directly at **1-855-242-0802** and follow the prompts.	**1-855-242-0802** (Aetna Better Health of Louisiana)		8 AM-5 PM ET Monday-Friday
Transportation (non-emergency)	For members: Reservations (call 48 hours ahead of time): **1-877-917-4150** 24-Hour Ride Assistance: **1-877-917-4151** TTY: **1-866-288-3133**	N/A	7-7 CT Monday-Friday
Magellan Specialized Behavior Health	**1-800-424-4489**	N/A	

Behavioral Health Services please see our online provider search tool for details surrounding Behavioral Health Services.

Agency Contacts & Important Contacts	**Phone Number**	**Facsimile**	**Hours and Days of Operation (excluding State holidays)**
Louisiana Department of Health Bureau of Health Services Financing TTY **1-800-220-5404**	**1-888-342-6207**	**1-877-523-2987**	Monday through Friday from 8 AM to 4:30 PM
Change Healthcare Customer Service Email Support: hdsupport@webmd.com	**1-800-845-6592**	N/A	24 hours / 7 days per week
Louisiana Relay	**1-800-846-5277**	N/A	24 hours / 7 days per week
Reporting Suspected Neglect or Fraud			
The Louisiana Department of Children and Family Services Child Abuse Hotline	**1-855-452-5437**	N/A	24 hours / 7 days per week
The National Domestic Violence Hotline	**1-800-799-SAFE** (7233)	N/A	24 hours / 7 days per week
The Louisiana Medicaid Fraud Division of the Louisiana Department of Health	**1-800-488-2917** (for provider fraud) **1-888-342-6207** (for recipient fraud)		

The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	**1-800-HHS-TIPS (1-800-447-8477)**		

In addition to the telephone numbers above, participating providers may access the Aetna Better Health of Louisiana website 24 hours a day, 7 days a week at **AetnaBetterHealth.com/Louisiana** for up-to-date information, forms, and other resources such as:

- Provider quick reference guide
- Member Rights and Responsibilities
- Searchable Provider Directory
- Credentialing Information
- Prior Authorization Grid
- Clinical Practice Guidelines
- Adult and Child Preventive Health Guidelines
- Member Handbook and Benefits
- Appeals Information and Forms
- Provider Newsletters

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Provider Experience Department Overview

Our Provider Experience Department serves as a liaison between the Health Plan and the provider community. Our staff is comprised of Provider Liaisons and Provider Service Representatives. Our Provider Liaisons conduct onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

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

- Advise of an address change
- View recent updates
- Locate forms
- Review member information
- Check member eligibility
- Find a participating provider or specialist
- Submitting prior authorizations
- Review or search the Preferred Drug List
- Notify the plan of a provider termination
- Notify the plan of changes to your practice
- Advise of a Tax ID or National Provider Identification (NPI) Number change
- Obtain a secure web portal or member care Login ID
- Review claims or remittance advice

Our Provider Experience Department supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards. Our staff is responsible for the creation and development of provider communication materials, including the Provider Manual, Periodic Provider Newsletters, Bulletins, Fax/Email blasts, website notices and the Provider Orientation Kit.

Provider Orientation

Aetna Better Health of Louisiana provides initial orientation for newly contracted providers within 30 days of being placed on an active status with Aetna Better Health of Louisiana and before you see members. In follow up to initial orientation, Aetna Better Health of Louisiana provides a variety of provider educational forums for ongoing provider training and education, such as routine provider office visits, group or individualized training sessions on select topics (i.e. appointment time requirements, claims coding, appointment availability standards, member benefits, Aetna Better Health of Louisiana website navigation), distribution of Periodic Provider Newsletters and bulletins containing updates and reminders, and online resources through our website at **AetnaBetterHealth.com/Louisiana**.

Provider Inquiries

Providers may contact us at **1-855-242-0802** between the hours of 7 AM and 7 PM, Monday through Friday, or email us at **LAProvider@aetna.com** for any and all questions including checking on the status of an inquiry, complaint, grievance, and appeal. Our Provider Experience Staff will respond within 48 business hours.

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Provider Enrollment

Beginning 4/1/2021, Louisiana Medicaid requires all* Medicaid Providers to enroll via the Louisiana Medicaid Portal located at www.lamedicaid.com. Additional information can be found in Louisiana Department of Health Informational Bulletin 21-5, March 5, 2021 in APPENDIX A: Program Updates. Enrollment guidance can be found at www.ldh.la.gov/medicaidproviderenrollment.

* Providers currently participating in the ABHLA network, must also validate their information and sign the state's provider participation agreement through the Louisiana Medicaid Portal within six months of the 4/1/2021 launch date.

Apply for Participation in the ABHLA Network

Only providers who are successfully enrolled and screened with Louisiana Medicaid may apply for participation in the Aetna Better Health of Louisiana network.

If you are interested in applying for participation in our Aetna Better Health of Louisiana network, please visit our website at **AetnaBetterHealth.com/Louisiana**, and complete the provider application forms (directions will be available online). If you would like to speak to a representative, about the application process or the status of your application, please contact our Provider Experience Department at **1-855-242-0802**. To determine if Aetna Better Health of Louisiana is accepting new providers in a specific region, please contact our Provider Experience Department at the number located above.

If you would like to mail your application, please mail to:

Aetna Better Health of Louisiana
Attention: Provider Experience
2400 Veterans Memorial Blvd., Suite 200
Kenner, LA 70062

Provider Responsibilities Overview

This section outlines general provider responsibilities; however, additional responsibilities are included throughout this Manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the Louisiana Healthy Louisiana Program, the Request for Proposal between LDH and Aetna Better Health and Louisiana, and your Provider Agreement, and requirements outlined in this Manual. Aetna Better Health of Louisiana may or may not specifically communicate such terms in forms other than your Provider Agreement and this Manual.

Providers must cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, the Louisiana Department of Health (LDH), The Louisiana Medicaid Fraud Division of the Louisiana Department of Health, Medicaid Fraud Control Unit (MFCU), Health and Human Services – Office of Inspector (HHS-OIG), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the U.S. Attorney's Office.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Providers must also assure the use of the most current diagnosis and treatment protocols and standards. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS).

Unique Identifier/National Provider Identifier

Providers who provide services to Aetna Better Health of Louisiana members must obtain identifiers. Each provider is required to have a unique identifier, and qualified providers must have a National Provider Identifier (NPI) on or after the compliance date established by the Centers for Medicare and Medicaid Services (CMS).

Appointment Availability Standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards, and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Providers are to ensure that the hours of operation being offered to all Medicaid members are no less than and/or equal to those offered to commercial members. Our Provider Experience Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the Louisiana Department of Health (LDH) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services.

The table below shows appointment wait time standards for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), and high volume Participating Specialist Providers (PSPs).

Emergency	Urgent	Non-urgent	Preventive	Specialty	Lab & X-ray
Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times. And an appointment shall be arranged within one (1) hour of request	Urgent Care within twenty-four (24) hours; Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by Aetna Better Health of Louisiana through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request for both physical and behavioral health.	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition	Routine physical health, non-urgent, or preventive care visits within 6 weeks. Routine, behavioral healthcare, non-urgent appointments shall be arranged within fourteen (14) days of referral.	Specialty care consultation within 1 month of referral or as clinically indicated	Lab and X-ray services (usual and customary) not to exceed three weeks for regular appointments and 48 hours for urgent care or as clinically indicated

Prenatal Care: Members will be seen within the following timeframes: (Initial appointment for prenatal visits for newly enrolled pregnant women will meet the following timetables from the postmark date the Healthy Louisiana Plan mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the Healthy Louisiana Plan is pregnancy. The timeframes below apply for existing member or new members whose basis of eligibility is something other than pregnancy from the date the Healthy Louisiana Plan or their subcontracted provider becomes aware of the pregnancy.)

- Within their first trimester within 14 days
- Within the second trimester within 7 days
- Within their third trimester within 3 days
- High risk pregnancies within 3 days of identification of high risk by the Healthy Louisiana Plan or maternity care provider, or immediately if an emergency exists

Notification of Pregnancy

Completing the Notification of Pregnancy form as early as possible allows us to best service our members to achieve a healthy pregnancy outcome. Please fill out this electronic form and submit so that it may directly reach our care management team in an expedited manner.

The completion of this form will help to identify high-risk pregnancies and assist in linking these members to case management enrollment. If you have any questions, please contact our Provider Experience department at **1-855-242-0802**.

If you prefer to fax this form, you may fax to **1-866-776-2813.** Attn: Case Management

In office, waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients must be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient must be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

Please note that follow-up to ED visits must be in accordance with ED attending provider discharge instructions.

Telephone Accessibility Standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available, or having on-call arrangements in place with other qualified participating Aetna Better Health of Louisiana providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services including, authorizing care and verifying member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent, and emergent health care issues are held to the same accessibility standards regardless if after hours coverage is managed by the PCP, current service provider, or the on-call provider.

All Providers must have a published after hours telephone number and maintain a system that will provide access to primary care 24-hours-a-day, 7-days-a-week. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between members, their PCPs, and practice staff. Providers must return calls within 30 minutes. We will routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all of the following situations:

- Answering the member telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs)
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

A telephone response should be considered acceptable/unacceptable based on the following criteria:
Acceptable – An active provider response, such as:

- Telephone is answered by provider, office staff, answering service, or voice mail.
- The answering service either:
  - Connects the caller directly to the provider
  - Contacts the provider on behalf of the caller and the provider returns the call
  - Provides a telephone number where the provider/covering provider can be reached
- The provider's answering machine message provides a telephone number to contact the provider/covering provider.

Unacceptable:

- The answering service:
  - Leaves a message for the provider on the PCP/covering provider's answering machine
  - Responds in an unprofessional manner
- The provider's answering machine message:
  - Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations
  - Instructs the caller to leave a message for the provider
- No answer;
- Listed number no longer in service;
- Provider no longer participating in the contractor's network;
- On hold for longer than five (5) minutes;
- Answering Service refuses to provide information for after-hours survey;
- Telephone lines persistently busy despite multiple attempts to contact the provider.

Provider must make certain that their hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals.

In the event that a PCP fails to meet telephone accessibility standards, a Provider Experience Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.

Covering Providers

Our Provider Experience Department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health of Louisiana. This notification must occur in advance of providing authorized services. Depending on the Program, reimbursement to a covering provider is based on the fee schedule. If members have other insurance coverage, providers must submit a paper bill and primary carrier EOB for reimbursement or electronically the bill and primary carrier EOB. Medicaid is always payor of last result. Failure to notify our Provider Experience Department of covering provider affiliations or other insurance coverage may result in claim denials and the provider may be responsible for reimbursing the covering provider.

Verifying Member Eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services. Providers are NOT reimbursed for services rendered to members who lost eligibility or who were not assigned to the primary care provider's panel (unless, s/he is a physician covering for the provider).

Member eligibility can be verified through one of the following ways:

- **Telephone Verification:** Call our Member Services Department to verify eligibility at **1-855-242-0802**. To protect member confidentiality, providers are asked for at least three pieces of identifying information such as the members identification number, date of birth and address before any eligibility information can be released.
- **Monthly Roster:** Monthly rosters are found on the Secure Website Portal (https://medicaid.aetna.com/MWP/login.fcc?TYPE=33554433&REALMOID=06-8b99ae55-7f0b-42c8-bb2c-ad6a6000c7ee&GUID=&SMAUTHREASON=0&METHOD=GET&SMAGENTNAME=yDnERTCDNc4ySe3gOph3XXzZ5ivKCiuMbjfUdnIRCYo4y6nCZ0RPZYUcXr96NUSO&TARGET=-SM-https%3a%2f%2fmedicaid%2eaetna%2ecom%2fMWP%2flanding%2flogin)
- Contact our Provider Experience Department for additional information about securing a confidential password to access the site. Note: rosters are only updated once a month.

Provider Secure Web Portal

The Secure Web Portal is a web-based platform that allows us to communicate member healthcare information directly with providers. Providers can perform many functions within this web-based platform. The following information can be attained from the Secure Web Portal:

- Member Eligibility Search – Verify current eligibility of one or more members
- Panel Roster – View the list of members currently assigned to the provider as the PCP.
- Provider List – Search for a specific provider by name, specialty, or location.
- Claims Status Search – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- Clinical Practice Guidelines
- Preventive health guidelines (adult and child)
- Provider Manual
- Remittance Advice Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates only remits associated with the user's account provider ID will be displayed.
- Provider Prior Authorization Look up Tool – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed. The tool will also allow providers to:
    - Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes simultaneously
    - Review Prior Authorization requirement by specific procedures or service groups
    - Receive immediate details as to whether the codes9s) are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
    - Export CPT/HCPS code results and information to Excel
    - Ensure staff works from the most up-to-date information on current prior authorization requirements
- Submit Authorizations – Submit an authorization request on-line. Three types of authorization types are available:
    - Medical Inpatient services including surgical and non-surgical, rehabilitation, and hospice
    - Outpatient Surgery
    - Home based services including hospice
    - Therapy
    - CT's MRI's, MRA PET scans, Angiography
    - Durable Medical Equipment – Rental
    - Non-Par providers must receive prior authorization for all treatment
    - We should include all information for Prior authorizations from **AetnaBetterHealth.com/Louisiana**
    - Skill nursing is only covered during home health services.

- Healthcare Effectiveness Data and Information Set (HEDIS) – Check the status of the member's compliance with any of the HEDIS measures. A "Yes" means the member has measures that they are not compliant with; a "No" means that the member has met the requirements.

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

Member Care Web Portal

The Member Care Web Portal is another web-based platform offered by Aetna Better Health of Louisiana that allows providers access to the member's care plan, other relevant member clinical data, and securely interact with Care Management staff.

Providers are able to do the following via the Member Care Web Portal:
For their Practice:

- Providers can view their own demographics, addresses, and phone and fax numbers for accuracy.
- Providers can update their own fax number and email addresses.

For their Patients:

- View and print member's care plan* and provide feedback to Case Manager via secure messaging.
- View a member's profile which contains:
  - Member's contact information
  - Member's demographic information
  - Member's Clinical Summary
  - Member's Gaps in Care (individual member)
  - Member's Care Plan
  - Member's Service Plans
  - Member's Assessments responses*
  - Member's Care Team: List of member's Health Care Team and contact information (e.g., specialists, caregivers)*, including names/relationship
  - Detailed member clinical profile: Detailed member information(claims-based data) for conditions, medications, and utilization data with the ability to drill-down to the claim level*
  - High-risk indicator* (based on existing information, past utilization, and member rank)
  - Conditions and Medications reported through claims
  - Member reported conditions and medications* (including Over the Counter (OTC), herbals, and supplements)
- View and provide updates and feedback on "HEDIS Gaps in Care" and "Care Consideration" alerts for their member panel*
- Secure messaging between provider and Case Manager
- Provider can look up members not on their panel (provider required to certify treatment purpose as justification for accessing records)

* Any member can limit provider access to clinical data except for: Members flagged for 42 C.F.R. Part 2 (substance abuse) must sign a disclosure form and list specific providers who can access their clinical data.

For additional information regarding the Member Care Web Portal, please access the Member Care Web Portal Navigation Guide located on our website.

Preventive or Screening Services
Providers are responsible for providing appropriate preventive care to members. These preventive services include, but are not limited to:

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations.
- Well woman visits (one well-woman gynecological examination per calendar year for women aged 21 and over is covered, when performed by a primary care provider or gynecologist. No referral is required for gynecologist visits.)
- Age and risk appropriate health screenings.

Educating members on their own health care
Aetna Better Health of Louisiana does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of a member and to advise them on:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

All providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Emergency Services
Authorizations are not required for emergency services. In an emergency, please advise the member to go to the nearest emergency department. If a provider is not able to provide services to a member who needs urgent or emergent care, or if they call after hours, the member should be referred to the closest in-network urgent care or emergency department.

Urgent Care Services
As the provider, you must serve the medical needs of our members; you are required to adhere to the all appointment availability standards. In some cases, it may be necessary for you to refer members to one of our network urgent care centers (after hours in most cases). Please reference the "Find a Provider" link on our website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in our network.

Periodically, Aetna Better Health of Louisiana will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Primary Care Providers (PCPs)
The primary role and responsibilities of PCPs include, but are not be limited to:

- Provide or arrange for urgent covered services as defined in your contract, including emergency medical services, to members on 24 hours per day, seven days per week basis.
- Providing primary and preventive care and acting as the member's advocate;
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of member care, and including, as appropriate, transitioning young adult members from pediatric to adult providers;
- Maintaining the member's medical record
- Provide to Members:
    - Office visits during regular office hours, ensuring that the hours of operation being offered to all Medicaid members are no less than and/or equal to those offered to commercial members.
    - Office visits or other services during non-office hours as determined to be medically necessary.
    - Respond to phone calls within a reasonable time and on an on-call basis 24 hours per day, seven days per week.

Primary Care Providers (PCPs) are responsible for rendering, or ensuring the provision of, covered preventive and primary care services for our members. These services will include, at a minimum, the treatment of routine illnesses, immunizations, health screening services, and maternity services, if applicable.

Primary Care Providers (PCPs) in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to members assigned to them, and attempt to verify coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to behavioral health providers, providers or hospitals within our network, as appropriate, and if necessary, referring members to out-of-network specialty providers;
- Coordinating with our Prior Authorization Department with regard to prior authorization procedures for members;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and hospitals; and
- Coordinating the medical care for the programs the member us assigned to, including at a minimum:
  - Oversight of drug regimens to prevent negative interactive effects
  - Follow-up for all emergency services
  - Coordination of inpatient care
  - Coordination of services provided on a referral basis, and
  - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs

Primary Care Providers (PCPs) are responsible for establishing and maintaining hospital admitting privileges that are sufficient to meet the needs of members, or entering into formal arrangements for management of inpatient hospital admissions of members. This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists should provide services to members upon receipt of a written referral form from the member's PCP or from another Aetna Better Health of Louisiana participating specialist. Specialists are required to coordinate with the PCP when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers the member to a different specialist or provider, then the original specialist must share these records, upon request, with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the member, other specialists, or other providers.

Primary Care Providers (PCPs) should only refer members to Aetna Better Health of Louisiana network specialists. If the member requires specialized care from a provider outside of our network, a prior authorization is required. A listing of in network specialist can be found in our provider directory.

Specialty Providers Acting as PCPs
In limited situations, a member may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. A specialist may be requested to serve as a PCP under the following conditions:

- When the member has a complex, chronic health condition that requires a specialist's care over a prolonged period and exceeds the capacity of the nonspecialist PCP (i.e., members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis etc.)
- When a member's health condition is life threatening or so degenerative and disabling in nature to warrant a specialist serve in the PCP role.
- In unique situations where terminating the clinician-member relationship would leave the member without access to proper care or services or would end a therapeutic relationship that has been developed over time leaving the member vulnerable or at risk for not receiving proper care or services.

Aetna Better Health of Louisiana's Chief Medical Officer (CMO) will coordinate efforts to review the request for a specialist to serve as PCP. The CMO will have the authority to make the final decision to grant PCP status taking into consideration the conditions noted above.

Specialty providers acting as PCPs must comply with the appointment, telephone, and after-hours standards noted in Chapter 2. This includes arranging for coverage 24 hours a day, 7 days a week.

Self-Referrals/Direct Access
Members may self-refer/directly access some services without an authorization from their PCP. These services include behavioral health care, vision care, adult dental care, family planning, and services provided by Women's Health Care Providers (WHCPs). The member must obtain these self-referred services from an Aetna Better Health of Louisiana provider.

Family planning services do not require prior authorization. Members may access family planning services from any qualified provider (note: It can be par or non-par; we do not restrict family planning services). Members also have direct access to WHCP services. Members have the right to select their own WHCP, including nurse midwives who participate in Aetna Better Health of Louisiana's network, and can obtain maternity and gynecological care without prior approval from a PCP.

Skilled Nursing Facility (SNF) Providers
Nursing Facilities (NF), Skilled Nursing Facilities (SNFs), or Nursing Homes provide services to members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members. Currently skilled nursing services are only preformed during home health services and should not be a covered service any other time.

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

Aetna Better Health of Louisiana will ensure the adherence to Medicaid law, which requires out-of-network practitioners to coordinate with the organization with respect to payment and ensure that the cost to members is no greater than it would be if the services were furnished in network.

Please note: Per Aetna Better Health, a provider is considered out of network while going through the contracting and credentialing process. This includes new provider groups, new individual providers and new providers joining existing groups.

Second Opinions

A member may request a second opinion from a provider within our network. Providers should refer the member to another network provider within an applicable specialty for the second opinion. Please note that there are no timeframes for referrals. If an Aetna Better Health of Louisiana provider is not available, Aetna Better Health will help the member get a second opinion from a non-participating provider at no cost to the member.

Provider Requested Member Transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask an Aetna Better Health of Louisiana member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a request for a Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific provider-patient relationship termination:

1. The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:
   Aetna Better Health
   Provider Experience Manager
   2400 Veterans Memorial Blvd., Suite 200
   Kenner, LA 70062
2. The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.
3. Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

In the case of a PCP, Aetna Better Health of Louisiana will work with the member to inform him/her on how to select another primary care provider.

Medical Records Review

Aetna Better Health of Louisiana's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within the Aetna Better Health of Louisiana provider network. Below is a list of Aetna Better Health of Louisiana medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of the Aetna Better Health of Louisiana Quality Management (QM) initiatives to maintain continuity and effective, quality patient care.

Provider records must be maintained in a legible, current, organized, and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health of Louisiana members immediately and completely available for review and copying by the Department and federal officials at the provider's place of business, or forward copies of records to the Department upon written request without charge.

Medical records must reflect the different aspects of patient care, including ancillary services. The member's medical record must be legible, organized in a consistent manner and must remain confidential and accessible to authorized persons only.

All medical records, where applicable and required by regulatory agencies, must be made available electronically.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements:

- Member identification information on each page of the medical record (i.e., name, Medicaid Identification Number)
- Documentation of identifying demographics including the member's name, address, telephone number, employer, Medicaid Identification Number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Complying with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to obtaining any required written member consents to disclose confidential medical records for complaint and appeal reviews
- Initial history for the member that includes family medical history, social history, operations, illnesses, accidents and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received
- Immunization records (recommended for adult members if available)
- Dental history if available, and current dental needs and services
- Current problem list (The record will contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions, and health maintenance concerns are identified in the medical record.)
- Patient visit data - Documentation of individual encounters must provide adequate evidence of, at a minimum:
    - History and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints
    - Plan of treatment
    - Diagnostic tests
    - Therapies and other prescribed regimens
    - Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or visit. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits
    - Referrals, recommendations for specialty, behavioral health, dental and vision care, and results thereof
    - Other aspects of patient care, including ancillary services
- Fiscal records - Providers will retain fiscal records relating to services they have rendered to members, regardless of whether the records have been produced manually or by computer
- Recommendations for specialty care, as well as behavioral health, dental and vision care and results thereof
- Current medications (Therapies, medications and other prescribed regimens - Drugs prescribed as part of the treatment, including quantities and dosages, will be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record will have a notation to the effect.)
- Documentation, initialed by the member's PCP, to signify review of:
    - Diagnostic information including:
        - Laboratory tests and screenings;
        - Radiology reports;
        - Physical examination notes; and
        - Other pertinent data

- Reports from referrals, consultations and specialists
- Emergency/urgent care reports
- Hospital discharge summaries (Discharge summaries are included as part of the medical record for (1) hospital admissions that occur while the patient is enrolled in Aetna Better Health of Louisiana and (2) prior admissions as necessary.)
- Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and behavioral health history
- Documentation as to whether or not an adult member has completed advance directives and location of the document (Louisiana advance directives include Living Will, Health Care Power of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated.)
- Documentation related to requests for release of information and subsequent releases,
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care
- Entries - Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider will countersign care rendered by ancillary personnel. Alterations of the record will be signed and dated
- Provider identification - Entries are identified as to author
- Legibility – Again, the record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
- Sterilization Consent form

Medical Record Audits

Aetna Better Health of Louisiana, LDH or its appointed authority, or CMS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, administrative responsibilities or quality of care issues. Providers must respond to these requests promptly within thirty (30) days of request. Medical records must be made available to LDH for quality review upon request and free of charge.

Access to Facilities and Records

Providers are required retain and make available all records pertaining to any aspect of services furnished to a members or their contract with Aetna Better Health of Louisiana for inspection, evaluation, and audit for the longer of:

- A period of five (5) years from the date of service; or
- Three (3) years after final payment is made under the provider's agreement and all pending matters are closed.

Documenting Member Appointments

When scheduling an appointment with a member over the telephone or in person (i.e. when a member appears at your office without an appointment), providers must verify eligibility and document the member's information in the member's medical record. You may access our website to electronically verify member eligibility or call the Member Services Department at **1-855-242-0802**.

Missed or Cancelled Appointments
Providers must:

- Document in the member's medical record, and follow-up on missed or canceled appointments, including missed EPSDT appointments.
- Conducting affirmative outreach to a member who misses an appointment by performing the minimum reasonable efforts to contact the member in order to bring the member's care into compliance with the standards
- Notify our Member Services Department when a member continually misses appointments.

Documenting Referrals
Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and behavioral health specialists within our network. Providers must follow the respective practices for emergency room care, second opinion, and noncompliant members.

Confidentiality and Accuracy of Member Records
Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies an Aetna Better Health of Louisiana member. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.

Specifically, our network providers must:

- Maintain accurate medical records and other health information.
- Help verify timely access by members to their medical records and other health information.
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information, and member information.

Provider must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations **(http://www.hhs.gov/ocr/privacy/)**.

Health Insurance Portability and Accountability Act of 1997 (HIPAA)
The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. The Health Insurance Portability and Accountability Act (HIPAA) impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. The Health Insurance Portability and Accountability Act (HIPAA) have established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit **http://www.hhs.gov/ocr/hipaa/**. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

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

- Train your staff on HIPAA;
- Consider the patient sign-in sheet;
- Keep patient records, papers and computer monitors out of view; and
- Have electric shredder or locked shred bins available.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information Protected Health Information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
    - The individual's past, present or future physical or mental health, or condition.
    - The provision of health care to the individual
    - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
    - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
    - Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health of Louisiana.
    - Release of data to third parties requires advance written approval from the Department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

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

For additional training or Q&A, please visit the following site at **http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm.**

Member Privacy Rights

Aetna Better Health of Louisiana's privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health of Louisiana personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to members or their representatives about Aetna Better Health of Louisiana's practices regarding their PHI
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests within required time standards
- Documenting requests and actions taken.

Member Privacy Requests

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

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

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

Cultural Competency

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

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health of Louisiana expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

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

Providers receive education about such important topics as:

- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment
- The impact that a member's religious and cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices).
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.)
- History of the disability rights movement and the progression of civil rights for people with disabilities.
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care

Our Provider Service Representatives will conduct initial cultural competency training during provider orientation meetings. The *Quality Interactions*® course series is designed to help you:

- Bridge cultures
- Build stronger patient relationships
- Provide more effective care to ethnic and minority patients
- Work with your patients to help obtain better health outcomes

Providers are required annually to access and complete the online cultural competency course, please visit: **aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html**

To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ Program. Aetna Better Health of Louisiana supports the Ask Me 3™ Program, as it is an effective tool designed to improve health communication between members and providers.

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health of Louisiana is required to verify that Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- The homeless
- Individuals with physical and mental disabilities

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health of Louisiana makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible to associated costs.

Our language interpreter vendor provides interpreter services at no cost to providers and members.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health of Louisiana Member Services Representatives will assist the member via a three-way call to communicate in the member's native language.
- For outgoing calls, Member Services Staff dial the language interpretation service and use an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Aetna Better Health of Louisiana staff (e.g., Case Managers) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health of Louisiana to link with an interpreter.

Aetna Better Health of Louisiana provides alternative methods of communication for members who are visually impaired, including large print and other formats. Contact our Member Services Department for alternative formats.

We strongly recommend the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Aetna Better Health of Louisiana offers sign language and over-the-phone interpreter services at no cost to the provider or member. Please contact Aetna Better Health of Louisiana at **1-855-242-0802** for more information on how to schedule these services in advance of an appointment.

Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Regular provider office will be conducted by our Provider Experience staff to verify that network providers are compliant.

Clinical Guidelines
Aetna Better Health of Louisiana has Clinical Guidelines and treatment protocols available to provider to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to members and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member;
- Constitute procedures for or the practice of medicine by the party distributing the guidelines; or
- Guarantee coverage or payment for the type or level of care proposed or provided.

Clinical Guidelines are available on our website at **AetnaBetterHealth.com/Louisiana.**

Office Administration Changes and Training
Providers are responsible to notify our Provider Experience Department on any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Experience Department to schedule staff training.

Continuity of Care
Providers terminating their contracts are required to provide a notice before terminating with Aetna Better Health of Louisiana. Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. Aetna Better Health of Louisiana is not responsible for payment of services rendered to members who are not eligible. You may also contact our Care Management Department for assistance.

Credentialing/Re-Credentialing
Aetna Better Health of Louisiana uses current NCQA standards and guidelines for the review, credentialing and re-credentialing of providers and uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

The Universal Credentialing DataSource Program allows providers to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the providers obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the provider for the same standard information. Providers update their information on a quarterly basis to verify data is maintained in a constant state of readiness. CAQH gathers and stores detailed data from more than 600,000 providers nationwide. All new providers, (with the exception of hospital based providers) including providers joining an existing participating practice with Aetna Better Health of Louisiana, must complete the credentialing process and be approved by the Credentialing Committee.

Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required.

Aetna Better Health shall provide a minimum of three written notices to a contracted provider with information regarding the re-credentialing process, including requirements and deadlines for compliance. The first notice shall be issued no later than six months prior to the expiration of the provider's current credentialing. The notice shall include the effective date of termination if the provider fails to meet the requirements and deadlines of the re-credentialing process. Aetna Better Health shall send the written notices required to the last mailing address and last email address submitted by the provider.

Please note: Credentialing and contracting are separate and distinct processes, therefore, the credentialing notification does not serve as the practitioner's notice of participation or participation effective date.
The credentialing process is completed within 60 days of receiving a clean contracting and credentialing packet. This includes new provider groups, new individual providers and new providers joining existing groups.

Licensure and Accreditation
Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.

Discrimination Laws
Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans With Disabilities Act
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.)
- The Anti-Kickback Statute (section 1128B(b) of the Social Security Act)
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164

In addition, our network providers must comply with all applicable laws, rules and regulations, and, as provided in applicable laws, rules and regulations, network providers are prohibited from discriminating against any member on the basis of health status.

Financial Liability for Payment for Services
In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health of Louisiana. However, a network provider may collect monies from members in accordance with the terms of the member's Handbook (if applicable). Providers must make certain that they are:

- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health of Louisiana, and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health of Louisiana for services furnished by providers that have been authorized by Aetna to service such members, as long as the member follows Aetna's rules for accessing services described in the approved Member Handbook.
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Agreeing to clearly advise a member, prior to furnishing a non-covered service, of the member's responsibility to pay the full cost of the services
- Agreeing that when referring a member to another provider for a non-covered service must verify that the member is aware of his or her obligation to pay in full for such non-covered services.

Continuity of Care for Pregnant Women
Members should be held harmless by the provider for the costs of medically necessary core benefits and services.

In the event a Medicaid eligible entering Aetna Better Health of Louisiana is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before Aetna Better Health of Louisiana enrollment, Aetna Better Health of Louisiana will be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as Aetna Better Health of Louisiana can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

In the event a member entering the health plan is in her second or third trimester of pregnancy and is receiving medically-necessary covered prenatal care services the day before enrollment, Aetna Better Health will be responsible for providing continued access to the prenatal care provider (whether contract or noncontract provider) for sixty (60) days post-partum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period.

Continuity for Behavioral Health Care

The PCP will provide basic behavioral health services and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

Provider Marketing

All health care providers delivering services to Aetna Better Health of Louisiana members enrolled in Healthy Louisiana plans are welcome to inform their patients of the Healthy Louisiana Plan they have chosen to participate with, but Healthy Louisiana has strict prohibitions against patient steering, which all providers must observe. The requirements below must be strictly observed by all Healthy Louisiana providers.

- Providers may inform their patients of all Healthy Louisiana Plans in which they participate, and can inform patients of the benefits, services, and specialty care services offered through the Healthy Louisiana Plan in which they participate.
- **Providers are not allowed to disclose only some of the Healthy Louisiana Plans in which they participate**. Disclosure of Healthy Louisiana Plan participation must be all or nothing.
- Providers can display signage, provided by the Healthy Louisiana Plan, at their location indicating which Healthy Louisiana Plans are accepted there, but must include all Healthy Louisiana Plans in which they participate in this signage.
- If a provider participates in only one Healthy Louisiana Plan, the provider can display signage for only one and can tell a patient that is the only Healthy Louisiana Plan accepted by that provider.
- Providers **MAY NOT RECOMMEND** one Healthy Louisiana Plan over another Healthy Louisiana Plan and **MAY NOT OFFER** patients incentives for selecting one Healthy Louisiana Plan over another.
- Providers **MAY NOT ASSIST** a patient in the selection of a specific Healthy Louisiana Plan. Additionally, patients may not use the provider's fax machine, office phone, computer, etc., to make such a selection, except as required for the completion of a Medicaid application as a function of being an enrolled Medicaid Application Center.
- Patients who need assistance with their Health Plan services should call the Member Services Hotline for the Plan in which they are enrolled, and those who wish to learn more about the different Healthy Louisiana Plans should contact the Healthy Louisiana Enrollment Broker at **1-855-229-6848** to receive assistance in making a Healthy Louisiana Plan decision.
- Under **NO CIRCUMSTANCES** is a provider allowed to change a member's Healthy Louisiana Plan for him/her, or request a Healthy Louisiana Plan reassignment on a member's behalf. **Members who wish to change their Healthy Louisiana Plan for cause must make this request to Medicaid themselves through the Healthy Louisiana Enrollment Broker.**

These prohibitions against patient steering apply to participation in the Healthy Louisiana programs.
If a provider or Health Plan is found to have engaged in-patient steering, they may be subject to sanctions such as, but not limited to monetary penalties, loss of linked patients and excluded from enrollment in Medicaid/Healthy Louisiana Plan network opportunities.

LDH Service Definitions Manual

Louisiana LDH Service Definitions Manual is available for providers upon request. To access online, please follow the link below:

http://new.LDH.louisiana.gov/assets/docs/BehavioralHealth/LBHP/LBHPSvcsManv7.pdf

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Services covered by Aetna Better Health of Louisiana are listed below. Some limitations and prior authorization requirements may apply.

All services must be medically necessary. If you have questions about covered services, call Member Services at **1-855-242-0802,** TTY **711**.

Behavioral Health Services are highlighted

Service/Benefit	Covered Service/Benefit	Limits
Assertive Community Treatment	Eligible adults can have a team of professionals help them with mental health and substance use services, housing and other social needs for community living.	For members 18 and older who are eligible for home and community based services. Prior authorization is required.
Basic behavioral health services	Services are provided in a primary care clinic and include screening for mental health and substance use issues, prevention, early intervention, medication management, treatment and referral to specialty services.	Not limited by Aetna Better Health of Louisiana
Bariatric Surgery	Bariatric surgery is covered when determined to be medically necessary	Prior authorization is required.
Breast Surgery	Mastectomy and breast conserving surgery is covered when it is determined to be medically necessary.	Prior authorization is required .
Chiropractic services	Medically necessary Chiropractic services when the service is provided as a result of a referral from an EPSDT medical screening provider or Primary Care Provider (PCP).	Covered for members from age 0-20
Community Psychiatric Support and Treatment (CPST)	Counseling and support provided at home, school, or work. Additional services may be available for members with special mental health care needs.	For members 21 and under For adults 21 and older who are eligible for home and community based services. Prior authorization may be required.
Crisis Intervention and Stabilization	You can get help right away if you have a mental health emergency or crisis.	
Dental	After the first visit, you should see your dentist every six months.	

Developmental and Autism Screening	Developmental and autism screenings administered during EPSDT preventive visits in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule	The plan will only reimburse the use of age-appropriate, caregiver-completed, and validated screening tools as recommended by the AAP. If a positive screening on a developmental or autism screen, the provider must give appropriate developmental health recommendations, refer the member for additional evaluation, or both, as clinically appropriate. Providers must document the screening tool(s) used, the result of the screen, and any action taken, if needed, in the members medical record. • Developmental screening and autism screening are currently reimbursed using the same procedure code. Providers may only receive reimbursement for one developmental screen and one autism screen per day of service. To receive reimbursement for both services
Dialysis	Hemodialysis and peritoneal dialysis are covered for the treatment of End Stage Renal Disease (ESRD).	Prior authorization is required.
Durable Medical Equipment	Medical equipment, appliances, and supplies such as wheelchairs, bed rails, walkers, and crutches	Prior authorization is required.
Emergency medical services	ER (Emergency Room) services	
Emergency medical transportation	Ambulance and helicopter	
End Stage Renal Disease Services (Dialysis)	Dialysis treatment (including routine laboratory services), medically necessary non-routine lab services, and medically necessary injections	

Early Periodic Screening, Diagnostic, and Treatment (EPSDT)/Well-Child Checkups	• Medical screenings • Developmental screenings • Vision screenings • Hearing screenings • Dental screenings • Periodic and inter-periodic Screenings	Covered for members age 0-20
Family planning services	May obtain services in or out of network (no cost for out of network family planning). Family planning services include: • Seven evaluation and management office visits per year for physical examinations for both males and females as it relates to family planning or family planning-related services; • Contraceptive counseling (including natural family planning), education, follow-ups, and referrals; • Laboratory procedures for the purposes of family planning and management of sexual health; • Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; and • Male and female sterilization procedures and follow up tests.	Elective abortions are not covered.
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)	Professional medical and basic behavioral health services furnished by doctors (Primary Care Providers), nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists and dentists.	Not limited by Aetna Better Health of Louisiana
Hearing aids	Hearing aids and related supplies such as earpieces and batteries	Not covered for members over age 21

Home health services	• Skilled nursing services • Home health aide • Physical, occupational or speech therapy • Home infusion • Wound therapy	Prior authorization is required.
	• Extended Home Health (EHH) Services • Extended Skilled Nursing Services • Intermittent Nursing (IN) Services	Not covered for members 21 and over. Covered for members birth through 20. Plan of Care (POC) and prior authorization are required when medically necessary to receive 3 or more hours per day. Daily nursing visits less than 3 hours per day for members under 21 not meeting medical necessity criteria for EHH do not require prior authorization.
Hospice	Care provided by a certified hospice agency for terminally ill members.	Prior authorization is required.
Immunizations	Covered for members 0-20 Some coverage for members 21 and up including flu, Human Papilloma virus (HPV), tetanus, and Pneumococcal polysaccharide vaccine (PPSV)	Limitations apply depending on member's age.
Inpatient hospital services	Inpatient hospital care needed for the treatment of an illness or injury that can only be provided safely and adequately in a hospital setting, including those basic services a hospital is expected to provide.	Prior authorization is required.
Lab tests and X-rays	Most diagnostic testing and radiological services ordered by the attending or consulting physician.	Prior authorization is required Need to specify diagnostic testing requiring PA. Not all labs should require PA
Licensed Mental Health Professionals (LMHP) are licensed by the State • Psychiatrists • Licensed Psychologists • Medical Psychologists • Professional Counselors • Clinical Social Workers • Addiction Counselors • Marriage and Family Therapists • Advanced Practice Registered Nurses (psychiatric specialists)	Outpatient counseling for mental health and substance use treatment	

Maternity care services	Prenatal through postpartum	
Mental health Inpatient Hospital Services	Mental health services provided in the hospital	Prior authorization may be required.
Medical transportation (OneCall)	Transportation to and from appointments for Medicaid covered services appointments and to extra services we offer such as adult dental care.	Not limited by Aetna Better Health of Louisiana
Non-emergency medical transportation	Transportation to and from appointments for Medicaid covered services appointments and to extra services we offer such as adult dental care and pharmacy following a visit to your provider.	
Nurse midwife and nurse practitioner services	Covered when performed in a doctor's office or clinic	
Nutritional/dietician consult services	Nutritional consultation	Prior authorization is required. Not covered for members over age 21
Outpatient services	Diagnostic and therapeutic outpatient services including outpatient surgery and rehabilitation services, therapeutic and diagnostic radiology services, chemotherapy and hemodialysis These services should be billed to Aetna Better Health in accordance with the Hospital Services Provider Manual.	Prior authorization may be required. Refer to the ABHLA Prior Authorization list or the Hospital Services manual for a list of services that require prior authorization.

Organ transplant and related services	Evaluation, transplant, and facility costs are covered.	Donor costs are not covered. Prior authorization is required.
Pediatric day healthcare services	Services include nursing care, respiratory care, physical therapy, speech therapy, occupational therapy, assistance with aids of daily living, transportation services, and education and training.	Covered for members 21 years old and younger when medically necessary. Prior authorization is required.

Peer Support	Support from people with the same experiences. This includes but is not limited to experiences living with a mental illness or caring for a child with a mental illness.	Not clinical in nature but viewed as a complimentary serviced of shared experience of living with a behavioral health condition or co-occurring disorder Certified Peer Support -Proc Code H0038-15 minute unit Certified Peer Support - Group (3-6 Members – max 2 hrs.) Proc Code H0038 HQ - 15 minute unit Certified Peer Support - Group (7-15 Members – max 2 hrs.) Proc Code H0038 UB - 15 minute unit Certified Peer Support - Collateral with Member present
Perinatal Depression Screening	The plan shall cover perinatal depression screening administered to any member's caregiver in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule.	The screening can be administered from birth to 1 year during an Early and Periodic Screening, If 2 or more children under age 1 present to care on the same day (e.g., twins or other siblings both under age 1), the provider must submit the claim under only one of the children. When performed on the same day as a developmental screening, providers must append modifier -59 to claims for perinatal depression screening.
Pharmacy services	Prescription medications that are on our formulary For a complete list of meds and/or to review the formulary, please visit www.**AetnaBetterHealth.com/Louisiana**.	Quantity limits, step therapy, and prior authorization may be required.

Physician/professional services	Professional medical services including those of a physician, nurse midwife, nurse practitioner, clinical nurse specialists or physician assistant.	Prior authorization may be required.
Podiatrist services	Office visits, certain radiology and lab procedures and other diagnostic procedures.	Prior authorization may be required.
Psychiatric Residential Treatment Facilities	Allows youth to live in a treatment facility to get the behavioral health care needed	For members under age 21 Prior authorization is required.
Psychiatrist Visits	Visits with a licensed psychiatrist A psychiatric nurse practitioner is also able to provide this service.	
Psychosocial Rehabilitation (PSR)	Services to help you feel healthy and more comfortable with other people This counseling can include family members and other helpers.	For members 21 and under For members 21 and older who are eligible for home and community based services. Prior authorization may be required.
Radiology services	Most diagnostic testing and radiological services ordered by the attending or consulting physician.	Only CT scans and MRI's require Prior authorization may be required
Rehabilitation services	Short term stays in a long-term care nursing facility for the purposes of rehabilitation.	Prior authorization is required.
Rehabilitation Substance Use	Outpatient and residential counseling and treatment for substance use conditions.	Prior authorization may be required.
Sexually Transmitted Disease (STD) services	Testing, counseling and treatment of all STDs and confidential HIV testing	
Telemedicine for behavioral health services	An alternative to clinic visits in areas that have limited access to behavioral health services. Meet with your behavioral health providers from a computer.	
Therapeutic Group Homes	Allows youth to live in a home-like setting with a small group of other youth to get the services needed	For members under age 21 Prior authorization is required.
Therapy services	Occupational, physical, speech, and language	Prior authorization is required.

Vision services	Adults 21 and over: Your covered services include optometrist services, a free annual eye exam, and $80 toward eyewear (frames, glass, or contact lenses). Members 21 and under: Services are covered when they: • Are given by a licensed network ophthalmologist or optometrist and • Conform to accepted methods of screening, diagnosis and treatment of: — Eye ailments — Visual impairments or conditions	Certain Limits apply. Prior authorization may be required.

Abortion Policy

Medicaid Payment for abortions is restricted and the following criteria must be met: physician must certify in own handwriting on the basis of his professional judgment the life of pregnant woman would be endangered if the fetus was carried to term. Certification statement which contains the name and address of the recipient must be specified on the claim. Terminating a pregnancy due to rape of incest the following requirements must be met: The recipient will report the act of rape or incest to police unless the treating doctor certifies in writing the victim was too physically or psychologically incapacitated to report the rape or incest and must be submitted to the Bureau of Health Services Financing along with the treating physician's claim for reimbursement for performing an abortion. Recipient will certify that the pregnancy is the result of rape or incest and this certification will be witnessed by the treating physician. The Office of Public Health Certification of Informed Consent-Abortion will be witnessed by treating physician and sent along with hard copy of claim.

Breast Reconstructive Surgery

Breast Reconstruction surgery performed after a mastectomy is a covered service, but breast reconstruction to establish symmetry with contralateral breast is not covered.

Wearable Cardioverter Defibrillator

Procedure code K0606 Health Plans were denying the Wearable Cardioverter Defibrillator. This device is a covered DMEPOS service for rental only and is located on the DMEPOS Fee Schedule/ Prior Authorization is required for this service to verify the medical necessity of the WCD and the WCD will not be used for experimental or investigational purposes. Device is for patients 18 years or older.

Freestanding Birthing Centers

Medicaid will cover delivery services for Medicaid recipients at free standing birthing centers. Centers will be reimbursed a one-time payment for each delivery equal to 90% of average per diem rates of surrounding hospitals providing labor and delivery services. Birthing centers are allowed to bill and be reimbursed for the code vaginal delivery only with a modifier 53. Reimbursement will be 75% of the professional services published fee schedule rate for services within the licensed midwife's scope of practice. Professional providers may bill and be reimbursed for each delivery by submitting the code for vaginal delivery only on their professional claims.

Common Observation Policy

The purpose of the outpatient hospital services program is to provide outpatient services to eligible Medicaid members performed on an outpatient basis in a hospital setting. Healthy Louisiana MCOs will reimburse up to forty-eight (48) hours of medically necessary care for a member to remain in an observational status. This time frame is for the physician to observe the member and to determine the need for further treatment, admission to an inpatient status, or for discharge. Observation and ancillary services do not require notification, precertification or authorization and will be covered up to forty-eight (48) hours.

Hospitals should bill the entire outpatient encounter, including Emergency Department (ED), Observation, and any associated services, on the same claim with the appropriate revenue codes, and all covered services are to be processed and paid separately. Any observation service over forty-eight (48) hours requires MCO authorization. For observation services beyond forty-eight (48) hours that are not authorized, MCOs will only deny the non-covered hours.

If a member is anticipated to be in observation status beyond forty-eight (48) hours, the hospital must notify the MCO as soon as reasonably possible for potential authorization of an extension of hours. The MCO and provider will work together to coordinate the provision of additional medical services prior to discharge of the member as needed. All observation status conversions to an inpatient hospital admission require notification to Aetna Better Health within one business day of the order to admit a member. All hospital facility charges on hospital day one are included in the inpatient stay and billed accordingly inclusive of emergency department/observation charges. Professional charges will continue to be billed separately.

ADDITIONAL SERVICES

Adult dental benefits

We will offer an exam and cleaning twice a year as well as a bitewing X-rays annually to adult members, every year we will cover up to $500 in fillings and extractions. Only available to adult members aged 21 and over who do not have dental coverage through another source.

Aetna Better Health of Louisiana uses DentaQuest dental services. Members can call DentaQuest at **1-844-234-9834 (TTY: 711)**, Monday – Friday from 7 AM to 7 PM CT.

Members do not need a referral to see a network dental provider. Members can find a dental provider in the provider directory online at **AetnaBetterHealth.com/Louisiana**.

Adult vision benefits

Members do not need a referral to see an in-network vision provider. Members can find a vision provider in the provider directory online at **AetnaBetterHealth.com/Louisiana**. Aetna Better Health of Louisiana uses Superior Vision for vision services. Members can call Superior Vision at **1-800-879-6901 (TTY: 711)**, Monday – Friday from 8 AM to 5 PM CT.

Covered services include a free annual eye exam and $80 toward eyewear (frames, glass, or contact lenses).

Mobile App

With the Aetna Better Health application, our members can get on demand access to the tools they need to stay healthy. It's easy. Member just downloads the app to their mobile device or tablet.

Mobile app features:

- Find a provider
- Request a Member ID card
- Change their PCP
- View their claims and prescriptions
- Message Member Services for questions or support
- Update their phone number, address and other important member details

Download app
To get the mobile app, members can download it from Apple's App Store or Google's Play Store. Search for Aetna Better Health to locate the app. It is free to download and to use. This application is available on certain devices and operating systems (OS).

Promise program for you and your baby
Members can earn Promise reward gift cards before and after their baby is born:

The more visits they make to their doctor during their pregnancy, the more rewards they can get.
- $25 for prenatal visits for the first 6 weeks of pregnancy or joining the plan
- $10 for each prenatal visit
- $50 for postpartum visit (3-8 weeks after delivery)
- $50 for completing Notice of Pregnancy form
- $50 for getting all 17P shots, for eligible members

Nurse line
Access to a nurse is available 24-hours a day, 7 days a week at **1-855-242-0802 (TTY: 711).**

Ted E. Bear, M.D.®, Kids Club
Ted. E. Bear, M.D. Kids Club members will be covered for the cost of an annual Scout membership. This applies to:
- Boy Scouts (including Boy Scouts, Cub Scouts, Exploring and Venturing)
- Girl Scouts
- As a bonus, Club members who join Boy Scouts get the *Boys' Life* magazine each year they are a Scout
- Club members who join Girl Scouts will receive credit toward Scout materials. Girls may choose one of two options after 6 months of continued participation: *A Girl's Guide to Girl Scouting* including one Journey Book, or a basic uniform.

In addition, we will offer **a weight management program** for children and adolescents.
- Members who join receive a pedometer or exercise band
- Plus, they receive gift cards from $15-$30 as they meet the goals they set

Annual wellness incentives for adults - earn gift cards after the member completes an adult checkup
- $25 gift card after annual wellness visit
- $15 gift card for annual diabetic dilated eye exam
- $15 gift card after women's annual mammogram
- $15 gift card after annual diabetic blood testing
- $15 gift card after annual cervical cancer screening
- $25 gift card for initial colonoscopy

Asthma condition management program - earn gift cards after the member manages their asthma
- $15 gift card for taking their prescribed medication
- $15 gift card for PCP follow-up visit after going to the emergency room
- $15 gift card for completing annual asthma assessment
- Free in-home environmental assessment

Care4Life diabetes coaching Program
Personalized text messages with appointment and medication reminders, exercise, and weight goal setting and tracking, education, and personal care manager support

Help to stop smoking
Smoking cessation medications for up to six months and health coaching and phone counseling. Medications available for up to 6 months - Patch, gum, lozenge, nasal spray, inhaler, varenicline, bupropion. Identification of risk stratification through completion of the Health Risk Questionnaire, Outreach Assessment, and development of a member-centered Care Plan.

Utilization of educational resources such as mailings from Krames and active, one-on-one, engagement in development of a plan of care for any member willing to participate in the Care Management program to include Face-to-Face visits for any member in the Intensive Program.

Free over-the-counter medicine and products with a doctor's prescription

Nurses, social workers, and community health workers to help members manage their health and get access to the care they need.

Medicaid Covered Services
Some services are covered by Medicaid but not by Aetna Better Health of Louisiana. Since these services are not covered by our Plan, you do not have to use our network providers to obtain these services.

Service	How to access
Specialized behavioral health	Aetna will administrator.
Children's dental services	Contact MCNA Dental at **1-855-702-6262** TTY: **1-800-955-8771** **www.mcnala.net**
Nursing facility services	Contact Louisiana Options in Long Term Care at **1-877-456-1146**
Personal care services for members 21 and older	Contact Louisiana Options in Long Term Care at **1-877-456-1146**
ICF/DD Services	Contact the Office for Citizens with Developmental Disabilities at **1-866-783-5553**
All Home & Community-Based Waiver Services	Contact the Office for Citizens with Developmental Disabilities at **1-866-783-5553**
Targeted Case Management Services	Contact the Office for Citizens with Developmental Disabilities at **1-866-783-5553**
Services provided through LDH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services)	Contact the Office for Citizens with Developmental Disabilities at **1-866-783-5553**
Individualized Education Plan (IEP) services provided by a school district	Contact the Louisiana Department of Education at **1-877-453-2721**
Medical Dental with the exception of the EPSDT varnishes provided in a primary care setting	Contact MCNA at **1-855-702-6262** TTY: **1-800-955-8771** **www.mcnala.net**

Cost for Services
Aetna Better Health of Louisiana has a contract with Healthy Louisiana to provide health care services with no cost sharing. This means members should not be asked to pay copay when they receive medical services.

Non-Covered Services

There are some services that Aetna Better Health of Louisiana does not cover. These include:

- Services or items used only for cosmetic purposes
- Elective abortions
- Treatment for infertility
- Experimental/Investigational procedures drugs and equipment (Phase I & II Clinical Trials are considered experimental)

Post-Stabilization Services

Aetna Better Health of Louisiana covers post-stabilization services provided by a contracted or non-contracted provider in any of the following situations:

- When Aetna Better Health of Louisiana authorized the services
- Such services were administered to maintain the member has stabilized condition within one (1) hour after a request to Aetna Better Health of Louisiana for authorization of further post-stabilization services.
- When Aetna Better Health of Louisiana does not respond to a request to authorize further post-stabilization services within one (1) hour, could not be contacted, or cannot reach an agreement with the treating provider concerning the member's care and a contracted provider is unavailable for a consultation. In this situation, the treating provider may continue the member's care until a contracted provider either concurs with the treating provider's plan of care or assumes responsibility for the member's care.

Transportation

If the member has an emergency and has no way to get to the hospital, call 911 for an ambulance.
If the member does not have transportation, we will cover transportation to medically covered services by Aetna Better Health of Louisiana. We will also cover transportation to Medicaid covered services such as dental care. We use a transportation vendor for member transportation needs.
Transportation is provided to the visit and to the pharmacy, only when the member goes to the directly to the pharmacy immediately following the appointment.

There is no limit on the number of trips provided.

Transportation appointments must be scheduled three 48 hours in advance. Reservations can be made up to thirty (30) days in advance. Our transportation vendor will assist with ongoing transportation needs for services such as dialysis, or other re-occurring treatments. When making reservations, keep in mind that members should not arrive more than one hour before their scheduled appointment.

To schedule a ride, call our transportation vendor at 1-877-917-4150, TTY 1-866-288-3133.

Please have these details ready when calling our transportation vendor:

- Name of the provider
- Provider's address
- Provider's telephone number
- Time of appointment
- Type of transportation needed (e.g., regular car, wheelchair-accessible van)

Medical Necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health of Louisiana's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

You can view a current list of the services that require authorization on our website at **AetnaBetterHealth.com/Louisiana**. If you are not already registered for the secure web portal, download an application from the Louisiana Providers section of the site. If you have questions or would like to get training on the secure provider web portal and the Prior Authorization Requirement Search Tool, please contact our Provider Experience Department at **1-855-242-0802**.

Emergency Services

Aetna Better Health of Louisiana covers emergency services without requiring prior authorization for members, whether the emergency services are provided by a contracted or non-contracted provider. Aetna Better Health of Louisiana will cover emergency services provided outside of the contracting area except in the following circumstances:

- When care is required because of circumstances that could reasonably have been foreseen prior to the members departure from the contracting area
- When routine delivery, at term, if member is outside the contracting area against medical advice, unless the member is outside of the contracting area due to circumstances beyond her control. Unexpected hospitalizations due to complications of pregnancy are covered.

Aetna Better Health of Louisiana will abide by the determination of the physician regarding whether a member is sufficiently stabilized for discharge or transfer to another facility.

Pharmacy Services

You can find a more comprehensive description of covered services in Chapter 18.

Interpretation Services

Telephone interpretive services are provided at no cost to members or providers. Personal interpreters can also be arranged in advance. Sign language services are also available. These services can be arranged in advance by calling Aetna Better Health of Louisiana's Member Services Department at **1-855-242-0802**.

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Mental Health/Substance Use Services

Behavioral health is defined as those services provided for the assessment and treatment of problems related to mental health and substance use disorders. Substance use disorders include abuse of alcohol and other drugs. In order to meet the behavioral health needs of our members, Aetna Better Health of Louisiana will provide a continuum of services to members at risk of or suffering from mental, addictive, or other behavioral disorders. We are an experienced behavioral health care organization and have contracted with behavioral health providers who are experienced in providing behavioral health services to the Louisiana population.

Specialized Behavioral health services is a covered benefit for Aetna Better Health members. Additional benefits may be available for ABHLA members for those who qualify. Providers can call the toll-free number located on the back of the member's identification card to access information about services, participating behavioral health providers and authorization information for members who request services from a behavioral health provider directly.

In addition, for all categories of members, Aetna Better Health of Louisiana will cover the diagnoses of diseases of organic origin categorized as altering the mental status of a member.

Aetna Better Health of Louisiana's Chronic Care Management Program ICM Objective:

- An integrated approach to physical and behavioral health conditions, that also addresses psychosocial circumstances, is critical to help our most vulnerable and highest risk. Team with the member and care providers to enhance care outcomes. Work as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage psycho-social complexity and challenging relationships with members and their families.
- Focuses on member health and well-being using behavioral change strategies, relationship building and engaging community and social systems to wrap around the member, to enhance resiliency and self-efficacy.
- Starts with assessing members as they are identified, evaluating them as "whole" beings, and including all elements surrounding them that may impact their health status.
- Assigns to an appropriate level of intervention intensity, and staff will team with them in managing their care.
- Tools and services assist in decreasing the need for invasive care and increasing self-management to improve health and well-being
- Establish a collaborative working relationship with providers in each region of the state
- Identify strengths: Assure we neither duplicate nor disrupt what is working well
- Identify and prioritize gaps in the local array of services and supports each members needs and conditions in general and priority populations in particular
- Identify and respond to opportunities for training and technical assistance to support providers

Availability

Mental Health/Substance Use Disorder (MH/SUD) providers must be accessible to members, including telephone access, 24 hours a day, and 7 days per week in order to advise members requiring urgent or emergency services. If the MH/SUD provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating providers must be arranged. Mental Health/Substance use disorder (MH/SUD) providers are required to meet our contractual standards for urgent and routine behavioral health appointments. For a complete list, please see Chapter 5 of this Manual.

Providers must deliver emergent or emergency visits immediately upon behavioral health member presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request.

Urgent Care
Urgent Care providers must have availability within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request.

Referral Process for Members Needing Mental Health/Substance Use Assistance
Members will be able to self-refer to any participating MH/SUD provider with our network without a referral from their Primary Care Provider (PCP).

Primary Care Provider Referral
We promote early intervention and health screening for identification of behavioral health problems and patient education. To that end, Aetna Better Health of Louisiana providers are expected to:

- Screen, evaluate, treat and refer (as medically appropriate), any behavioral health problem/disorder;
- Treat mental health and substance use disorders within the scope of their practice;
- Inform members how and where to obtain behavioral health services; and
- Understand that members may self-refer to an Aetna Better Health of Louisiana behavioral health care provider without a referral from the member's Primary Care Provider (PCP).

Coordination Between Behavioral Health and Physical Health Services
We are committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated and referred for physical health, behavioral health , , . With the member's permission, our case management staff can facilitate coordination of case management related substance use screening and behavioral health evaluation, and treatment.

Members seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. Primary Care Providers (PCPs) are encouraged to use behavioral health screening tools, treat behavioral health issues that are within their scope of practice and refer members to behavioral health providers when appropriate. Members seen by behavioral health providers are screened for co-existing medical issues. Behavioral health providers will refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so. Mental Health/Substance use (MH/SUD) providers are asked to communicate any concerns regarding the member's medical condition to the PCP, with the members consent if required, and work collaboratively on a plan of care.

Information is shared between Aetna Better Health of Louisiana and participating behavioral health and medical providers to verify interactions with the member result in appropriate coordination between medical and behavioral health care.

The Primary Care Provider and behavioral health provider are asked to share pertinent history and test results within 24 hours of receipt of results in urgent or emergent cases, and notification within 10 business days of receipts o results for non-urgent or non-emergent lab results. Members will be able to self-refer to any participating MH/SUD provider with our network without a prior authorization or a referral from their PCP.

Routine, non-urgent, or preventative care visits shall be arranged within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral.

Provider Assessments
On an annual basis, Aetna Better Health of Louisiana along with other Managed Care Organizations (MCOs) will conduct an assessment of practice integration using the Integrated Practice Assessment Tool (IPAT) on those providers who are likely to interface with the behavioral health populations.

Medical Records Standards
Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services. Detailed information on Medical Records Standards can be found in Chapter 3 of this Manual.

Mental Health Parity and Addition Equality Act (MHPAEA)
The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted to verify "parity" or fairness between mental health and substance use disorder (MH/SUD) benefits and medical/surgical benefits covered by a Managed Care Organization (MCO) such as Aetna Better Health of Louisiana. Enacted in 2008, MHPAEA does not require an (MOC) to offer MH/SUD benefits, but if the plan does so, it must offer the benefits on par with the other medical/surgical benefits it covers. In 2010, The Departments of Treasury, Labor, and Health and Human Services issued Interim Final Regulations (IFR) implementing the law. On Friday November 8, 2013, the Departments issued a Final Rule (FR) implementing the law.

A simple example of a parity requirement would be the frequency of office visits. Under MHPAEA, a plan may not allow a patient to have an unlimited number of medically necessary appointments with a dermatologist, but limit patients to only 5 appointments with a psychiatrist. However, while the premise of the law seems simple, the regulations related to the law are quite complicated, and therefore, implementation of the law has been complicated. This brief summary of the law is intended to help providers understand the law and the rights it affords them.

Links to Key Materials:

- Final regulation, available at **www.dol.gov/ebsa/pdf/mhpaeafinalrule.pdf**
- Interim Final Regulation, available at **www.dol.gov/ebsa/mentalhealthparity/**
- FAQs about ACA Implementation Part XVII and Mental Health Parity Implementation, available at **www.dol.gov/ebsa/faqs/faq-aca17.html**
- U.S. Department of Health and Human Services' Study: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, available at **www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf**
- News release, available at **http://www.dol.gov/ebsa/newsroom/2013/13-2158-NAT.html**
- CMS January 16, 2013 letter to State Health Officials and Medicaid Directors, available at **www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf**
- CMS overview document **www.cms.gov/regulations-and-guidance/health-insurance-reform/healthinsreformforconsume/downloads/mhpaea.pdf**
- **www.aetnabetterhealth.com/louisiana/assets/pdf/providers/**

Aetna Better Health of Louisiana is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers, and members each year, with new members upon enrollment, and new providers upon joining our network.

Treating a member with respect and dignity is good business for the provider's office and often can improve health outcomes. Your contract with Aetna Better Health of Louisiana requires compliance with member rights and responsibilities, especially treating members with respect and dignity. Understanding member' rights and responsibilities are important because you can help members to better understand their role in and improve their compliance with treatment plans.

It is Aetna Better Health of Louisiana's policy not to discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of member rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

In the event that Aetna Better Health of Louisiana is made aware of an issue with a member not receiving the rights as identified above, Aetna Better Health of Louisiana will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.

In the event Aetna Better Health of Louisiana is made aware of an issue when the member is not demonstrating the responsibilities as outlined above, Aetna Better Health of Louisiana will make good faith efforts to address the issue with the member and educate the member on their responsibilities.

Members have the following rights and responsibilities:

Member Rights
Members, their families, and guardians have the right to information related Aetna Better Health of Louisiana, its services, its providers and member rights and responsibilities in a language they can understand.

Members have the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy
- Privacy when you are at an office visit, getting treatment or talking to the health plan. Have your privacy protected.
- Know if your health information was shared without your okay
- To participate in decisions regarding his/her health care, including the right to refuse treatment for religious and any other reason
- To a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition

- To receive all information — e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives — in a manner and format that may be easily understood as defined in the Contract between LDH and Aetna Better Health of Louisiana
- To receive assistance from both LDH and the Enrollment Broker in understanding the requirements and benefits of Aetna Better Health of Louisiana
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services
- As a potential member, to receive information about the basic features of the Healthy Louisiana program; which populations may or may not enroll in the program and Aetna Better Health of Louisiana's responsibilities for coordination of care in a timely manner in order to make an informed choice
- To receive information on Aetna Better Health of Louisiana's services, to include, but not limited to:
  - Benefits covered;
  - Procedures for obtaining benefits, including any authorization requirements;
  - Any cost sharing requirements;
  - Service area;
  - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals;
  - Any restrictions on member's freedom of choice among network providers;
  - Providers not accepting new patients; and
  - Benefits not offered by Aetna Better Health of Louisiana but available to members and how to obtain those benefits, including how transportation is provided.

- To receive a complete description of disenrollment rights at least annually
- To receive notice of any significant changes in core benefits and services at least 30 days before the intended effective date of the change
- To receive information on grievance, appeal and State Fair Hearing procedures
- To voice complaints, grievances, or appeals about Aetna Better Health of Louisiana of the care provided to members
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and post- stabilization services;
  - That emergency services do not require prior authorization;
  - The process and procedures for obtaining emergency services;
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract;
  - Member's right to use any hospital or other setting for emergency care; and
  - Post-stabilization care services rules as detailed in 42 CFR §422.113(c).
- To receive Aetna Better Health of Louisiana's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To make recommendations about Aetna Better Health of Louisiana's member rights and responsibilities policy
- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way Aetna Better Health of Louisiana, its providers, or LDH treat the member.

Member Responsibilities

Aetna Better Health of Louisiana encourages members to be responsible for their own health care by becoming informed and active participants in their care. Aetna Better Health of Louisiana members, their families, or guardians are responsible for:

- Knowing the name of the assigned PCP and care manager
- Familiarizing themselves about their coverage and the rules they must follow to get care to the best of the member's ability
- Respecting the health care professionals providing service
- Contacting Aetna Better Health of Louisiana to obtain information or share any concerns, questions or problems
- Accurately providing all necessary health related information needed by the professional staff providing care or letting the provider know the reasons the treatment cannot be followed, as soon as possible
- Following instructions and guidelines agreed upon with the health care professionals giving care and cooperating fully with providers in following mutually acceptable courses of treatment
- Understanding their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible, and letting their doctor know if they do not understand
- Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider
- Reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and worsening of the condition arises
- Reporting changes like address, telephone number and assets, and other matters that could affect the member's eligibility to the office where the member applied for Medicaid services
- Protecting their member identification card and providing it each time they receive services
- Informing Aetna Better Health of Louisiana of the loss or theft of their ID card
- Disclosing other insurance they may have and applying for other benefits they may be eligible for
- Scheduling appointments during office hours, when possible
- Being present at scheduled appointments, arriving on time, and making any needed follow-up appointments
- Notifying the health care professionals in advance if it is necessary to cancel or reschedule an appointment
- Bringing immunization records to all appointments for children under eighteen (18) years of age
- Accessing preventive care services, living health lifestyles, and avoiding behaviors known to be detrimental to their health
- Following Aetna Better Health of Louisiana's grievance processes if they have a disagreement with a provider.

For questions or concerns, please contact our Provider Experience Department at **1-855-242-0802**.

Member Rights Under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations that receive financial assistance from any federal department or agency, including hospitals, nursing homes, mental health centers, and human service programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in, and have access to, program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People who have a history of physical or mental impairment, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating members may not, on the basis of disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits
- Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers

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The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

The EPSDT Program consists of two mutually supportive, operational components: **(1) assuring the availability and accessibility of required health care resources; and (2) helping members and their guardians effectively use these resources.** These components enable Medicaid agencies to manage a comprehensive health program of prevention and treatment, to seek out eligible members and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the patient's health needs through initial and periodic examinations and evaluations, and to see that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly. (Adapted from CMS website at **www.cms.gov/MedicaidEarlyPeriodicScrn/**).

Periodicity Schedule

The American Academy of Pediatrics publishes periodicity schedules that identify minimum guidelines for EPSDT screenings. You can view updated schedules on their website at **http://brightfutures.aap.org/clinical_practice.html**.

Identifying Barriers to Care

Understanding barriers to care is essential to helping members receive appropriate care, including regular preventive services. We find that although most members and caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. A recent study by the U.S. Department of Health and Human Services found that fewer than 50 percent of children in the study sample received any documented EPSDT services. To address this, Aetna Better Health of Louisiana trains its Member Services and Care Management Staff to identify potential obstacles to care during communications with members, their family/caregivers, Primary Care Providers (PCPs) and other relevant entities and works to maintain access to services.

Examples of barriers to preventive care that we have encountered include:

- Cultural or linguistic issues
- Lack of perceived need if the member is not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Lack of transportation
- Scheduling difficulties and other access issues

We work with providers to routinely link members with services designed to enhance access to preventive services, including:

- Facilitating interpreter services
- Locating a provider who speaks a particular language
- Arranging transportation to medical appointments
- Linking members with other needed community-based support services

Aetna Better Health of Louisiana closely monitors EPSDT metrics throughout the year to identify trends and potential opportunities for improvement. Aetna Better Health of Louisiana also notifies members annually of their eligibility for EPSDT services and encourages the use of the services.

Educating Members about EPSDT Services

Aetna Better Health of Louisiana informs members about the availability and importance of EPSDT services, including information regarding wellness promotion programs that Aetna Better Health of Louisiana offers. The information process includes:

- Member Handbook & Evidence of Coverage
- Member newsletters and bulletins
- Aetna Better Health of Louisiana's website
- Educational flyers
- Reminder postcards
- Care plan interventions for high risk members enrolled in care management
- Member Services care gap education

Provider Responsibilities in Providing EPSDT Services

Participating providers will be contractually required to do the following in providing EPSDT services:

- Provide EPSDT screenings and immunizations to children aged birth to twenty-one (21) years of age in accordance with Louisiana's periodicity schedule, including federal and State laws standards and national guidelines (i.e., American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care) and as federally mandated.
- Avoid delays in pediatric screenings and services by taking advantage of opportunities (for instance, provide an immunization, or screening during a visit for a mild acute illness or injury or during a sibling's visit).
- Fully document all elements of each EPSDT assessment, including anticipatory guidance and follow-up activities on the state-required standard encounter documentation form and verify that the record is completed and readable.
- Comply with Aetna Better Health of Louisiana's Minimum Medical Record Standards for Quality Management, EPSDT Guidelines and other requirements under the law.
- Cooperate with Aetna Better Health of Louisiana's periodic reviews of EPSDT services, which will include chart reviews to assess compliance with standards.
- Report members' EPSDT visits by recording the applicable Current Procedural Terminology (CPT) preventive codes on the required claim submission form
- Contact members or their parents/guardians after a missed EPSDT appointment so that it can be rescheduled.
- Have systems in place to document and track referrals including those resulting from an EPSDT visit. The system should document the date of the referral, date of the appointment and date information is received documenting that the appointment occurred.

Aetna Better Health of Louisiana requires participating providers to make the following recommended and covered services available to EPSDT-eligible children at the ages recommended on the state Medicaid regulators' periodicity schedule:

- Immunizations, education, and screening services, provided at recommended ages in the child's development, including all of the following:
  - Comprehensive health and developmental history (including assessment of both physical and mental health development)
  - Comprehensive unclothed physical exam
  - Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines)
  - Laboratory tests
  - Health education/anticipatory guidance - Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental exams provide the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention
  - Vision services, including periodic screening and treatment for defects in vision, including eyeglasses
  - Dental services, including oral screening, periodic direct referrals for dental examinations (according to the state periodicity schedule), relief of pain and infections, restoration of teeth, and maintenance of dental health
  - Hearing services, including, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
  - Lead toxicity screening, consists of two components, verbal risk assessment and blood lead testing in accordance with CMS and Louisiana state requirements. Other necessary health care to correct or ameliorate physical and mental illnesses and conditions discovered by the screening process
- Diagnostic services, including referrals for further evaluation whenever such a need is discovered during a screening examination
- Treatment or other measures to correct or improve defects and physical and mental illnesses or conditions discovered by the screening services

For questions or concerns, please contact our Provider Experience Department at **1-855-242-0802**.

PCP Notification

On at least a quarterly basis Aetna Better Health of Louisiana will provide all PCPs with a list of members who have not had an encounter and who have not complied with the EPSDT periodicity and immunization schedules for children.

Direct-Access Immunizations

Member may receive influenza and pneumococcal vaccines from any network provider without a referral, and there is no cost to the member if it is the only service provided at that visit.

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Members with Special Needs

Adults with special needs include our members with complex and chronic medical conditions requiring specialized health care services. This includes persons with disabilities due to physical illnesses or conditions, behavioral health conditions, substance use disorders, and developmental disabilities. Members may be identified as having special needs because they are homeless. Children with special health care needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition, and who require health and related services of a type or amount beyond that generally required by children.

Aetna Better Health of Louisiana developed methods for:

- Promoting well-child care to children with special needs, who may be cared for by multiple subspecialists
- Health promotion and disease prevention for adults and children identified as having special needs
- Coordination and approval for specialty care when required
- Diagnostic and intervention strategies to address the specific special needs of these members
- Coordination and approval of home therapies and home care services when indicated
- Care management for adults with special needs to address self-care education to reduce long-term complications and to coordinate care so that long-term complications may be treated as necessary
- Care management systems to assure that children with serious, chronic and rare disorders receive appropriate diagnostic work ups on a timely basis
- Access to specialty centers inside and outside of Louisiana for diagnosis and treatment of rare disorders

The Initial Health Screen (HIS) for new members will assist us in identifying those with special needs. We will also review hospital and pharmacy utilization data. Additionally, we rely on you, our network providers, to identify members who are at risk of or have special needs and those who are at risk for nursing home level of care. Once identified, we will follow-up with a Comprehensive Needs Assessment for each of these members.

Aetna Better Health of Louisiana has policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

Aetna Better Health of Louisiana will develop care plans that address the member's service requirements with respect to specialist physician care, durable medical equipment, medical supplies, home health services, social services, transportation, etc. Our care management and utilization management teams collaborate closely so that all required services are furnished on a timely basis. We facilitate communication among providers, whether they are in or out of our network.

Outreach and enrollment staff is trained to work with members with special needs, to be knowledgeable about their care needs and concerns. Our staff uses interpreters when necessary to communicate with members who prefer not to or are unable to communicate in English, and use the LA Relay system and American Sign Language interpreters, if necessary.

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services, the member may receive care from a contracted specialist or a contracted specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center will be responsible for providing and coordinating the member's primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, will be permitted to treat the member without a referral from the member's Primary Care Provider (PCP) and may authorize such referrals, procedures, tests and other medical services. If approval is obtained to receive services from a non-network provider, the care will be provided at no cost to the member. If our network does not have a provider or center with the expertise the member requires, we will authorize care out of network.

After-hours protocol for members with special needs is addressed during initial provider trainings, in our Provider Manual. Providers must be aware that non-urgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs. We expect our contracted providers to have systems for members with special needs to reach a provider outside of regular office hours. Our Aetna Better Health of Louisiana Nurse Line is available 24 hours a day, 7 days a week for members with an urgent or crisis situation.

Aetna Better Health of Louisiana require our contacted providers to use the most current diagnosis and treatment protocols and standards established by the medical community in conjunction with the Louisiana Department of Health (LDH). During initial provider orientations, we will highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

Provider Monitoring

The methods we utilize to monitor our providers and members compliance/success in obtaining the appropriate care associated with EPSDT include a multi-pronged approach to maximize our quality results and care of this specific member population. The methods include, but are not limited to:

- Analysis and evaluation of provider utilization
    - EPSDT Audit and other provider office visits
    - EPSDT Compliance Report
- Tracking and trending provider data
    - Evaluation of performance measures and outcome data including Healthcare Effectiveness Data and Information Set (HEDIS®) and Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) results (monitoring results on a monthly basis)
- Review and tracking of member grievances and appeals and provider complaints to identify trends
    - Peer review of quality, safety, utilization and risk management referrals
    - Recredentialing review activities
    - Review of gaps in care reports and analysis of data from PCP profiles and performance reports
    - Review of sentinel events
- Monitoring network capacity and availability and accessibility to care delivery systems, recredentialing review activities

Our Provider Experience Department educates providers about EPSDT program requirements and monitors the adequacy of our EPSDT network. Provider Experience Staff may take referrals from a provider to have a member outreached by care management staff, especially if the provider has been unable to reach the member to schedule an appointment for EPSDT-related services. Providers Services Staff may also take referrals from providers who identify problems through EPSDT exams.

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Tools to Identify and Track At-Risk Members

Aetna Better Health of Louisiana uses data-driven tools to provide early detection of members who are at risk of becoming high cost, who have actionable gaps or errors in care and who may benefit from Care Management. These tools have two main components. The first is our predictive modeling tool known as the CORE model, or Consolidated Outreach and Risk Evaluation, which uses predictive modeling based on claims data, pharmacy data, and diagnoses along with predictive modeling that indicates each member's risk of ED utilization and inpatient admission over the next twelve (12) months. We supplement this information with data collected from Health Risk Assessments. We track member information in a web-based care management tracking application. These tools, described below, enable us to work closely with providers, members and their families or caregivers to help improve clinical outcomes and enhance the quality of members' lives.

Predictive Modeling

Aetna Better Health of Louisiana's predictive modeling software identifies and stratifies members who are eligible for our care management programs. It sorts, analyzes, and interprets historical claims, pharmacy, clinical and demographic data to identify gaps in care and to make predictions about future health risks for each member. The application funnels information from these various sources into a member profile that allows our Case Managers to access a concise twelve (12) month summary of activity. This data then links to our customized care management tracking application.

Once analyzed, our predictive modeling software ranks members and prepares a monthly "target" report of the members most likely to benefit from care management services. In addition to the scoring methodology, predictive modeling also looks at certain "triggers" to alert Case Managers to potential risk factors, including:

- Members with new hospital authorizations (currently inpatient) or authorizations for certain scheduled services (i.e. home health or selected surgical procedures)
- Call tracking from Aetna Better Health of Louisiana's Member Services Department

Initial Health Screen (IHS)

Aetna Better Health of Louisiana also assesses members through the Initial Health Screen (His) tool. Aetna Better Health of Louisiana staff members go over the IHS with the member or caregiver during a telephone call made to each member to welcome them to the health plan. The IHS gathers:

- Member contact information
- Primary Care Provider (PCP) or medical home information
- Member's health history and self-rated assessment of health
- Frequency of ER use
- Medication usage

CM Business Application Systems

Our care management business application system stores and retrieves member data, claims data, pharmacy data, and history of member interventions and collaboration. It houses a comprehensive assessment, condition-specific questionnaires and care plans and allows care management staff to set tasks and reminders to complete actions specific to each member. It provides a forum for clear and concise documentation of communication with providers, members, and caregivers. It retains history of events for use of the information in future cases. The system interfaces with our predictive modeling software, the inpatient census tool and allows documents to be linked to the case. It also provides multiple queries and reports that measure anything from staff productivity and staff interventions to coordination and collaboration and outcomes in care management.

Medical Necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider and in accordance with Aetna Better Health of Louisiana's guidelines for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

Any such services must be clinically appropriate, individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-Demonstration approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary".

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, the member's family/caregiver and the PCP, as well as any other providers, programs, agencies that have evaluated the member. Medical necessity determinations must be made by qualified and trained health care providers.

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Concurrent Review Overview

Aetna Better Health of Louisiana conducts concurrent utilization review on each member admitted to an inpatient facility. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Milliman Care Guidelines®. Admission certification is conducted within one business day of receiving notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. Our nurses conduct these reviews. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members. Our medical directors make rounds on site as necessary.

All inpatient admissions require notification to Aetna Better Health of Louisiana within one business day of the admission. All planned (non- emergency) inpatient admissions require prior authorization.

Milliman Care Guidelines

Aetna Better Health of Louisiana uses the Milliman Care Guidelines® to verify consistency in hospital–based utilization practices. The guidelines span the continuum of member care and describe best practices for treating common conditions. The Milliman Care Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to any covered service is available for review upon request.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse (CRN) works with the hospital discharge team and attending physicians to verify that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning
- Facilitating or attending discharge planning meetings for members with complex and multiple discharge needs.
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, Durable Medical Equipment (DME)/medical supply companies, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

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Primary care providers (PCP) or treating providers are responsible for initiating and coordinating a members request for authorization. However, specialists, PCPs and other providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting provider is responsible for complying with Aetna Better Health of Louisiana's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health of Louisiana will not prohibit or otherwise restrict providers, acting within the lawful scope of their practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health of Louisiana about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Emergency Services

Emergency medical services are permitted to be delivered in or out of network without obtaining prior authorization if the member was admitted for the treatment of an emergency medical condition. Aetna Better Health of Louisiana will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Payment will not be withheld from providers in or out of network. However, all inpatient admissions require notification within one (1) business day of the admission. The notification will be documented by the Prior Authorization Department or concurrent review clinician.

Post-stabilization Services

Aetna Better Health of Louisiana will cover post-stabilization services under the following circumstances without prior authorization, whether or not the services are provided by an Aetna Better Health of Louisiana network provider:

- The provider requested prior approval for the post-stabilization services, but Aetna Better Health of Louisiana did not respond within one hour of the request
- The provider could not reach Aetna Better Health of Louisiana to request prior approval for the services and has proof of due diligence in attempting to do so
- The Aetna Better Health of Louisiana representative and the treating provider could not reach an agreement concerning the member's care, and an Aetna Better Health of Louisiana medical director was not available for consultation
    - Note: In such cases, the treating provider will be allowed an opportunity to consult with an Aetna Better Health of Louisiana medical director; therefore, the treating provider may continue with the member's care until a medical director is reached or any of the following criteria are met;
    - An Aetna Better Health of Louisiana provider with privileges at the treating hospital assumes responsibility for the member's care;
    - An Aetna Better Health of Louisiana provider assumes responsibility for the member's care through transfer;
    - Aetna Better Health of Louisiana and the treating provider reach an agreement concerning the member's care; or
    - The member is discharged.

Services Requiring Prior Authorization

Our Secure Web Portal located on our website, lists the services that require prior authorization, consistent with Aetna Better Health of Louisiana's policies and governing regulations. The list is updated at least annually and updated periodically as appropriate.

Unauthorized services will not be reimbursed and authorization is not a guarantee of payment. All out of network services must be authorized.

Exceptions to Prior Authorizations

- Access to family planning services
- Well-woman services by an in-network provider
- Emergency medical services

Provider Requirements

Generally, a member's PCP, or treating provider is responsible for initiating and coordinating a request for authorization.

A prior authorization request must include the following:

- Current, applicable codes may include:
  - Current Procedural Terminology (CPT)
  - International Classification of Diseases, ICD-10
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the member
- Primary care provider or treating provider
- Name, address, phone and fax number and signature, if applicable, of the referring or provider
- Name, address, phone and fax number of the consulting provider
- Problem/diagnosis, including the ICD-9 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request. Clinical information is due by 3 PM If received after 3 PM it will be considered as received on the next business day.

We will take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe. Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, will not be entitled to payment for the provision of such item or service. *"We reserve the right to deny coverage of services should a provider fail to, or refuse to, respond to our request(s) for medical record information. "*

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 Secure Provider Web Portal located on the Aetna Better Health of Louisiana 's website at **AetnaBetterHealth.com/Louisiana**, or
- Fax the request form to **1-844-227-9205** (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing, or
- Through our toll-free number

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Provider Secure Web Portal at **AetnaBetterHealth.com/Louisiana**, or call us at **1-855-242-0802**. The portal will allow you to check status, view history, and email a Case Manager for further clarification if needed.

For further information about the Secure Web Portal, please review Chapter 4 of this manual. If response for non-emergency prior authorization is not received within 15 days, please contact us at **1-855-242-0802**.

Treating Provider Becomes Unavailable
Aetna Better Health of Louisiana will provide notice to a member, or the parent or legal guardian and to the involved state agency as appropriate, notice regarding who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice will be provided within seven (7) calendar days from the date we become aware of such, if it is prior to the change occurring.

Medical Necessity Criteria
To support prior authorization decisions, Aetna Better Health of Louisiana uses nationally recognized, and community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of Louisiana policies and procedures.

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. Aetna Better Health of Louisiana does not specifically reward practitioners or other individuals for issuing denials of coverage or care, or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of Louisiana uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of Louisiana's population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting providers when appropriate. Providers may obtain a copy of the utilization criteria upon request by contacting an Aetna Better Health of Louisiana provider experience representative. These are to be consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency
- Applicable Milliman Care Guidelines (MCG) as the primary decision support for most medical diagnoses and conditions
- Aetna Better Health of Louisiana Clinical Policy Bulletins (CPBs)
- Aetna Better Health of Louisiana Policy Council Review

If MCG state "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna Better Health of Louisiana CPBs, should be consulted and utilized.

For prior authorization of outpatient and inpatient services, Aetna Better Health of Louisiana uses:

- Criteria required by applicable State or federal regulatory agency
- LOCUS/CASII Guidelines/American Society of Addiction Medicine (ASAM)
- Aetna Better Health of Louisiana Clinical Policy Bulletins (CPB's)
- Aetna Better Health of Louisiana Clinical Policy Council Review

Medical, dental, and behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Timeliness of Decisions and Notifications to Providers, and Members

Aetna Better Health of Louisiana makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the Louisiana Department of Health (LDH) .Aetna Better Health of Louisiana adheres to the following decision/notification time standards. Notice will be provided as expeditiously as the member's health condition requires, but in a timeframe not to exceed 14 calendar days following receipt of the request for service, in accordance with 42 C.F.R. 438.210)d)1. Aetna Better Health of Louisiana ensures the availability of appropriate staff between the hours of 7 AM and 7 PM, seven days a week, to respond to authorization requests within the established time frames. Departments that handle pre-prior authorizations must meet the timeliness standards appropriate to the services required.

Decision/Notification Requirements

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	72 hours from receipt of request	Practitioner/Provider	Oral and Electronic/Written
Urgent pre-service denial	72 hours from receipt of request	Practitioner/Provider Member	Oral and Electronic/Written
Non-urgent pre-service approval	80% of standard service authorizations within two (2) business days of obtaining appropriate medical information But no later than 14 calendar days from receipt of the request	Practitioner/Provider	Oral and Electronic/Written
Non-urgent pre-service denial	Verbally notify within one (1) business day of making the initial determination and documented confirmation within two (2) business days of making the initial certification	Practitioner/Provider Member	Oral and Electronic/Written
Urgent concurrent approval	95% within one (1) business day and ninety-nine point five percent (99.5%) within two (2) business days of obtaining appropriate medical information	Practitioner/Provider	Oral and Electronic/Written
Urgent concurrent denial	Notify provider verbally within one (1) business day and provide documented confirmation within two (2) business days of making the initial certification	Practitioner/Provider	Oral and Electronic/Written
Post-service approval	30 calendar days of obtaining the results of appropriate medical information but no later than 365 days from the date of service	Practitioner/Provider	Oral or Electronic/Written

Decision	Decision/notification timeframe	Notification to	Notification method
Post-service denial	30 calendar days as above	Practitioner/Provider Member	Electronic/Written
Termination, Suspension Reduction of Prior Authorization	At least 10 calendar days before the date of the action	Practitioner/Provider Member	Electronic/Written

Prior Authorization Period of Validation

Prior authorization numbers are valid for the date of service authorized or for a period not to exceed sixty (60) days after the date of service authorized. The member must be enrolled and eligible on each date of service.

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Aetna Better Health of Louisiana will assign a prior authorization number, which refers to and documents the approval. Aetna Better Health of Louisiana sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health of Louisiana makes such decisions on a case-by-case basis in consultation with Aetna Better Health of Louisiana's medical director.

Notice of Action Requirements

Aetna Better Health of Louisiana provides the provider and the member with written notification (i.e., Notice of Action -NOA) of any decision to deny, reduce, suspend, or terminate a prior authorization request, limits, or to authorize a service in the amount, duration or scope that is less than requested or denies payment, in whole or part, for a service.

The notice will include:

- The action that Aetna Better Health of Louisiana has or intends to take
- The specific reason for the action, customized to the member circumstances, and in easily understandable language to the member
- A reference to the benefit provision, guideline, or protocol or other similar criterion on which the denial decision was based
- The name and contact information for the physician or dentist that reviewed and denied the service
- Notification that, upon request, the provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that provider has the opportunity to discuss medical, dental, and behavioral healthcare UM denial decisions with a physician or other appropriate reviewer
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeals process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The member's or provider (with written permission of the member) right to request a Medicaid State Fair Hearing and instructions about how to request a Medicaid State Fair Hearing
- A description of the expedited appeals process for urgent preservice or urgent concurrent denials
- The circumstances under which expedited resolution is available and how to request it

- The member's right to request continued benefits pending the resolution of the appeal or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these benefits
- Translation service information
- The procedures for exercising the members rights

Continuation of Benefits

Aetna Better Health of Louisiana will continue member's benefits during the appeal process if:

- The member or the provider files the appeal timely
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider (i.e. a network provider)
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal

Aetna Better Health of Louisiana will continue the member's benefits until one of the following occurs:

- The member withdraws the appeal.
- A State fair hearing office issues a hearing decision adverse to the member.
- The time period or service limits of a previously authorized service has been met

Prior Authorization and Coordination of Benefits

If other insurance is the primary payer before Aetna Better Health of Louisiana, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

Self-Referrals

Aetna Better Health of Louisiana does not require referrals from Primary Care Providers (PCP), or treating providers. Members may self-refer access some services without an authorization from their PCP. These services include behavioral health care, vision care; Medicaid approved Alcohol and Drug Addiction facilities, adult dental care, family planning, and women's health care services. The member must obtain these self-referred services from Aetna Better Health of Louisiana's provider network, except in the case of family planning.

Member may access family planning services from any qualified provider. Members also have direct access to Women's Health Care Provider (WHCP) services. Members have the right to select their own women's health care provider, including nurse midwives participating in Aetna Better Health of Louisiana's network, and can obtain maternity and gynecological care without prior approval from a PCP.

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We are committed to support the quality of healthcare you provide to Members each day. You can refer to this chapter for information about:

- Our Quality Assessment and Performance Improvement Program (QAPI)
- Clinical Practice and Preventive Health Guidelines
- Performance Measures
- Member Experience
- Performance Improvement Projects (PIPs)
- Patient Safety
- Continuity and Coordination of Medical Care
- Continuity of Coordination Between Medical Care and Behavioral Healthcare
- Medical Record Reviews
- Provider Monitoring and Treatment Record Reviews
- NCQA Accreditation
- Delegation

Our Quality Assessment and Improvement Program

Our Quality Assessment and Improvement Program (QAPI) is designed to facilitate a Member's access to high-quality medical and/or behavioral healthcare, access to primary and specialty care, continuity and coordination of care across settings, and culturally competent care, including quality and appropriateness of care furnished to Members with special health care needs.

With our QAPI, we measure and track key aspects of care and services, use data-driven monitoring to identify improvement opportunities, implement interventions and analyze data to determine overall intervention effectiveness in improving clinical care and Member outcomes.

Our strategies include performance projects, medical record audits, performance measures, Plan-Do-Study-Act cycles or continuous quality improvement activities, member and provider surveys, and activities that address healthcare disparities identified through data collection.

We strive for continuous improvement and innovation in meeting Members' healthcare needs and work with you to facilitate Members' access to high-quality healthcare in the right place, at the right time, and in the most effective and efficient manner possible. We obtain feedback from key stakeholders, Members and their families/caregivers, and providers, using feedback to make recommendations to improve performance.

We develop QAPI objectives each year as outlined in our annual QAPI Program Description, which documents the scope, structure and function of the QAPI. We also evaluate our success in achieving our annual QAPI goals each year and document the results in our Quality Assessment and Improvement Program Evaluation. The QAPI Program Description and our annual evaluation are available to you upon request. Please call the Member Services Department at **1-855-242-0802** and ask for the Quality Department to receive your free copy.

Quality Management Work plan:
Our program description includes a work plan that shows our progress on the Quality Improvement (QI) activities throughout the year. The work plan includes our objectives, timeframe for each activity's completion, the person who is responsible for each activity, and how we monitor previously identified issues. We evaluate and document ongoing monitoring activities quarterly and semi-annually for:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Members' experience

Quality Management and Utilization Management Committee:
Your participation in the QAPI and feedback is important to us. We may ask you to become a member, or you may volunteer. The broad range of experience you bring will assist us in making decisions that may positively impact the Members you serve. The meetings occur quarterly, and sometimes more frequently if needed. We also provide a stipend to you for your participation. If you would like to become a member, please contact the Quality Department and we will send you an invite.

Quality improvement (QI) Activities:

Provider contracts specify that providers cooperate with Aetna Better Health's quality improvement (QI) activities to:

- Improve the quality of care, services and the Member experience, including the collection and evaluation of data
- Cooperate with QI activities, and provide clinical documentation, medical records and/or treatment records when requested by the Health Plan
- Allow the organization to collect and use performance measurement data
- Assist the organization in improving clinical and service measures
- Maintain the confidentiality of member information and records

We encourage you to freely communicate with our Members about all treatment options, regardless of benefit coverage limitations.

Clinical Practice and Preventive Health Guidelines
Our physical health and behavioral health clinical practice guidelines, and our preventive health guidelines help ensure quality preventive care and care management is provided to our Members. We adopt and/or endorse evidence-based, disease-specific clinical practice and preventive guidelines that are either developed by credible medical sources and/or agencies or through regional partnerships. We periodically update our guidelines to include new information about treatments, medications and technology that reflects best practices. We review our clinical practice guidelines at least every two years, or whenever we learn about new medical evidence, to ensure consistency with accepted practice standards. We also make updated information available to you in a variety of ways, including through the Aetna Better Health website and our Provider newsletter. You can access our guidelines by clicking on the link **AetnaBetterHealth.com/Louisiana/providers/guidelines**.

Performance Measures
Aetna Better Health is required to report on specific performance measures as prescribed by the Louisiana Department of Health (LDH), the Office of Behavioral Health (OBH), and other State agencies. The State may change the performance yearly and sets the goal for improvement. Some of the performance measures are incentive based, and the Health Plan can receive a bonus for surpassing the goal or we may receive a financial penalty if we fail to meet State expectations.

It is important for you to ensure Members receive the tests and screenings they need to stay healthy. If you correctly code for the services provided, we can capture the work you've done administratively. This will lessen the burden of you receiving multiple faxed medical record requests during the annual HEDIS audit.

Healthcare Effectiveness Data and Information Set (HEDIS):
HEDIS measures are industry-standard indicators of the quality of care health plan Members receive. Aetna Better Health collects HEDIS data annually as well as on a monthly basis to monitor trends and identify opportunities to improve care for Members. HEDIS data is also evaluated against national and regional HEDIS benchmarks to assess the performance of our network. As you respond to our HEDIS-related requests, we are able to measure the quality of care you provide.

State Performance Metrics (Non-HEDIS):
Aetna Better Health is required to report on specific performance measures prescribed by the Louisiana Department of Health (LDH), the Office of Behavioral Health (OBH), and other State agencies as requested. These measures are drawn from: the CMS Children's Health Insurance Reauthorization Act (CHIPRA) and Adult Quality Measure Core Set, Agency for Healthcare Research and Quality (AHRQ), Preventive Quality Indicators (PQI) and also includes State of Louisiana specific measures and other nationally-recognized measures.

Reporting/ Member Gaps in Care:
You will receive a report listing the names of your Members who are overdue for important health-related screenings and lab tests, or who may benefit from a discussion about medication usage. We recommend that you use this gap in care report as a guide for providing the necessary services needed by our Members to keep them healthy. For more information about our gap in care reports or how you can improve your HEDIS and State performance rating scores, please call the Member Services Department at **1-855-242-0802** and ask for the Quality Department.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Assistance:
The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is the foundation for ensuring comprehensive and necessary medical care to all Medicaid recipients under the age of 21. Compliance with this program is essential for prompt identification of problems that, if left undiagnosed or untreated, could create greater disabilities or diminish one's likelihood of achieving future life goals. Aetna Better Health works to ensure that our Members, especially those who are children, receive all services required to diagnose and treat potential and ongoing problems in a timely and culturally sensitive manner. Based on the EPSDT Periodicity Schedule, the Care Management and Quality Management teams provides outreach calls and mailings to remind Members about upcoming and past due wellness visits, offering assistance to address the barriers to attending appointments. Staff will also outreach to providers with Members who have missed wellness visits.

Performance Improvement Projects
Performance Improvement Projects (PIPs) engage the Health Plan, quality managers, providers and members as a team with the common goal of improving patient care.[2] The Health Plan, in collaboration with the State, targets improvement for a specific activity. The next step is to identify barriers to care and then implement interventions to improve member outcomes. The interventions are tracked quarterly, and analyzed annually. The current PIPs selected by LDH are:

- Improving Prenatal and Postpartum Care to Reduce the Risk of Preterm Birth
- Improving the Quality of Diagnosis, Management, and Care Coordination for Children and Adolescents with ADHD.

You will receive a notice by email, web, or mail if a PIP is changed, discontinued, or added. The Quality Management personnel may outreach to you to discuss these initiatives and/or you may contact them directly to learn more about these projects.

Member Experience
We implement different mechanisms to assess and improve member experience. We monitor the services provided and try to identify ways to improve how we do business and improve the quality of care being received.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS):
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized survey that measures Members' experience with the services provided by you and us. This survey addresses child and/or their legal guardian and adult Members' experience with getting needed care, getting care quickly, how well you communicate, customer service, how decisions are made, health promotion and education completed, and how their coordination of care. They also rate their personal doctor, the specialist they see, the health care provided, as well as health plan's services. We may contact you with survey results to address any concerns.

Behavioral Health Surveys:
The Behavioral Health survey is designed to assess member experiences and satisfaction with the behavioral health care received by Aetna Better Health child and adult Members. This survey addresses child and/or their legal guardian and adult Members' perceived improvement in their mental health, timeliness of receiving services or treatment, how the provider interacted with them, treatment, medication, and obtaining necessary information, and using Health Plan benefits. Results will be used to evaluate performance and identify gaps in service so that action can be taken to improve member experiences. You may be contacted with survey results to address any concerns.

Patient safety
We address patient safety by:

- Distributing to Members information pertaining to optimal clinical practices and enhancing their ability to monitor the safety of their own care
- Improve continuity and coordination of care between providers or site of care to avoid miscommunication or delays in care that can lead to poor outcomes
- Review of Potential Quality Of Care (PQOC) concerns expressed by Members, and taking action on complaints related to clinical safety[3]
- Monitoring adverse and unanticipated events, such as events resulting in death or serious physical or psychological injury occurring in inpatient and residential settings, and identifying trends that could indicate unsafe environments or practices in these contracted institutions. Providers are required to fill out the LDH Adverse Incident Reporting Form and fax it to Aetna Better Health at **1-860-262-9174**.

[2] ABH EQR ATR 2016-2017 Page 8
[3] HP NCQA 2018 QI 5

- Monitoring Health Care Acquired Conditions (HCACs), Other Provider Preventable Conditions (OPPCs), Serious Reportable Events (SREs) and Serious Reportable Adverse Events (SRAEs)
- All providers are required to inform Aetna Better Health of HACs, SREs, SRAEs and PPCs that occur when serving Members.
- Aetna Better Health will not compensate providers or permit providers to bill Members for services related to the occurrence of SREs, SRAEs and PPCs. Such nonpayment will not prevent patient access to healthcare services.

Continuity and Coordination of Medical Care

Aetna Better Health monitors and takes action to improve continuity and coordination of care across the health care network. Accessibility of Members to their primary care physician, specialist, and other necessary services is key to care coordination. The patient-centered medical home model is most strongly linked with clinical quality of care coordination, access, continuity, and communication.

Annually, we collect data on member movement between providers and across setting to identify opportunities for improvement through:

- Medical Record Review coordination of care audits
- Provider Continuity of Care Surveys
- Tracking 17 P medication administration for high risk pregnancies
- Ted E. Bear Weight and Nutrition Counseling Program for children and adolescent with obesity
- NICU Program with affiliated hospitals for premature birthed babies to assess the effectives of 17P medication administration
- Decreasing Emergency Room (ER) utilization rates through ER diversion.

Continuity and Coordination of Between Medical Care and Behavioral Healthcare

We also participate in behavioral healthcare clinical studies to look at how care is coordinated between the medical and behavioral healthcare provider. The key activities we focus on include:

- Provider Survey Continuity of Care between the Medical Care provider and the Behavioral Health clinician
- Treatment record reviews for behavioral health communication and collaboration with the member's primary care physician
- Care managers care coordination as part of their utilization management functions.
- Use of the complaints to identify concerns voiced by the member
- Antidepressant Medical Management (AMM) HEDIS® Measure for member treatment of depression
- Use a unified system or single case record for the member's medical and behavioral health management
- Fidelity monitoring of supportive services for children with serious behavioral health conditions who are at risk of out of home placement and those with serious mental illness
- Review of reports of our member's transition from inpatient psychiatric unit to skilled nursing level of care

Medical Record Reviews
We use medical record documentation standards to assess your record-keeping practices and we may audit these practices as part of ongoing network management.

You are required to cooperate with our chart audits. Chart audits are a part of our contractual obligations with regulatory agencies to monitor appropriateness of care and the quality of record-keeping.

Site visits initiated in response to complaints or quality concerns always include a medical record-keeping practice reviews. We will set up a time with you in advance to review the medical records. If you have any questions about our record review process you may call the Member Services Department at 1-855-242-0802 and ask for the Quality Department.

Provider Monitoring and Treatment Record Reviews
We monitor specialized behavioral health care and substance abuse providers and facilities across all levels of care for adherence to State and Federal standards. Monitoring activities include, but are not limited to:

- On-site facility site visit, at a minimum of every three years and if a complaint is received
- Treatment record reviews (TRR) to assess your record keeping practices and adherence to clinical evidence-based practice guidelines
- Desktop administrative audits of programs, policies, training records, and credentialing files
- Member interviews of services received
- Corrective actions plans issued, based on the degree of provider non-compliance with review criteria
- Follow-up activity to ensure action has been completed to prevent recurrence of the same issue

Confidentiality of member medical and/or behavioral health records

Aetna Better Health requires that providers comply with all applicable federal and state laws relating to the confidentiality of Member medical and behavioral health records, including but not limited to the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA).

Providers must:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office and/or a password-protected electronic medical record when staff is not present
- Prohibit unauthorized review and/or removal of medical records
- Maintain and adhere to policies and procedures regarding patient confidentiality and record retention

Aetna Better Health monitors providers' compliance with its confidentiality policies through clinical quality reviews and audits. Aetna Better Health requires providers, upon request, to provide Member medical information and medical and/or behavioral health records for the following purposes:

- Administering Aetna Better Health's benefit plans, such as claims payment, coordination of benefits, subrogation, enrollment eligibility verification, reinsurance and audit activities
- Managing care, such as utilization management and quality improvement activities
- Carrying out Member satisfaction procedures described in our Member handbook
- Participating in reporting on quality and utilization indicators, such as HEDIS
- Complying with the law

Note: A Member's consent/authorization to release medical records to Aetna Better Health for the purpose of an appeal and/or any quality activity is not necessary.

National Committee for Quality Assurance (NCQA)
Aetna Better Health must attain, and retain health plan accreditation by NCQA. As such, we adhere to NCQA standards and guidelines to measure, analyze and improve healthcare services. Aetna Better Health is contractually obligated to provide information to accreditation agencies, state and federal governments about the quality of care that our Members receive.

Delegation
Selected aspects of our members' services, claims, utilization management, pharmacy, disease management, and credentialing programs may be delegated to providers, service organizations, and vendors. We review these programs prior to delegation, and at least annually thereafter. We also perform ongoing monitoring, reviewing reports at least semi-annually. Please call the Member Services Department at **1-855-242-0802** and ask for the Quality Department if you have any questions or want to know more about delegation.

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Providers are required to comply with the Patient Self-Determination Act (PSDA), Physician Orders for Life Sustaining Treatment Act (POLST) and, the Louisiana Advance Directive rules (RS 40:1299.58.1 & RS 28:221), including all other State and federal laws regarding advance directives for adult members.

Advance Directives

Aetna Better Health of Louisiana defines advance directives as a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

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

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

For additional information about medical record requirements, please visit Chapter 3 of this Manual.

Patient Self-Determination Act (PSDA)

The Patient Self-Determination Act (PSDA), passed in 1990 and instituted on December 1, 1991, encourages all people to make choices and decisions now about the types and extent of medical care they want to accept or refuse should they become unable to make those decisions due to illness.

The PSDA requires all health care agencies (hospitals, long-term care facilities, and home health agencies) receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. Aetna Better Health of Louisiana requires our providers to comply with this act.

For additional information about the PSDA, please visit www.gapna.org/patient-self-determination-act-psda

Physician Orders for Life Sustaining Treatment (POLST) Act

Aetna Better Health of Louisiana requires providers to comply with the Physician Orders for Life Sustaining Treatment Act (POLST). The creation of this act allows members to indicate their preferences and instructions regarding life-sustaining treatment. This act implements the Physician's Order for Life-Sustaining Treatment (POLST) program. The POLST protocol requires a health care professional to discuss available treatment options with seriously ill members (or their advocate/family member), and these preferences are then documented on a standardized medical form that the member keeps with them.

The form must be signed by a member's attending provider or advanced practice nurse. This form then must become part of a member's medical record, as this form will follow the member from one healthcare setting to another, including hospital, home, nursing home, or hospice.

Concerns

Complaints concerning noncompliance with advance directive requirements may be filed with Aetna Better Health of Louisiana as a grievance or complaint, or with the State of Louisiana Department of Health at **1-855-725-0288**.

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Aetna Better Health of Louisiana processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable State and federal laws, rules and regulations. Aetna Better Health of Louisiana will not pay claims submitted by a provider who is excluded from participation in LA Medicaid or LA Healthy Louisiana Programs, or any program under federal law, or is not in good standing with the Louisiana Department of Health (LDH).

Aetna Better Health of Louisiana uses our business application system to process and adjudicate claims. Both electronic and manual claims submissions are accepted. To assist us in processing and paying claims efficiently, accurately and timely, Aetna Better Health of Louisiana encourages providers to submit claims electronically. To facilitate electronic claims submissions, Aetna Better Health of Louisiana has developed a business relationship with Change Healthcare. Aetna Better Health of Louisiana 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 each business day. Within twenty-hour (24) hours of file receipt, Aetna Better Health of Louisiana provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

Encounters

Billing Encounters and Claims Overview
Our Claims Inquiry Claims Research (CICR) Department is responsible for claims adjudication; resubmissions, and claims inquiry/research.

Aetna Better Health of Louisiana is required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.

- Providers must use valid International Classification of Disease, 9th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of The Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk Adjustment Processing System. Important notes: The ICD10 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Report all secondary diagnoses that impact clinical evaluation, management, and treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

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

Rejected (Voided) Claims

Aetna Better Health of Louisiana may reject claims because of missing or incomplete information. Paper claims that are received by Aetna Better Health of Louisiana that are screened and rejected prior to scanning must be returned to the provider with a letter notifying them of the rejection. Paper claims received by Aetna Better Health of Louisiana that are scanned prior to screening and then rejected, are not required to accompany the rejection letter.

A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system.

The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, must include the following:

- The date the letter was generated;
- The patient or member name;
- Provider identification, if available, such as provider ID number, TIN or NPI;
- The date of each service;
- The patient account number assigned by the provider;
- The total billed charges;
- The date the claim was received; and
- The reasons for rejection.

CMS Risk Adjustment Data Validation

Risk Adjustment Data Validation (RADV) is an audit process to verify the integrity and accuracy of risk-adjusted payment. CMS may require us to request medical records to support randomly selected claims to verify the accuracy of diagnosis codes submitted.

It is important for providers and their office staff to be aware of risk adjustment data validation activities because we may request medical record documentation. Accurate risk-adjusted payment depends on the accurate diagnostic coding derived from the member's medical record.

The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no later than January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to fairly and accurately adjust payments made to Aetna Better Health of Louisiana by CMS based on the health status and demographic characteristics of a member. CMS requires us to submit diagnosis data regarding physician, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

The Centers for Medicare and Medicaid Services (CMS) uses the Hierarchical Condition Category (HCC) payment model referred to as CMS-HCC model. This model uses the ICD-9 CM as the official diagnosis code set in determining the risk-adjustment factors for each member. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-9 CM codes by disease groups known as HCCs.

Providers are required to submit accurate, complete, and truthful risk adjustment data to us. Failure to submit complete and accurate risk adjustment data to CMS may affect payments made to Aetna Better Health of Louisiana and payments made by Aetna Better Health of Louisiana to the provider organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for a member can increase their medical costs. The CMS hierarchical condition categories HCC model for coexisting conditions that should be coded for hospital and physician services are as follows:

- Code all documented conditions that coexist at time of encounter/visit and that require or affect member care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Providers and hospital outpatient departments should not code diagnoses documented as "probable", "suspected", "questionable", "rule out" or "working" diagnosis. Rather, providers and hospital outpatient departments should code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted by Aetna Better Health of Louisiana. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient, and physician diagnoses submitted by the provider to us. In addition, regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules, and regulations. The Centers for Medicare and Medicaid Services (CMS) may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the Centers for Medicare and Medicaid Services website at http://csscoperations.com/.

Billing and Claims

When to Bill a Member

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

A member may be billed **ONLY** when the member knowingly agrees to receive non-covered services under the Healthy Louisiana Program:

- Provider MUST notify the member in advance that the charges will not be covered under the program.
- Provider MUST have the member sign a statement agreeing to pay for the services and place the document in the member's medical record.

When to File a Claim

All claims and encounters must be reported to us, including prepaid services.

Timely Filing of Claim Submissions

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

- **New Claim Submissions** – Medicaid-only and third party liability claims must be filed on a valid claim form within 365 days the date services (per HCAPPA) were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the member.
- **Claim Resubmissions** – Claim resubmissions must be filed within 180 days from the date of adverse determination of a claim.
- **Retroactive Eligibility Claim Submissions** – Aetna Better Health of Louisiana shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is submitted within one hundred and eighty (180) days from the member's linkage to Aetna Better Health of Louisiana. The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted to Aetna Better Health of Louisiana by the latter of the three hundred and sixty-fifth (365) calendar day from the date of service or one hundred and eighty (180) days from the member's linkage to Aetna Better Health of Louisiana.

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

Claims Processing Timeframes

- Within five (5) business days of receipt of a claim, Aetna Better Health of Louisiana shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.
- Ninety percent (90%) of all clean claims must be processed and paid or denied within fifteen (15) business days of the date of receipt.
- Ninety-nine percent (99%) of all clean claims must be processed and paid or denied within thirty (30) calendar days of the date of receipt.
- All pended claims must be fully adjudicated within sixty (60) calendar days of the date of receipt.

How to File a Claim

1) Select the appropriate claim form (refer to table below).

Service	Claim Form
Medical and professional services	**CMS 1500 Form**
Hospital inpatient, outpatient, skilled nursing and emergency room services	**CMS UB-04 Form**
Dental services that are considered medical services (oral surgery, anesthesiology)	**CMS 1500 Form**

Instructions on how to fill out the claim forms can be found on our website at **AetnaBetterHealth.com/Louisiana**.

2) Complete the claim form.
   a) Claims must be legible and suitable for imaging and microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
   b) The claim form may be returned unprocessed (unaccepted) if illegible or poor quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.
3) Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as members' medical records, clearly label and send to Aetna Better Health of Louisiana at the correct address.
   a) Electronic Clearing House
   Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
   - Change Healthcare is the EDI vendor we use.
   - Contact your software vendor directly for further questions about your electronic billing.
   - Contact our Provider Experience Department for more information about electronic billing.

   All electronic submission will be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health of Louisiana policies and procedures.

   b) Through the Mail

Claims	Mail To	Electronic Submission
Medical	Aetna Better Health of Louisiana P.O. Box 61808 Phoenix, AZ 85082-1808	Through Electronic Clearinghouse **www.emdeon.com/** or Change HealthCare "WebConnect" **https://office.emdeon.com/secure/scripts/inq.dll?MfcISAPICommand=LogIn**

About WebConnect

Aetna Better Health of Louisiana uses Change Healthcare WebConnect. WebConnect is a web based solution set that simplifies the everyday tasks the provider practices by integrating eligibility and benefits verification, claims and payment management as well as clinical tools all into one easy to use application. There are no provider costs for specialized software or per-transaction fees, even providers who previously only interfaced by submitting claims manually may utilize WebConnect for automated payer interaction.

Features

- Secure personalized web portal for submitting providers
- Automated electronic batch claim submission & real-time patient eligibility, benefit verification, referrals, pre-certs, authorizations, claim inquiry and more
- Fast implementation
- Real-time provider enrollment offers immediate electronic capability

Benefits

- Improves auto-adjudication rates
- Increases automation and improves efficiency
- Reduces call center volumes and associated expenses
- Eliminates requirement for capital investments in IT and staffing related to internal portal development and maintenance
- Drives providers directly to payers' websites
- Improves provider satisfaction

Please visit Change Healthcare to gain access: **.com/secure/scripts/inq.dll?MfcISAPICommand=LogIn**

Correct Coding Initiative

Aetna Better Health of Louisiana follows the same standards as NCCI's Medicaid performs edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit **www.cms.hhs.gov/NationalCorrectCodInitEd/.**

Aetna Better Health of Louisiana utilizes Claim Check as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

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

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

Correct Coding

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

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

Incorrect Coding

Examples of incorrect coding include:

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

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health of Louisiana can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

- **Modifier 59 – Distinct Procedural Services** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).
- **Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.
- **Modifier 50 – Bilateral Procedure** - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. We follow the same billing process as CMS and HFS when billing for bilateral procedures. Services should be billed on one line reporting one unit with a 50 modifier.
- **Modifier 57 – Decision for Surgery** – must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners indicate:
  Need to include all valid modifiers. CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows:
  XE Separate Encounter, a service that is distinct because it occurred during a separate encounter
  XS Separate Structure, a service that is distinct because it was performed on a separate organ/structure
  XP Separate Practitioner, a service that is distinct because it was performed by a different practitioner
  XU Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service

  AA Anesthesiologist Anesthesia services performed personally by the anesthesiologist
  QY Anesthesiologist Medical direction* of one CRNA
  QK Anesthesiologist Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
  QX CRNA service with direction by an anesthesiologist
  QZ CRNA service without medical direction by an anesthesiologist *
  47 Delivering Physician Anesthesia provided by delivering physician

52 Delivering Physician or Anesthesiologist Reduced services
QS** Anesthesiologist or CRNA Monitored Anesthesia Care Service
The QS modifier is a secondary modifier only, and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA). The QS modifier indicates that the provider **did not introduce the epidural catheter for anesthesia, but **did monitor** the recipient after catheter placement
62 two surgeons Performance of procedure requiring the skills of two surgeons66 surgical team performance of highly complex procedure requiring the concomitant services of several physicians (transplants)
79 unrelated procedure or service by the same physician during the postoperative period
80 assistant surgeons
AS First Assistant in surgery
GT telemedicine Services provided via interactive audio and video telecommunications system
Q5 Reciprocal Billing Arrangement Services provided by a substitute physician on an occasional reciprocal basis not over a continuous period of longer than 60 days. Does not apply to substitution within the same group.
QW - Laboratory required when billing certain laboratory codes
TH Prenatal Visits Required to indicate E&M pre-natal services rendered in the MD office. This will also exempt the service from the adult evaluation and management visit limit.

> "*Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier "-57" to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period."*

Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

Checking Status of Claims
Providers may check the status of a claim by accessing our secure website or by calling the Claims Inquiry Claims Research (CICR) Department. To check the status of a disputed, resubmitted, and reconsidered claim, please contact the CICR Department.

Payment Adjustments for Dis-enrolled Members
For members dis-enrolled due to the validation of a duplicate Medicaid ID, Aetna Better Health of Louisiana shall not recover claim payments under the retroactively dis-enrolled member's ID if the remaining valid ID is linked to another MCO or FFS. Aetna Better health of Louisiana shall subrogate to the MCO that paid the claim(s) for the dates of service.

Payment Continuation of Higher Level Services
Aetna Better Health of Louisiana shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless Aetna Better Health of Louisiana can provide the service through an in-network or out-of-network provider for a lower level of care.

Payment to Providers
At a minimum, Aetna Better Health of Louisiana shall run one (1) provider payment cycle per week, on the same day each week.

Aetna Better Health of Louisiana shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) day claims processing deadline. Interest owed to the provider must be paid the same date that the claim is adjudicated, and reported on the encounter submission to the Fiscal Intermediary (FI) as defined in the MCO Systems Companion Guide.

Online Status through Aetna Better Health of Louisiana's Secure Website

Aetna Better Health of Louisiana encourages providers to take advantage of using our online Provider Secure Web Portal at **AetnaBetterHealth.com/Louisiana**, as it is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The Provider Secure Web Portal is located on the website. Provider must register to use our portal. Please see Chapter 4 for additional details surrounding the Provider Secure Web Portal.

Calling the Claims Inquiry Claims Research Department

The Claims Inquiry Claims Research (CICR) Department is also available to:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing:
    - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
    - Excludes rebilling a claim (the entire claim must be resubmitted with corrections.
      Please be prepared to give the service representative the following information:
        - Provider name or National Provider Identification (NPI) number with applicable suffix if appropriate
        - Member name and member identification number
        - Date of service.
        - Claim number from the remittance advice on which you have received payment or denial of the claim.

Claim Resubmission

Providers have 180 days from the paid date to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute reconsideration or claim dispute.

Providers may resubmit a claim that:

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

Include the following information when filing a resubmission:

- Use the Resubmission Form located on our website.
- An updated copy of the claim. All lines must be rebilled. A copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid
- Any additional documentation required.
- A brief note describing requested correction
- Clearly label as "Resubmission" at the top of the claim in black ink and mail to appropriate claims address.

Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to deny as a duplicate.

Please note: Providers will receive an EOB when their disputed claim has been processed. Providers may call our CICR Department during regular office hours to speak with a representative about their claim dispute. The CICR Department will be able to verbally acknowledge receipt of the resubmission, reconsideration and the claim dispute. Our staff will be able to discuss, answer questions, and provide details about status. Providers can review our Secure Web Portal to check the status of a resubmitted/reprocessed and adjusted claim. These claims will be noted as "Paid" in the portal. To view our portal, please click on the portal tab, which is located under the provider page, which can be found on the following website: **AetnaBetterHealth.com/Louisiana.**

If Aetna Better Health of Louisiana or LDH or its subcontractors discover errors made by Aetna Better Health of Louisiana when a claim was adjudicated, Aetna Better Health of Louisiana shall make corrections and reprocess the claim within thirty (30) calendar days of discovery, or if circumstances exist that prevent Aetna Better Health of Louisiana from meeting this time frame, a specified date shall be approved by LDH. Aetna Better Health of Louisiana will automatically recycle all impacted claims for all providers within 15 days and will not require the provider to resubmit the impacted claims.

Claim Recoupments

Aetna Better Health of Louisiana shall provide written prior notification to a provider of its intent to recoup any payment.

For members dis-enrolled due to invalidation of a duplicate Medicaid ID, Aetna Better Health of Louisiana shall not recover claim payments under the retroactively dis-enrolled member's ID if the remaining, valid ID is also linked to the same MCO for the retroactive disenrollment period. Aetna Better Health of Louisiana will work with the specific MCO and shall identify these duplicate Medicaid IDs for a single member and resolve the duplication so that histories of the duplicate records are linked or merged.

If the member's aid category and/or type case changed from MCO eligible to MCO excluded, previous capitation payments for excluded months will be recouped from the MCO. The MCO shall initiate recoupments of payments to providers within 60 days of the date LDH notifies the MCO of the change. The MCO shall instruct the provider to resubmit the claim(s) to the Medicaid fee-for-service program (if applicable).

Instruction for Specific Claims Types

Aetna Better Health of Louisiana General Claims Payment Information

Our claims are always paid in accordance with the terms outlined in your provider contract. Prior authorized services from Non-Participating Health Providers will be paid in accordance with Original Medicare claim processing rules.

Applied Behavioral Analysis (ABA) Claims

ABA-based services are available to Medicaid recipients under 21 years of age. Our claims team will use the ABA description code and fee schedule found on the Louisiana Medicaid Fee Schedule website for billing and payment of claims.

Skilled Nursing Facilities (SNF)

Providers submitting claims for SNFs should use CMS UB-04 Form.

Providers must bill in accordance with standard Medicare RUGS billing requirement rules for Aetna Better Health of Louisiana, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: **www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp**

Clinical Laboratory Improvement Amendments (CLIA) Claims

All professional service and independent laboratory providers are to include a valid CLIA number on all claims submitted for laboratory services, including CLIA waived tests. Claims submitted with an absent, incorrect or invalid CLIA number will deny. Providers submitting claims for CLIA should use a CMS 1500 form.

Home Health Claims

Providers submitting claims for Home Health should use a CMS UB-04 form not a CMS 1500.
Skilled nursing codes as part of home health providers must bill in accordance with contract. Non-Participating Health Providers must bill according to CMS HHPPS requirement rules for Aetna. For additional information regarding CMS Home Health Prospective Payment System (HHPPS), please refer to the following CMS website address: **www.cms.gov/HomeHealthPPS/**

Rate Modifiers for Extended Home Health

Modifiers are available for routine home health and EHH (beneficiaries age 0 through 20), to reflect specific scenarios as indicated in the table below. All modifier requests must be submitted with the PA and approved in order to be reimbursed. Refer to the Louisiana Medicaid Home Health Services Fee Schedule at www.lamedicaid.com.

Modifier	Modifier Name
U2	Second Daily Visit
U3	Third Daily Visit
TT	Multiple Beneficiaries in the Same Setting
TG	High Complexity
TN	Rural/Outside Area
TV	Weekends/Holidays
UH	Services Provided in the Evening (6pm – 11:59pm)
UJ	Services Provided at Night (12am – 5:59am)
TU	Overtime (DOES NOT REQUIRE PA)

The above modifiers address enhanced rates for situations in which two beneficiaries are cared for simultaneously (TT), for children in EHH with high medical needs (TG), for overnight shifts for EHH (UH, UJ) for weekend/holiday shifts for EHH (TV), and for EHH services in rural areas (TN). These rate modifiers may be used in applicable circumstances to provide an enhanced reimbursement rate to home health providers in order to facilitate fully staffing prior approved EHH services for class members.

A home health agency may also submit claims using the TU modifier to identify hours for an EHH enrollee that were paid as overtime to the nurse delivering the care. This modifier shall not require prior authorization but must be for hours already authorized for the enrollee. When billing, this modifier may be used in addition to any other authorized modifiers (e.g., TG) for procedure codes S9123 and S9124, but shall be paid at a minimum of 1.5 times the base rate of the procedure code.

The use of this modifier is subject to post-payment review. ABHLA requires home health agencies to maintain all necessary documentation to support the use of this modifier. Non-compliance with written policy may result in recoupment and additional sanctions, as deemed appropriate by Louisiana Medicaid.

Durable Medical Equipment (DME) Rental Claims

Providers submitting claims for Durable Medical Equipment (DME) Rental should use CMS 1500 Form.

DME rental claims are only paid up to the purchase price of the durable medical equipment.

Units billed for the program equal 1 per month. Units billed for Medicaid equal the amount of days billed. Since appropriate billing for CMS is 1 Unit per month, in order to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from and to date) of the rental. Medicaid will calculate the amount of days needed for the claim based on the date span.

Same Day Readmission
Providers submitting claims for inpatient facilities should use CMS UB-04 Form.

There may be occasions where a member may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission with twenty-four (24) hours.

> ***Example:*** *Discharge Date: 10/2/10 at 11 AM*
> *Readmission Date: 10/3/10 at 9 AM*

Since the readmission was within twenty-four (24) hours, this would be considered a same day readmission per above definition.

Hospice Claims
The only claims payable during a hospice election period by Aetna Better Health of Louisiana would be additional benefits covered under Aetna Better Health of Louisiana that would not normally be covered under the covered services.

HCPCS Codes
There may be differences in what codes can be billed for Medicare versus Medicaid. We follow Medicare billing requirement rules, which could result in separate billing for claims under Aetna. While most claims can be processed under both Medicare and Medicaid, there may be instances where separate billing may be required.

Sterilization Claims
Ancillary provider claims can be paid if sterilization form is provided OR paid from the surgeons paid claim that includes the form.

HB 434 (Act 319) Summary
A policy or procedure proposed by a managed care organization shall not be implemented unless the department has provided its express written approval to the managed care organization after the expiration of the public notice period (45 days). Where “policy or procedure" shall mean a requirement governing the administration of managed care organizations specific to billing guidelines, medical management and utilization review guidelines, case management guidelines, claims processing guidelines and edits, grievance and appeals procedures and process, other guidelines or manuals containing pertinent information related to operations and pre-processing claims, and core benefits and services.

Remittance Advice
Provider Remittance Advice
Aetna Better Health of Louisiana generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice (“remit”) as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call our Provider Experience Department if you are interested in receiving electronic remittance advices.

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

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Louisiana for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of Louisiana due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of Louisiana after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed along with the last four digits of the bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. Tax Identification Number (TIN) refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
    - Member Name
    - ID
    - Birth Date
    - Account Number
    - Authorization ID, if Obtained
    - Provider Name
    - Claim Status
    - Claim Number
    - Refund Amount, if Applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Experience Department for assistance with this process. Payment for the Program will be made on separate checks, one check from Medicare, and one check from Medicaid.

HB 424 (Act 330) Summary

Claim Denials

- Applies to: MCOs, MCO Subcontractors , FFS, and FFS Contractors
- Applies to claims denied based on an opinion or interpretation of one of the following:
  - Law
  - Regulation
  - Policy
  - Procedure
  - Medical criteria or guideline
- Requires that the following be provided along with the remittance advice (RA), whether produced in paper format or electronically:
  - Instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline IF it is housed within the public domain; or
  - A copy of the applicable law, regulation, policy, procedure, or medical criteria or guideline.

Prior Authorization Criteria and Denials

- Applies to: MCOs, MCO Subcontractors , FFS, and FFS Contractors
- Prior authorization (PA) criteria must be:
  - Available online in an easily searchable format; or
  - Furnished to the provider with 24 hours of request.
  - Ex: Policy states that providers are able to access PA criteria at ANYTIME, prior to or after submitting a PA through the online searchable format provided OR by email request with a 24 hour response time.
- PA denial notices must be given to the provider in writing within 3 days of the denial decision.
  - Ex: Policy explicitly states this timeline.
- Applies to PAs denied based on an interpretation of one of the following:
  - Law
  - Regulation
  - Policy
  - Procedure
  - Medical criteria or guideline
- Requires that the following be provided in the PA denial notice:
  - Instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline IF it is housed within the public domain; or
  - A copy of the applicable law, regulation, policy, procedure, or medical criteria or guideline.
  - Ex: The denial letter includes a hard copy of or INSTRUCTIONS to the applicable portion of the law, regulation, policy procedure or medical criteria or guideline that was used to make the determination.
  - OK: This treatment was denied based on the interpretation of this medical guideline (link provided), in section (section title provided), on page (page provided) and in paragraphs (paragraph provided).
  - NOT OK: This treatment was denied based on the interpretation of this medical guideline (link provided is general page or does not include instructions).

Claims Submission

Claims Filing Formats

Providers can elect to file claims with Aetna Better Health of Louisiana in either an electronic or a hard copy format. Claims must be submitted using either the CM 1500 or UB 04 formats, based on your provider type as detailed below.

Electronic Claims Submission

- In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health of Louisiana encourages providers to electronically submit claims, through Change Healthcare.
- Please use the Payer ID number 128LA when submitting claims to Aetna Better Health of Louisiana for both CMS 1500 and UB 04 forms. You can submit claims by visiting Change Healthcare at **www.emdeon.com/**. Before submitting a claim through your clearinghouse, please verify that your clearinghouse is compatible with Change Healthcare.

Important Points to Remember

- Aetna Better Health of Louisiana does not accept direct EDI submissions from its providers.
- Aetna Better Health of Louisiana does not perform any 837 testing directly with its providers, but performs such testing with Change Healthcare.
- For electronic resubmissions, providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.
- Providers must be ICD-10 compliance upon roll out.

Paper Claims Submission

Providers can submit hard copy CM 1500 or UB 04 claims directly to Aetna Better Health of Louisiana via mail to the following address:

Aetna Better Health of Louisiana
P.O. Box 61808
Phoenix, AZ 85082-1808

Risk Pool Criteria

If the claims paid exceed the revenues funded to the account, the providers will fund part or the entire shortfall. If the funding exceeds paid claims, part or all of the excess is distributed to the participating providers.

Encounter Data Management (EDM) System

Aetna Better Health of Louisiana uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to LDH requirements. The EDM System also warehouses encounter data from vendors, and formats it for submission to LDH. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness and we then submit encounter data to LDH. Our EDM System processes CMS1500, UB04 (or UB92), Dental, Pharmacy and Long Term Care claims and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-9, CPT-4, HCPCS-I, II). Our provider contracts require providers to submit claims on the approved claim form and each claim must contain the necessary data requirements. Part of our encounter protocol is the requirement for providers to utilize NDC coding in accordance with the Department's requirements.

The EDM System has top-of-the-line functionality to accurately, and consistently track encounters throughout the submission continuum including collection, validation, reporting, and correction. Our EDM System is able to electronically accept a HIPAA-compliant 837 (I and P) electronic claim transaction, 835 Claim Payment/Advice transaction and the NCPDP D.O. or PAH transaction in standard format and we require our providers and their clearinghouses to send electronic claims in these formats.

We collect claims information from multiple data sources into the EDM System for processing, including data from our QNXT ™ claims adjudication system as well as data from third-party vendors under contract to process various claims, such as dental, vision, transportation and pharmacy. Our EDM System accommodates all data sources and provides a single repository for the collection of claims/encounters. Through our EDM System, we conduct a coordinated set of edits and data checks and identify potential data issues at the earliest possible stage of the process. Below we describe in more detail the different checkpoints.

Claims Processing

Our business application system has a series of active claim edits to determine if the appropriate claim fields contain the required values. We deny, completely or in part, claims submitted without required information or with invalid information. The provider is required to resubmit the claim with valid information before they receive payment. After adjudication and payment, we export claims data from our business application system into our EDM System. Our Encounter Management Unit validates the receipt of all claims data into EDM System using a transfer validation report. The Encounter Management Unit researches, tracks, and reports any discrepancy until that discrepancy is completely resolved.

Pended Claims

If a clean claim is received, but additional information is required for adjudication, Aetna Better Health of Louisiana may pend the claim and request in writing (notification via e-mail, Web site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all necessary information such that the claim can be adjudicated within established timeframes.

Claims System Editing

Aetna Better Health of Louisiana shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CMS, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than 30 days after notification, unless otherwise directed by LDH. This includes annual and other fee schedule updates.

Third Party Liability (TPL)

Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available Third Party Liability (TPL) resources must meet their legal obligation to pay claims before Aetna Better Health of Louisiana pays for the care of an individual eligible for Medicaid.

Aetna Better Health of Louisiana shall take reasonable measures to determine TPL.

Aetna Better Health of Louisiana shall coordinate benefits in accordance with 42 CFR §433.135, et seq. and La. R.S. 46:460.71, so that costs for services otherwise payable by Aetna Better Health of Louisiana are cost avoided or recovered from a liable party. The two methods used are cost avoidance and post-payment recovery. Aetna Better Health of Louisiana shall use these methods as described in federal and state law.

Establishing TPL takes place when Aetna Better Health of Louisiana receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or services delivered to a member.

If the probable existence of TPL cannot be established Aetna Better Health of Louisiana must adjudicate the claim. Aetna Better Health of Louisiana must then utilize post-payment recovery if TPL is later determined to exist which is described in further detail below.

The term “state” shall be interpreted to mean “MCO” for purposes of complying with the federal regulations referenced above. Aetna Better Health of Louisiana may utilize subcontractors to comply with coordination of benefit efforts for services provided pursuant to this contract.

For the eligible Medicaid population that is dually enrolled in Medicare, Medicaid-covered specialized behavioral health services that are not covered by Medicare shall be paid by Aetna Better Health of Louisiana. For dually eligible individuals, Medicare "crossover" claims (claims for services that are covered by Medicare as the primary payer) are excluded from coverage under the capitated rates. These services will be administered separately by the Fiscal Intermediary from the services covered under the capitation rates effective under this contract. In the event that a dually eligible individual's Medicare benefits have been exhausted as of the date of service on which a Medicare covered behavioral health service was provided, Medicaid will be considered primary. Claims for those services will no longer be considered "crossover" claims, and Aetna Better Health of Louisiana shall be responsible for payment. Specific payment mechanisms surrounding these populations shall be determined by LDH in the MCO Systems Companion Guide.

Aetna Better Health of Louisiana must update its system with daily TPL records sent from LDH's Fiscal Intermediary (FI) within one (1) business day of receipt. Aetna Better Health of Louisiana must reconcile its system with weekly TPL reconciliation files sent from LDH's FI within one (1) business day of receipt. If a P enrolled member is unable to access services or treatment until an update is made, Aetna Better Health of Louisiana must verify and update its system within four (4) business hours of receipt of an update request. Participants are persons age 55 years or older, live in the PACE provider service area and are certified to meet nursing facility level of care and financially eligible for Medicaid long term care. Participation is voluntary and enrollees may disenroll at any time. P enrolled members are members enrolled with Aetna Better Health of Louisiana for Medical, Behavioral Health, Pharmacy and Transportation services. This includes updates on coverage, including removal of coverage that existed prior to the member's linkage to Aetna Better Health of Louisiana that impacts current provider adjudication or member service access (i.e. pharmacy awaiting TPL update to fulfill prescription). Such updates must be submitted to LDH Third Party Liability contractor on the Louisiana Department of Health Medicaid Recipient Insurance Information Update Form the same day the update is made in Aetna Better Health of Louisiana's system.

Encounter Staging Area

One of the unique features of our EDM System is the Encounter Staging Area. The Encounter Staging Area enables the Encounter Management Unit to evaluate all data files from our business application system and third party vendors (e.g., Pharmacy Benefit Management, dental, transportation, or vision vendors) for accuracy and completeness prior to loading into the EDM System. We maintain encounters in the staging area until the Encounter Management Unit validates that each encounter contains all required data and populated with appropriate values.

Our Encounter Management Unit directs, monitors, tracks, and reports issue resolution. The Encounter Management Unit is responsible for tracking resolution of all discrepancies.

Encounter Data Management (EDM) System Scrub Edits

This EDM System feature allows the Encounter Management Unit to apply LDH edit profiles to identify records that may be unacceptable to the LDH. Our Encounter Management Unit is able to customize our EDM System edits to match the edit standards and other requirements of the LDH. This means that we can align our encounter edit configuration with the LDH's configuration to improve encounter acceptance rates.

Encounter Tracking Reports

Encounter Tracking Reports are another unique feature of our EDM System. Reports are custom tailored for each plan.

Our Encounter Management Unit uses a series of customized management reports to monitor, identify, track, and resolve problems in the EDM System or issues with an encounter file. Using these reports our Encounter Management Unit is able to identify the status of each encounter in the EDM by claim adjudication date and date of service. Using these highly responsive and functional reports, our Encounter Management Unit can monitor the accuracy, timeliness, and completeness of encounter transactions from entry into EDM System, submission to and acceptance by the Department. Reports are run to verify that all appropriate claims have been extracted from the claims processing system.

Data Correction

As described above, the Encounter Management Unit is responsible for the EDM System. This responsibility includes managing the data correction process should it be necessary to resubmit an encounter due to rejection of the encounter by the Department.

Our Encounter Management Unit uses two processes to manage encounter correction activities:

1) Encounters requiring re-adjudication and those where re-adjudication is unnecessary. If re-adjudication is unnecessary, the Encounter Management Unit will execute corrections to allow resubmission of encounter errors in accordance with the Department encounter correction protocol.
2) Encounter errors that require claim re-adjudication are reprocessed in the appropriate claim system, the adjusted claim is imported into the EDM for resubmission to the Department in accordance with the encounter correction protocol, which is tailored to the Department's requirements. The Encounter Data Management System (EDM) generates, as required, the appropriate void, replacement and corrected records.

Although our data correction procedures enable the Encounter Management Unit to identify and correct encounters that failed the Department's acceptance process we prefer to initially process and submit accurate encounters. We apply lessons learned through the data correction procedures to improve our EDM System scrub and edit described above. In this way, we will expand our EDM System scrub edits to improve accuracy of our encounter submissions and to minimize encounter rejections. This is part of our continuous process improvement protocol.

Our Encounter Management Unit is important to the timely, accurate, and complete processing and submission of encounter data to the LDH. Our Encounter Management Unit has specially trained correction analysts with experience, knowledge, and training in encounter management, claim adjudication, and claim research. This substantial skill base allows us to research and adjust encounters errors accurately and efficiently. Additionally, the unit includes technical analysts who perform the data extract and import functions, perform data analysis, and are responsible for oversight and monitoring of encounter files submissions to the LDH. The team includes a technical supervisor and a project manager to monitor the program.

Another critical step in our encounter data correction process is the encounter error report. We generate this report upon receipt of response files from the Department, and give our Encounter Management Unit critical information to identify and quantify encounter errors by type and age. These data facilitate the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

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Grievance System Overview

Members may file grievances or appeals directly with Aetna Better Health verbally, in writing or by email to member services. A provider, acting on behalf of a member and with the member's written consent, may file a grievance, appeal, verbally, in writing or by fax. A member or their representative can also ask for a State Fair Hearing through the Division of Administration, Administrative Law Judge Division.

Aetna Better Health ensures that all members and providers are informed of the grievances, appeals, and procedures. This information is contained in the member handbook and provider manual. Forms used to file grievance, appeals and the link to access the State Fair Hearing site are available on our web site. Forms are also available in hard copy upon request. When requested, we give members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to provider interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter. Oral interpretation services and alternate formats are available to members at no cost. If you need help in another language, call 1-855-242-0802 (toll-free).

Notifying Members of Grievance System Process

Members are educated regarding the grievance system process through:

- Instructions in the Member Handbook:
  - The handbook is included in all new member welcome packets and mailed in time to reach the member within ten (10) days of receiving notification of the member's enrollment. Instructions also provide information regarding what to do in case of denial, reduction, suspension, or termination of services
- Articles in the Aetna Better Health member newsletters
- The Aetna Better Health website

Any changes to the grievance system process are submitted to the Louisiana Department of Health (LDH) for approval prior to implementation. Members are then notified at least thirty (30) calendar days in advance of any changes in Aetna Better Health's grievance or appeal policies, when possible.
Aetna Better Health complies with BBA rules and applicable state requirements policies on content, timing, and translation of all member information related to members' grievance rights.

Notifying Contractors and Providers of Grievance System Process

Information regarding the grievance system process is distributed to all contractors and to all in-network providers at the time they enter into a contract and to out-of-network providers within ten (10) calendar days of prior approval of a service or the date of receipt of a claim, whichever is earlier.

Member Grievance System

Standard Grievance

The member or the member's authorized representative, including providers, may file a grievance with Aetna Better Health orally or in writing. In most cases, a decision on the outcome of the grievance is reached within 30 days of the date the grievance was filed but no later than ninety (90) days. An acknowledgement letter is sent within 5 business days of receipt.
All members are advised in writing of the outcome of the investigation of the grievance within two (2) days of its resolution. The Notice of Resolution includes the decision reached and the reasons for the decision and the telephone number and address where the member can speak with someone regarding the decision.

Expedited Grievance

Aetna Better Health resolves all grievances effectively and efficiently. On occasion, certain issues may require a quick decision. These issues, known as expedited grievances, occur in situations where the member was denied expedited appeal processing or Aetna Better Health took an extension on the decision making timeframe for an appeal. A member or their authorized representative, including providers may request an expedited grievance either orally or in writing within sixty (60) calendar days from the day of the decision or event in question. Written confirmation or the member's written consent is required to have the provider act on the member's behalf. Expedited grievances will be resolved within 72 hours of receipt.

How to File a Grievance

Grievances may be filed by calling Member Services at **1-855-242-0802**, for the hearing impaired LA Relay 7-1-1 or they may be submitted in writing via fax to: **860-607-7657** or postal mail to:

Aetna Better Health
Appeals and Grievance Manager
P.O. BOX 81139
5801 Postal Rd
Cleveland, OH 44181

Standard Appeal

A member may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with Aetna Better Health either written, by fax or verbally. If a member filed an appeal verbally, a written request to appeal must be sent within 15 days of the oral/verbal appeal. Authorized member representatives, including providers, may also file an appeal on the member's behalf. All appeals must be filed no later than 60 calendar days from the postmark on the Aetna Better Health Notice of Adverse benefit determination, also referred to as a Notice of Action (NOA). A written consent form signed by the member allowing the provider or representative to file an appeal on the member's behalf must be submitted PRIOR to or with the pertinent documents before an appeal process can begin. The appeals process will include, as parties to the appeal, the member and his or her representative or the legal representative of a deceased member's estate

Aetna Better Health ensures that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, which requests an expedited resolution or supports a member's appeal.
NOA informs members and providers of the following:

- Our decision and the reasons for our decision
- The requirement and timeframes for filing an appeal
- The availability of assistance in the filing process
- The toll-free numbers that the member can use to file an appeal by phone
- The procedures for exercising the rights to appeal or request a State fair hearing
- That the member may represent himself or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them
- Notice of any actions required of Aetna Better Health
- Notice of our opportunity to use the dispute resolution process as described in the Provider Agreement
- The specific regulations that support, or the change in Federal or State law that requires the action
- The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services
- The circumstances under which expedited resolution is available and how to request it
- Any appeal rights that the state chooses to make available to providers to challenge the failure of the organization to cover a service

If the member requests services to continue while the appeal is being reviewed, the request for services must be filed within 10 calendar days of the health plan mailing the notice of adverse benefit determination or Notice of Action letter, or the intended effective date of our proposed adverse benefit determination.

A decision on the outcome of the appeal is reached within 30 days of the date the appeal was filed. If we are unable to make a decision on the appeal within 30 days, we may ask to extend the appeal decision date by 14 calendar days. In these cases, we will provide information describing the reason for the delay in writing to the member and, upon request, to LDH, and the appeal will be resolved within forty-four (44) days from receipt.

All members are advised in writing of the outcome of the investigation of the appeal within two (2) days of the decision. The Appeal Decision letter includes the decision reached, the reasons for the decision, the telephone number and address where the member can speak with someone regarding the decision. The notice also tells a member how to obtain information on filing a State Fair Hearing.
A brief overview of the appeals process follows:

- Verbal and written appeals are accepted
- Aetna Better Health notifies members of receipt of the appeal within (five) 5 business days
- Members are advised of their right to provide more information and documents for their appeal either in person or in writing
- Members are advised of their right to view their appeal file
- Members may be present either onsite or via telephone when the Appeal Committee reviews their appeal
- All appeals will be resolved within 30 calendar days (or 44 days if an extension is needed and we provide a reason for the extension or the member requests the extension) after Aetna Better Health receives the appeal

The decision letter, including an explanation for the decision, is mailed to the member within 2 calendar days of the Appeal Committee's decision

- If Aetna Better Health does not agree with the member's appeal and issues a denial decision, and the member continued to receive services, the member may be responsible for cost of services received during the appeal process.
- If Aetna Better Health reverses our original decision and approves the appeal, services will begin immediately
- If Aetna Better Health does not agree with the member's appeal, the member can ask for a Medicaid State Fair Hearing and request to receive benefits while the hearing is pending

Expedited Appeal
Aetna Better Health resolves all appeals as quickly as the member's health condition requires. On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where the member's provider or Aetna Better Health determines that the standard appeal timeframes will seriously harm the member's health.

A member or their authorized representative, including providers may request an expedited appeal either orally or in writing no later than 60 calendar days from the postmark on the Notice of Adverse benefit determination. Written confirmation or the member's written consent is required to have the provider act on the member's behalf. Expedited appeals will be resolved within 72 hours of receipt. If Aetna Better Health believes it is not medically necessary to make a decision in 72 days, the member's appeal will be decided within the normal 30 day timeframe. We will attempt to call the member to advise that we are following the standard timeframes and we will send written notification within two (2) calendar days with this information. The notification will include information that the member may file a grievance if they are dissatisfied with the denial of expedited processing time of their appeal.

If Aetna Better Health is unable to resolve an expedited appeal within 72 hours, we may extend the 72 hour period by up to 14 calendar days. In these cases, we will provide information describing the reason for the delay in writing to the member and, upon request, to LDH.

Members can request that services continue during the appeal if the appeal begins within 10 calendar days from the date of the Notice of Adverse benefit determination. If Aetna Better Health does not agree with the member's appeal and issues a denial decision, and the member continued to receive services, the member may be responsible for cost of services received during the appeal process. If Aetna Better Health reverses our original decision and approves the appeal, services will begin immediately.

How to File an Appeal

Appeals may be filed by calling Member Services at **1-855-242-0802**, for the hearing impaired LA Relay 7-1-1 or they may be submitted in writing via fax to: **860-607-7657** or postal mail to:

Aetna Better Health
Appeals and Grievance Department
P.O. BOX 81139
5801 Postal Rd
Cleveland, OH 44181

Failure to Make a Timely Decision

Appeals must be resolved within stated timeframes and all parties must be informed of Aetna Better Health's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

Provider Grievance System

Aetna Better Health and the contracted health care provider are responsible for resolving any contractual disputes that may arise between the two (2) parties through the Provider Grievances System process; no grievance will disrupt or interfere with the provisions of services to the member. Provider disputes, grievances, and appeals will be settled according to the terms of the provider's contractual agreement.
Aetna Better Health will inform Providers through the Provider Manual and other mediums including newsletters, training, provider orientation, the website and by the provider calling their Provider Experience Representative about the provider dispute process.

Provider Disputes

Providers may file a dispute regarding any aspect of the health plan's administrative functions, policies, procedures, or concerns regarding the payment of a claim. Provider disputes regarding administrative issues are received, researched, and reviewed within the Provider Experience department of Aetna Better Health. Provider disputes related to claim payment issues are delegated to Claims Inquiry /Claims Research (CICR) for analysis and research. Aetna Better Health will notify the provider of its decision by phone, email, fax, or postal mail.

The Provider may be required to complete and submit the Provider Dispute Form and any appropriate supporting documentation to designated department listed on the form. The Provider Dispute Form is accessible on Aetna Better Health's website, via fax or by mail.

The Provider Experience Manager assigns the Dispute Form to a Provider Experience Representative to research, analyze, and resolve. In the event of a claim dispute, it is delegated to Claims Inquiry Claims Research (CICR) to research, analyze, and review. Aetna Better Health will mail its written notice of its decision to the Provider. Requests for claim resubmissions including reconsideration or corrections that are received with a supporting claim at the health plan are forwarded to the plan specific claims Post Office (P.O.) Box for claims processing.

Rendering providers have the ability to submit a dispute for those provider claims or group of claims that have been denied or underpaid within 180 calendar days of the notice of the payment notification.

- Disputing a claim payment or denial based on a fee schedule or contractual issue
- Disputing a claim payment or denial based on a coding issue
- Any other reason for billing disputes

Note: Provider payment disputes do not include disputes related to medical necessity.
Providers can file a verbal dispute with Aetna Better Health of Louisiana by calling Provider Experience Department at **1-855-242-0802.**

To file a reconsideration in writing, providers must complete the provider claims reconsideration/dispute form (located on our public website) and mail to:

Aetna Better Health of Louisiana
P.O. Box 61808
Phoenix, AZ 85082-1808
Attn: Cost Containment

In the event the Provider remains dissatisfied with the dispute determination, the Provider is notified via a written notice. If the provider is not satisfied with the resolution of the dispute, the provider may be initiate a grievance.

Aetna Better Health's Provider Experience Representatives are available to discuss a Provider's dissatisfaction of an issue covered by this policy, and if unable to satisfy the Provider's dispute, the Provider Grievance Process will be offered.

Providers may file a provider dispute by:

- Calling Provider Experience at **1-855-242-0802**
- Faxing Provider Experience at **860-607-7658**
- Emailing Provider Experience at **LAProvider@aetna.com**
- Completing a Participating Provider Claims Reconsideration/Dispute Form and mailing it to:

  Aetna Better Health of Louisiana
  P.O. Box 61808
  Phoenix, AZ 85082-1808
  Attn: Cost Containment

Provider Grievances or Complaints

In the event a provider remains dissatisfied with the dispute determination, the provider may file a written complaint, called a grievance or a verbal complaint. Providers may also file grievances including but not limited issues related to health plan staff, contracted vendors, or formulary.

Providers are allowed thirty (30) days from the date of the occurrence to file a written complaint with Aetna Better Health. An acknowledgement letter will be sent within three (3) business days summarizing the grievance and will include instruction on how to:

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

If the grievance requires research or input by another department, the Grievance System manager will forward the information to the affected department and coordinate with the affected department to thoroughly research each grievance using applicable statutory, regulatory, and contractual provisions and Aetna Better Health's written policies and procedures, collecting pertinent facts from all parties.

The provider is offered a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.

The grievance with all research will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider with same or similar specialty if the grievance is related to a clinical issue. The Grievance Committee will consider the additional information and will resolve the grievance. A decision will be made within 30 calendar days of receipt and the provider will be notified in writing within 3 business days of the resolution.

Providers may file a provider grievance by:

- Calling Provider Experience at **1-855-242-0802**
- Faxing Appeals and Grievance at **860-607-7657**
- Emailing Appeals and Grievance at **LAAppealsandGrievances@aetna.com**
- Writing Aetna Better Health at:

  Aetna Better Health
  Grievance System Manager
  P.O. BOX 81040
  5801 Postal Rd
  Cleveland, OH 44181

A trained and qualified Appeals and Grievance Manager assumes primary responsibility for coordinating and managing Provider grievances, and for disseminating information to the Provider about the status of the grievance.

Provider Appeals

Providers may file an appeal with Aetna Better Health if a medical procedure or item performed or given to an Aetna Better Health member has been denied reimbursement due to lack of medical necessity or no prior authorization when an authorization was required. A provider may also file an appeal, if they have a claim that has been denied or paid differently than expected and was not resolved to the provider's satisfaction through the dispute process. Filing an appeal will not negatively affect or impact the Aetna Better Health member or providers who treat the member.

Providers requesting to file an expedited appeal for a prior authorization denial and have not yet rendered services will be transferred to the Expedited Member Appeals process defined in the Members section of this document. Expedited requests do need written member consent for the provider to act on behalf of the member and they must meet expedited criteria, that waiting the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Provider appeals will be decided within **thirty (30**) calendar days of receipt of all necessary information, unless an extension of time is warranted. The resolution period may be extended up to fourteen (14) calendar days if Aetna Better Health shows that there is a need for additional information and that the delay is in the provider's best interest. If the resolution timeframe is being extended, Aetna Better Health will send written notice of the delay within the original **30**-day processing allowance. An acknowledgement letter will be sent within five (5) calendar days of receipt and will include instruction on how to:

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

Participating and non-participating providers should follow the appeals process:

- Provider must submit the appeal request in writing, via mail or fax, within **60** calendar days from one of the following dates:
  - The date Aetna Better Health transmitted the remittance advice or other electronic notice, or the postmark date if the remittance advice or other notice was provided in non-electronic format; or
  - The date Aetna Better Health recoups monies paid for a previous claim.

- Additional or new clinical documents sent to Aetna Better Health will be reviewed by the medical director to re-determine if the additional or new clinical documents will support the appeal in meeting medical necessity.
- A resolution letter will be mailed within **30** calendar days from receipt of the appeal and the provider will be notified in writing within 3 business days of the resolution.

Providers may file a provider appeal by:

- Calling Provider Experience at **1-855-242-0802**
- Faxing the Appeals and Grievance Manager at **860-607-7657**
- Emailing the Appeals and Grievance Manager at **LAAppealsandGrievances@aetna.com**
- Writing Aetna Better Health at:

  Aetna Better Health
  Appeals and Grievance Manager
  P.O. BOX 81040
  5801 Postal Rd
  Cleveland, OH 44181

Independent Review

The Independent Review process was established to resolve claims disputes when a provider believes the health plan has partially or totally denied claims incorrectly. Independent Review is a two (2) step process which may be initiated by submitting an Independent Review Reconsideration form to Aetna Better Health within 180 calendar days of the Remittance Advice paid, denial, or recoupment date.

- Aetna Better Health will acknowledge receipt of the Independent Review Reconsideration in writing within 5 calendar days and will render a decision within 45 days of receipt
- If Aetna Better Health upholds the adverse determination the provider then has 60 days from the date the provider receives the decision to request an independent review. If a decision is not made within 45 days, the provider may request an independent review with LDH.
- LDH will determine eligibility for review and assign the independent review to an independent reviewer.
- The independent reviewer will contact providers *within 14 calendar days* if eligible documentation is needed from the provider by the independent review.
- The independent reviewer will render a decision within the time frames allowed, per Act 349.

The independent review request (after Aetna has made decision on your reconsideration request) can be sent to:
LDH/Health Plan Management
ATTN: Independent Review
PO Box 91030 Bin 24
Baton Rouge, La 70821-9283

Arbitration

Provider has the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If Company and Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his/her certifying association. Arbitration conducted pursuant to this Section shall be binding on all Parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless Company and Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the Parties. [RFP § 17.6.5]. A provider should review their contract with ABH for any specific language related to arbitration.

State Fair Hearing (only member has the right to request for SFH)
Providers may ask for a State Fair Hearing on behalf of the member, with the member's permission and signed consent form from Louisiana Department of Health (LDH) within 120 days of the date we sent your appeal decision letter. The Louisiana Division of Administrative Law makes a recommendation about your hearing to the Secretary of LDH. The Secretary of LDH makes the final decision about your appeal.

You can file a State Fair Hearing request by phone, fax, mail or on the web. Mail: P.O. Box 4189 Baton Rouge, Louisiana 70821-4189 Fax: **225-219-9823** Phone: **225-342-5800** Web: **www.adminlaw.state.la.us/HH.htm**

LDH Dispute Process
In the event a provider remains dissatisfied with their claim dispute or grievance determination or they are unable to get a timely response from Aetna Better Health, the provider may file a dispute directly to LDH. There are also specific circumstances when the issue in dispute should be handled by LDH, such as a request for coverage for an item or service that is not covered under the benefit plan. For example, the request for coverage of a specialized behavioral health service that is covered by a separate behavioral plan. In the case of a benefit, that is not a unique covered benefit of Aetna Better Health of Louisiana; the provider can file a dispute directly to LDH. For issues where the provider remains unsatisfied or the issue is identified as an LDH responsibility, Provider Experience will provide education to the provider on their right to dispute through LDH. To contact LDH:

- **E-mail** LDH staff at **ProviderRelations@la.gov.** Be sure to include details on attempts to resolve the issue at the Health Plan level as well as contact information (contact name, provider name, e-mail and phone number) so that Healthy Louisiana staff can follow up with any questions.

LDH often posts news, informational bulletins and frequently asked questions to address systemic or trending provider issues. Providers can subscribe to updates from Healthy Louisiana to be notified of any newsletter or informational bulletin postings, and providers are encouraged to visit the provider portal at **www.Medicaid.LA.gov** for the latest provider news and information.

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Fraud, Waste and Abuse

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

Aetna Better Health of Louisiana uses a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Experience, Member Services, Medical Management, as well as providers and members, shares the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Special Investigations Unit (SIU)

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

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information, or want to report potential fraud, waste, or abuse. The number is **1-800-338-6361**. The hotline has proven to be an effective tool, and Aetna Better Health of Louisiana encourages providers and contractors to use it.

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

Reporting Suspected Fraud and Abuse

Participating providers are required to report to Aetna Better Health of Louisiana all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone to the confidential Aetna Better Health of Louisiana Compliance Hotline at **1-855-725-0288**
- By phone to our confidential Special Investigation Unit (SIU) at **1-800-338-6361**

Note*:* If you provide your contact information, your identity will be kept confidential.

You can also report provider fraud to LDH, at **1-800-488-2917** or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS** (**1-800-447-8477**).
(**http://LDH.state.la.us/index.cfm/page/219**)

The Louisiana Department of Health Program Integrity Unit was created by statute to preserve the integrity of the Medicaid program by conducting and coordinating Fraud, Waste, and Abuse control activities for all State agencies responsible for services funded by Medicaid.

A provider's best practice for preventing fraud, waste, and abuse (also applies to laboratories as mandated by 42 C.F.R. 493) is to:

- Develop a compliance program
- Monitor claims for accuracy - verify coding reflects services provided
- Monitor medical records – verify documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem
- Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

Fraud, Waste, and Abuse Defined

- **Fraud**: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.
- **Waste**: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- **Abuse**: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of Fraud, Waste, and Abuse

Examples of Fraud, Waste, and Abuse include:

- Charging in excess for services or supplier
- Providing medically unnecessary services
- Billing for items or services that should not be paid for by Medicaid
- Billing for services that were never rendered
- Billing for services at a higher rate than is actually justified
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health of Louisiana due to improper payments to providers, or overpayments
- Physical or sexual abuse of members

Fraud, Waste, and Abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions
- Switching a member's prescription based on illegal inducements rather than based on clinical needs.
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing login information
- Falsifying information in order to justify coverage
- Failing to provide medically necessary services
- Offering members a cash payment as an inducement to enroll in a specific plan
- Selecting or denying members based on their illness profile or other discriminating factors.
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider).

- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the members fail to keep. Another example is a "multi patient" in which a provider visits a nursing home billing for twenty (20) nursing home visits without furnishing any specific service to the members.
- Double billing such as billing both Aetna Better Health of Louisiana and the member, or billing Aetna Better Health of Louisiana and another member.
- Misrepresenting the date services were rendered or the identity of the member who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-covered service that was rendered.

Fraud, Waste and Abuse can incur risk to members as well:

- Unnecessary procedures may cause injury or death
- Falsely billed procedures create an erroneous record of the member's medical history.
- Diluted or substituted drugs may render treatment ineffective or expose the member to harmful side effects or drug interactions.
- Prescription narcotics on the black market contribute to drug abuse and addition.

In addition, member fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit
- Looping (i.e., arranging for a continuation of services under another members ID)
- Forging and altering prescriptions.
- Doctor shopping (i.e., when a member consults a number of doctors for obtaining multiple prescriptions for narcotic painkillers or other drugs Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

FWA Audits

When post payment audits are complete with findings, SIU will issue an overpayment letter detailing the results of the review. This letter will include a statement regarding the provider's opportunity to rebut the findings.

The provider will contact the SIU within 15 days. The SIU will instruct the provider to submit any details, additional documents, or reference material in writing.

The provider may also request a peer-to-peer review with the medical directors / clinical review team. The SIU will coordinate this meeting and include the appropriate personnel requested by the provider, SIU and the health plan.

The provider will be notified of the outcome of the rebuttal. If the provider continues to dispute the findings, the next steps in their appeal process will be based on the guidelines in the appeals and grievances outlined in Chapter 16 of this manual.

FWA Prepayment Review

One of the tools used by the SIU to identify potential fraud, waste and abuse is prepayment review. Providers identified for billing irregularities, aberrances to their peers, possible service not rendered, etc. might be placed on prepayment review. Provider's will be notified in a letter explaining their claims will require medical records prior to payment by the MCO. This notification will include the reason for the prepayment review along with instructions on what medical records are required and where they should be sent. The letter also includes information regarding the providers right to appeal a claim denial after the documentation is reviewed.

Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote Aetna Better Health of Louisiana's commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
2. Designation of a Compliance Officer: Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
3. Effective Compliance Training: Development and implementation of regular, effective education, and training
4. Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
5. Disciplinary Mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the Medicaid program.
6. Effective Lines of Communication: Between the Compliance Officer and the organization's employees, managers, and directors and members of the compliance committee, as well as related entities
    a. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, will maintaining confidentiality.
    b. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health of Louisiana.
7. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

<u>Relevant Laws</u>

There are several relevant laws that apply to Fraud, Waste, and Abuse:

- The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:
    — Knowingly presenting a false or fraudulent claim for payment or approval
    — Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
    — Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

  "Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.

  Providers contracted with Aetna Better Health of Louisiana must agree to be bound by and comply with all applicable State and federal laws and regulations.

- Anti-Kickback Statute
    - The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

- Self-Referral Prohibition Statute (Stark Law)
    - Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.

- Red Flag Rule (Identity Theft Protection)
    - Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

- Health Insurance Portability and Accountability Act (HIPAA) requires:
    - Transaction standards
    - Minimum security requirements
    - Minimum privacy protections for protected health information
    - National Provider Identification (NPIs) numbers

- The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

- Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing Aetna Better Health of Louisiana services through Healthy Louisiana.

- Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), Aetna Better Health of Louisiana providers will follow federal and State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for children and families accessing Aetna Better Health of Louisiana services through Healthy Louisiana.

- The Louisiana False Claims Act (LAFCA), otherwise known as the Medical Assistance Programs Integrity Law (MAPIL) , Chapter RS 46:437.1, which was enacted in 1996 intends the secretary of the Louisiana Department of Health, Attorney General and whistleblowers to be agents of the state with the ability, authority and resources to pursue civil monetary penalties, liquidating damages, or other remedies to protect the fiscal and programmatic integrity of the medical assistance programs from health care providers and other persons who engage in fraud, misrepresentation, abuse, or other ill practices, as set forth herein, to obtain payments to which these health care providers or persons are not entitled. RS 46:437.1, 1997, No.1373, §1

- Under the criminal provisions of the Louisiana Medical Assistance Programs Assistance Integrity Law (MAPIL), codified at RS 46:437.1, 1997, No.1373, §1., providers with Aetna Better Health of Louisiana will refrain from engaging in fraud or other criminal violations relating to Title XIX (Medicaid)-funded programs. Prohibited conduct includes, but is not limited to: (a) fraudulent receipt of payments or benefits; (b) false claims, statements or omissions, or conversion of benefits or payments; (c) kickbacks, rebates and bribes; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments. Providers engaging in criminal violations may be excluded from participation in Medicaid and other health care programs under RS 46:437.1, 1997, No.1373, §1

- Under the civil provisions of the MAPIL, codified at RS 46:438.6, providers with Aetna Better Health of Louisiana: (1) will repay with interest any amounts received as a result of unintentional violations; and (2) are liable to pay up to triple damages and (as a result of the Louisiana False Claims Act) between $5,500 and $11,000 per false claim when violations of the Medicaid statute are intentional, or when there is a violation of the Louisiana False Claims Act. Providers engaging in civil violations may be excluded from participation in Medicaid and other health care programs under RS 46:437.14

- Under the Medical Assistance Programs Assistance Integrity Law (MAPIL), codified at RS 46:438.3, licensed providers are prohibited from engaging in conduct that amounts to, "dishonesty, fraud, deception, misrepresentation, false promise, or false pretense" or involves false or fraudulent advertising

- Under the Medical Assistance Programs Assistance Integrity Law (MAPIL), codified at RS 46:440.3,Whistleblower Protection and Cause of Action., provider agencies are prohibited from taking retaliatory action against employees who: (a) disclose or threaten to disclose to a supervisor or any public agency an activity, policy or practice of the provider agency or another business with which the provider agency shares a business relationship, that the employee reasonably believes to be illegal, fraudulent and criminal; (b) provides information or testimony to any public agency conducting an investigation, hearing or inquiry into any violation of law, rule or regulation by the provider agency or another business with which the provider agency shares a business relationship; or (c) objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes is illegal, fraudulent, criminal or incompatible with a clear mandate of public policy concerning the public health, safety or welfare, or protection of the environment.

- Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program Prohibits identified entities and providers excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

Administrative Sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable)
- Suspension of provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
    - Automatic disbarment
    - Prison time

Additional Resources

- **www.legis.state.la.us/lss/lss.asp?doc=100852&showback=**
- **www.LDH.state.la.us/index.cfm/page/219**
- **www.LDH.state.la.us/index.cfm/form/22**

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Mandated Reporters

As mandated by Louisiana Administrative Code and Louisiana Statues Annotated (RS 14:403.2), all providers who work or have any contact with an Aetna Better Health of Louisiana member, are required as "mandated reporters" to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency. A full version of the Louisiana Administrative Code can be found on the State of Louisiana Office of Administrative Law website at **www.doa.la.gov/Pages/osr/lac/Code.aspx**.

Children

Providers must report suspected or known child abuse, and neglect to the Department of Child and Family Services (DCFS) (**1-855-452-5437**) or law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Vulnerable Adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, and financial exploitation of a vulnerable adult immediately to one of the following State agencies:

- The National Domestic Violence Hotline at **1-800-799-SAFE** (7233)
- Reporting Agencies
  - Adult/Elderly Protection Services – **1-800-898-4910**
  - Intermediate Care Facility for Developmentally Disabled - complaints – **1-877-343-5179**
  - Home Health – **1-800-327-3419**
  - Nursing Home – **1-888-810-1819**
  - Support Coordination (Case Management) – **1-800-660-0488**
  - Home & Community Based Service Provider (HCBS) – **1-800-660-0488**

For members living in a nursing home or ICF/DD, providers must report incidences via the Online Tracking Incident System (OTIS)

- **www.LDH.state.la.us/index.cfm/page/280**

State law provides immunity from any criminal or civil liability because of good faith reports of child abuse or neglect. Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine up to $1,000 or imprisonment up to six months.

Reporting Identifying Information

Any provider who suspects that a member may be in need of protective services should contact the appropriate State agencies with the following identifying information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location
- Information about family members or caretakers if available
- Specific information about the abusive incident or the circumstances contributing to risk of harm (e.g., when the incident occurred, the extent of the injuries, how the member says it happened, and any other pertinent information)

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health of Louisiana's Compliance Hotline at **1-855-725-0288.**

Our providers must fully cooperate with the investigating agency and will make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g).

Examinations to Determine Abuse or Neglect

When a State agency notifies Aetna Better Health of Louisiana of a potential case of neglect and abuse of a member, our case managers will work with the agency and the Primary Care Provider (PCP) to help the member receive timely physical examinations for determination of abuse or neglect. In addition, Aetna Better Health of Louisiana also notifies the appropriate regulatory agency of the report.

Depending on the situation, Aetna Better Health of Louisiana case managers will provide member with information about shelters and domestic violence assistance programs along with providing verbal support.

Examples, Behaviors and Signs

Abuse

Examples of Abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (Bed sores)
- Missing teeth
- Broken bones/Sprains
- Spotty balding from pulled hair
- Marks from restraints
- Domestic violence

Behavior Indicators of a Child Wary of Adult Contacts:

- Apprehensive when other children cry
- Behavioral extremes
- Aggressiveness
- Withdrawal
- Frightened of parents
- Afraid to go home
- Reports injury by parents

Behaviors of Abusers (Caregiver and /or Family Member):

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Neglect

Types of Neglect:

- The intentional withholding of basic necessities and care
- Not providing basic necessities and care because of lack of experience, information, or ability

Signs of Neglect:

- Malnutrition or dehydration
- Un-kept appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of Neglect:

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

Financial Exploitation

Examples of Financial Exploitation:

- Caregiver, family member, or professional expresses excessive interest in the amount of money being spent on the member
- Forcing member to give away property or possessions
- Forcing member to change a will or sign over control of assets

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Pharmacy Management Overview

Aetna Better Health of Louisiana covers prescription medications and certain over-the-counter medicines when you write a prescription for members enrolled in the Louisiana Family Cares program. Pharmacy is administered through CVS Caremark. CVS Caremark is responsible for pharmacy network contracting, mail order delivery, and network Point-of-Sale (POS) claim processing. Aetna Better Health of Louisiana is responsible for formulary development, drug utilization review, and prior authorization. For a complete list of drugs listed within the therapeutic classes, please visit our website at **AetnaBetterHealth.com/Louisiana,** under provider, then pharmacy.

Prescriptions, Drug Formulary and Specialty Injectables

Check the current Aetna Better Health of Louisiana formulary before writing a prescription for either prescription or over-the-counter drugs. If the drug is not listed, a Pharmacy Prior Authorization Request form must be completed before the drug will be considered. Please also include any supporting medical records that will assist with the review of the prior authorization request. Pharmacy Prior Authorization forms are available on our website and requests may be made telephonically (**1-855-242-0802)** or via fax (**1-844-699-2889)**. Note: Aetna Better Health of Louisiana will cover non-formulary non-excluded medications for members new to the plan for the first 60 days of enrollment.

Aetna Better Health of Louisiana members must have their prescriptions filled at a network pharmacy.

Prior Authorization Process

Aetna Better Health of Louisiana's pharmacy Prior Authorization (PA) processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate. Our pharmacy PA process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. Typically, we require providers to obtain PA prior to prescribing or dispensing the following:

- Injectables dispensed by a pharmacy provider
- Non-formulary drugs that are not excluded under a State's Medicaid program
- Prescriptions that do not conform to Aetna Better Health of Louisiana's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)
- Brand name drug requests, when a "A" rated generic equivalent is available

Aetna Better Health of Louisiana's Medical Director is in charge of generating adverse decisions, including a complete denial or approval of a different medication. Using specific, evidence-based PA pharmacy review guidelines Aetna Better Health of Louisiana's Medical Director may require additional information prior to making a determination as to the medical necessity of the drug requested. This information may include, but is not limited to, evidence indicating:

- Formulary alternatives have been tried and failed or cannot be tolerated (i.e., step therapy)
- There are no therapeutic alternatives listed in the formulary
- There is no clinical evidence that the proposed treatment is contraindicated (i.e., correctly indicated as established by the Federal Drug Administration (FDA) or as accepted by established drug compendia)

The prescribing provider and member will be appropriately notified of all decisions in accordance with regulatory requirements. Prior to making a final decision, our Medical Director may contact the prescriber to discuss the case or consult with a board certified physician from an appropriate specialty area such as a psychiatrist.

Aetna Better Health of Louisiana will fill prescriptions for a 72-hour supply if the member's prescription has not been filled due to a pending PA decision

Step Therapy and Quantity Limits
The step therapy program requires certain first-line drugs, such as generic drugs or formulary brand drugs, to be prescribed prior to approval of specific second-line drugs. Drugs having step therapy are identified on the formulary with "STEP".

Certain drugs on the Aetna Better Health of Louisiana formulary have quantity limits and are identified on the formulary with "QLL" The QLLs are established based on FDA-approved dosing levels and on national established/recognized guidelines pertaining to the treatment and management of the diagnosis it is being used to treat.

To request an override for the step therapy and quantity limit, please fax a Pharmacy Prior Authorization Request form and any supporting medical records that will assist with the review of the request to **1-844-699-2889**.

CVS Caremark Specialty Pharmacy
CVS Caremark Specialty Pharmacy is a pharmacy that offers medications for a variety of conditions, such as cancer, hemophilia, immune deficiency, multiple sclerosis, and rheumatoid arthritis, which are not often available at local pharmacies. Specialty medications require prior authorization before they can be filled and delivered. Providers can call **1-855-232-3596** to request prior authorization, or complete the applicable prior authorization form and fax to **1-855-296-0323**.

Specialty medications can be delivered to the provider's office, member's home, or other location as requested.

Mail Order Prescriptions
Aetna Better Health of Louisiana offers mail order prescription services through CVS Caremark. Members can access this service in one of three ways.

- By calling CVS Caremark, toll free at **1-855-271-6603/TTY 1-800-863-5488**. Monday to Friday between 8 AM and 8 PM, Eastern Time. They will help the member sign up for mail order service. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
- By going to **www.caremark.com/wps/portal/!ut/p/c4/04_SB8K8xLLM9MSSzPy8xBz9CP1An_z0zDz9gnRHRQDSauup/** The member can log in and sign up for Mail Service online. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
- By requesting their provider to write a prescription for a 90-day supply with up to one year of refills. Then the member calls CVS Caremark and asks CVS Caremark to mail them a Mail Service order form. When the member receives the form, the member fills it out and mails CVS Caremark the prescription and the order form. Forms should be mailed to:

  CVS CAREMARK
  PO Box 94467
  Palatine, IL 60094-4467

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The following forms will be available online at **AetnaBetterHealth.com/Louisiana.**

- **Abortion Certification Form**
  To be completed by the provider attesting to the need for an abortion based on the criteria indicated in the form.

- **Consent to Sterilization**
  Consent to sterilization must be signed by both the enrollee and the provider performing the sterilization.

- **Acknowledgment of Hysterectomy Information**
  An acknowledgment of information provided related to hysterectomy to be signed by both the enrollee and provider.

- **Provider Claims Dispute Form**
  To be completed by a provider who needs to file a claim dispute.

- **Pharmacy Coverage Determination Request Form**

Each provider who contracts with a Healthy Louisiana Plan to furnish services to the members will be assured of the following rights:

- A Health Care Professional, acting within the lawful scope of practice, will not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
  - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or non-treatment.
  - The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and State Fair Hearing procedures.
- To have access to the Healthy Louisiana Plan's policies and procedures covering the authorization of services.
- To be notified of any decision by the Healthy Louisiana Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge, at the request of the Medicaid/CHIP member on their behalf, the denial of coverage of, or payment for, medical assistance.
- The Healthy Louisiana Plan's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.

MCOs, including ABHLA, are required to comply with all court-ordered requirements.

AJ v LDH (3:19-CV-00324)

This section explains the class-action lawsuit AJ v. LDH (3:19-CV-00324) and the implementation and operation of key provisions of the settlement agreement in that litigation.

Class Members

All current and future Medicaid beneficiaries under the age of 21 in Louisiana who are certified in the Children's Choice Waiver, the New Opportunities Waiver, the Supports Waiver, or the Residential Options Waiver who are also prior authorized to receive extended home health (EHH) services or intermittent nursing (IN) services which do not require prior authorization but are not receiving some or all of the hours of extended home health services or intermittent nursing services as authorized by Louisiana Medicaid.

Litigation Summary

AJ v. LDH, filed on May 22, 2019, seeks to enforce rights under the EPSDT and reasonable promptness mandates of Title XIX of the Social Security Act, the Americans with Disabilities Act [42 U.S.C. §12131, et seq.], and Section 504 of the Rehabilitation Act [29 U.S.C. §794] by compelling the Department to arrange for the in-home skilled nursing care prior authorized for Medicaid-enrolled, medically fragile children. Because of their medical needs, class members have been prior authorized to receive EHH services to be able to live in the community. Data reflect gaps between the EHH service amounts prior authorized and the EHH service amounts actually delivered to class members. Potential service gaps in medically necessary IN services to class members also fall under the scope of the litigation. The suit has been settled, and the corresponding settlement agreement was approved by the court on March 31, 2020.

Prohibited Acts

ABHLA is prohibited from reducing prior approved EHH service amounts for *class members* to increase the percentage of prior approved EHH services actually delivered. Such reduction in the amount of services that have been prior approved is contrary to federal Medicaid law and would constitute a due process violation under the United States Constitution.

Settlement Implementation

ABHLA must adhere to the settlement agreement and implement it per the following:

Crisis Response Team

Louisiana Medicaid has established a Crisis Response Team (CRT), the primary responsibility of which is arranging for in-home nursing services for class members when such services are unavailable through existing Medicaid home health agencies within the class member's LDH region. ABHLA is responsible for accepting referrals from the CRT and arranging service fulfillment.

Support coordinators or case managers have the obligation promptly to make referrals to the CRT for any class member who, after making reasonable efforts to receive EHH or IN services:

- Has received less than 90% of his or her prior approved EHH or medically necessary IN services for at least two consecutive weeks; or
- Has been unable to locate a home health provider in his or her LDH Region or has been denied enrollment by all home health providers in his or her LDH Region; or
- Is otherwise facing a serious risk of institutionalization due to lack of EHH or IN services.

In addition, when a need for IN has been identified and a class member is being terminated from existing EHH services where the class member's LDH region does not have a provider for IN services on the date that the notice of denial has been sent, the class member must be immediately referred to the CRT. In such situations, a reasonable effort includes a reevaluation of whether or not the class member should have been found eligible for EHH services.

The CRT operates in addition to, and does not replace, the responsibilities of a class member's existing support coordinator or case manager.

ABHLA must submit a weekly report to LDH documenting the actions taken to ensure service provision and fulfillment for CRT referral members. ABHLA must submit a monthly report detailing the hours and service provision for class members.

Class Member Denial Notices

Notices to class members denying EHH services must contain contact information for the CRT when there is an identified need for IN services, i.e., for in-home skilled nursing services of visits with a duration shorter than three contiguous hours per day.

Contact information for the CRT is as follows:

- E-mail: crisisresponseteam@la.gov
- Telephone: (866) 729-0017

Additionally, in situations when a class member is being referred to the CRT due to the unavailability of a provider for IN services concurrent with a termination from existing EHH services, the notice of denial to the class member of the EHH services termination must also notify the class member of the referral to the CRT.

Case Management

Support coordinators or case managers must document in the progress notes for each class member all prior approved EHH or medically necessary IN services and whether those EHH or IN services are provided, as reported by the family, including whether the family has refused the offered services and, if so, the basis for the refusal.

Additional Rate Modifiers

Louisiana Medicaid has published a Home Health Services Fee Schedule that includes modifiers with enhanced rates for EHH. Refer to Rate Modifiers for Extended Home Health in Chapter 15 for further information on how to apply these rate modifiers.

Termination

The settlement period for AJ v. LDH is scheduled to terminate on March 31, 2025, unless otherwise ordered by the court.

Chisholm v. LDH

Class members in Chisholm v. LDH (Case 2:97-cv-03274) are defined as follows: All current and future beneficiaries of Medicaid in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry.

ABHLA must comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the Chisholm Compliance Guide and accompanying MCO User Manual.

DOJ Agreement

The target population of the Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana) are defined as follows: (a) Medicaid-eligible individuals over age 18 with serious mental illness (SMI) currently residing in nursing facilities; (b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement during the course of this Agreement, or have been referred within two years prior to the effective date of this Agreement; and (c) excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.

ABHLA must comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the DOJ Agreement Compliance Guide.

Monitoring of Denial Notices

LDH monitors denial and partial denial notices to ensure compliance with federal requirements regarding timely and adequate notices of benefit determinations for prior authorized services. An auditing and monitoring process was established following the Wells v. Gee litigation (Case 3:14-CV-00155). As a result of the joint stipulation from the Wells v. Gee settlement, LDH developed multiple templates to help the MCOs maintain compliance with federal requirements as it pertains to the development of denial and partial denial notices of prior authorized services.

APPENDIX A: PROGRAM UPDATES

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This appendix provides a reference for all Louisiana Medicaid program updates. For additional information, see the Louisiana Department of Health's Medicaid Informational Bulletins Page.

Louisiana Department of Health Informational Bulletin 21-5, March 5, 2021

New Louisiana Medicaid Provider Enrollment Portal

Louisiana Medicaid will launch a new Louisiana Medicaid Provider Enrollment Portal in April 2021 to screen and enroll all Medicaid providers. The enrollment portal is being designed to meet a Centers for Medicare and Medicaid Services (CMS) requirement and must be used by all Medicaid providers. This includes current managed care organization (MCO) –only providers, existing fee-for-service providers, and any new providers enrolling for the first time. Once it becomes available, the new enrollment portal will be accessed through Medicaid's fiscal intermediary website at https://www.lamedicaid.com.

A second, informational website for providers has been created at www.ldh.la.gov/medicaidproviderenrollment. The site includes guidance to help providers prepare for the launch and navigate enrollment. It also includes a form for submitting feedback and asking questions.

Timeline for Completing the New Enrollment and Screening Process

All current providers, whether participating as a fee-for-service provider, MCO-only provider, or both, must validate their information and sign the state's provider participation agreement through the portal within six months of the launch date.

Prior to the portal launch date, Gainwell Technologies, Louisiana Medicaid's fiscal intermediary, will send an invitation to the address and email address on file for current providers. The notice will inform providers when they can access the new Louisiana Medicaid Provider Enrollment Portal to complete the enrollment and screening process. For providers enrolled with an MCO, Gainwell Technologies will send the invitation to the mailing address that is on file with the MCO. For providers only enrolled in fee-for-service Medicaid and not with any of the MCOs, Gainwell Technologies will send the invitations to the service location address which they have on file.

Providers will receive additional notice of the time frame they have to enroll when the portal launches. They will have at least six months to complete the enrollment process through the portal after it becomes available. Any existing Medicaid provider that does not complete the enrollment and screening process through the new portal within the established time frame will have their claims denied after that time period.

Things to do in Preparation

To prepare for the new enrollment and screening process, providers should:

- Talk to their office staff that typically help with enrollment and credentialing processes.
- Look up their National Provider Identifier (NPI) and assigned taxonomies here.
- Review all taxonomy options here.

Additionally, MCO-only providers should decide whether they also want to participate in the fee-for-service model. Providers are not required to enroll as fee-for-service unless they would like to do so.

If a provider needs to update their contact information, use the information below to determine how to best update their information.

- Fee-for-service providers can update their service location address by completing this form.
- MCO-only providers can update their mailing address and/or email address by contacting each MCO with which they are enrolled. MCO contact information can be found here.
- Any provider contracted with Magellan can update their contact information through Magellan's provider portal.
- DentaQuest providers can update contact information by downloading this form and then emailing it to standardupdates@dentaquest.com.
- MCNA providers should send updated contact information to contactus@mcna.net, or mail to MCNA Dental, Attn: Credentialing, 200 West Cypress Creek Road, Suite #500, Fort Lauderdale, Florida 33309.

Enrollment and Credentialing

Under the current process, managed care providers are not required to enroll directly with Louisiana Medicaid through the fiscal intermediary, Gainwell. A provider that becomes a managed care provider is credentialed and contracted with an MCO. If the provider is a fee-for-service provider, they must enroll as a Louisiana Medicaid provider and complete a screening process through the state's fiscal intermediary.

The new process requires that all providers complete their enrollment and screening through the new web-based portal. This will bring the state into compliance with current federal requirements. Per CMS requirements, all providers must be screened by the state at the following intervals:

- When they initially apply for and submit an application to become a Medicaid provider;
- Upon reenrollment (reactivation of a previously closed provider number) in the state's Medicaid program; and
- At least once every five years to revalidate their enrollment, which is similar to the recredentialing process that all MCOs complete every three years. MCO-only providers also must still complete the recredentialing process with MCOs every three years.

This process does not take the place of the normal MCO credentialing process. MCO-only providers must still be enrolled, credentialed and contracted with each of the MCOs with which they would like to participate. Current MCO-only providers have no additional steps to complete after completing the enrollment process through the new Louisiana Medicaid Provider Enrollment Portal, but they will need to complete the MCO recredentialing process every three years for each MCO with which they are contracted . If they do not do so, they will be disenrolled from the managed care plan with which they are contracted. New providers will need to complete the credentialing process with MCOs after they complete the enrollment process with the state through the new portal.

After the initial enrollment period for current MCO-only and fee-for-service providers, the portal will be updated for all new providers to enroll with the state. At that point, fee-for-service providers will no longer have to complete the paper enrollment process currently used. The new Louisiana Medicaid Provider Enrollment Portal will streamline and update the application process.

Completing this new enrollment process does not require a provider to participate in the fee-for-service model. Providers may continue with their current business model and will not be mandated to provide care through the fee-for-service model, unless that is their preference.

Purpose of the New Enrollment Portal

As a part of the Affordable Care Act and later refined in the 21st Century Cures Act, federal laws enforced by CMS require that states screen and enroll all providers. The new Louisiana Medicaid Provider Enrollment Portal will bring Louisiana Medicaid into compliance with CMS revalidation and managed care screening requirements and federal law. The portal will be prepopulated with information that the state and MCOs already have on file so that the provider can more easily submit an application through the portal. This streamlined process eliminates the need to complete and mail a paper application. Also, providers will have the ability to track their application through the portal.

Additional information and updates will be provided in updates to this Informational Bulletin.