AETNA BETTER HEALTH® OF LOUISIANA

Spring 2015

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Welcome providers

At Aetna Better Health of Louisiana, we value our provider partners. We want to work with you to provide timely, safe and effective health care to our members.

Good communication among our providers and our plan administrators is key to the delivery of quality health care services to our members. Please don't hesitate to contact us any time with any questions you have.

On our website, **www.aetnabetterhealth.com/louisiana**, you will find these resources to help make your job easier:

- Your provider manual
- Information about clinical practices
- The forms and resources you need
- The latest provider news and notices

Value Added Benefits

Unlimited free over-the-counter (OTC) medicines and products with prescription
Aetna Better Health of Louisiana offers at no cost to our members, unlimited OTC medicines and products with a doctor's prescription to all members. Please remember to write a prescription for your members' OTC medicines.

Free circumcision
Aetna Better Health of Louisiana will cover the cost of newborn male's circumcision. We do not require prior authorization for this procedure. For reimbursement of newborn male member circumcision, use CPT Code 54160: Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less).

HEDIS

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) for the managed care industry. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

HEDIS performance measures assist you in providing timely and appropriate care for your patients; provide you with a picture of the overall health and wellness of our members, allowing you to identify gaps in care and develop programs/interventions to help increase compliance and improve health outcomes.

17-P Alpha-Hydroxyprogesterone Caproate and Makena

Aetna Better Health of Louisiana will cover the weekly intramuscular injection of 17-P Alpha-Hydroxyprogesterone Caproate (compounded formula) and Makena for use in pregnant women with a history of pre-term delivery before 37 weeks gestation and no symptoms of pre-term labor in the current pregnancy. We do not require prior authorization for these drugs.

For reimbursement of 17-P, use HCPCS code J3490-TH, (The "J" code and "TH" modifier must be used); For reimbursement for administration of injection, you may use a lower level "office visit" (99211-TH) if no higher level evaluation and management service has been billed on that date; and include ICD-9 diagnosis code V23.41 (Pregnancy with history of pre-term labor).

EPSDT

EPSDT (Early and Periodic Screening Diagnosis and Testing) is a federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment and other measures to correct or ameliorate any defects and chronic conditions discovered. EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of "medical assistance".

Our EPSDT goals
Our EPSDT goals are as follows:
- 75 percent of our EPSDT eligible members under age 21 will receive their well-child/well-care visits
- A strong partnership with our providers
- Coordination of care across providers
- High member satisfaction
- Low ER utilization

If you have any questions regarding our EPSDT program, please contact Candi Meredith, EPSDT Coordinator at MeredithC@aetna.com or 504-667-4471.

Meet Our CEO

Salli Duncan
CEO, Aetna Better Health of Louisiana

Salli joined Aetna on December 15, 2014 as the first employee of Aetna Better Health of Louisiana. Salli was most recently Vice President of Operations for an emergency response and telehealth monitoring company, VRI, in Dayton, Ohio. VRI provided 24/7 in-home monitoring and response services for individuals to facilitate ongoing independence, safety and optimal level of wellness in their homes. In this role she was responsible for the clinical call center, compliance, technical support, in-home installation and service, project management, customer service and dealer support.

Prior to joining, VRI, Salli held multiple executive level positions over a 12-year span in a 1-million- member Medicaid plan, CareSource, which was also located in Dayton, Ohio. These positions included medical and care management, quality management and network operations.

Salli received her undergraduate degree in nursing from Miami University and MBA from University of Phoenix. She also completed the Black Belt Certification Program from Villanova University. Post college, Salli was an ICU nurse for several years at Miami Valley Hospital and held a variety of leadership positions in various healthcare settings including home health and long term care.

Provider Service Department

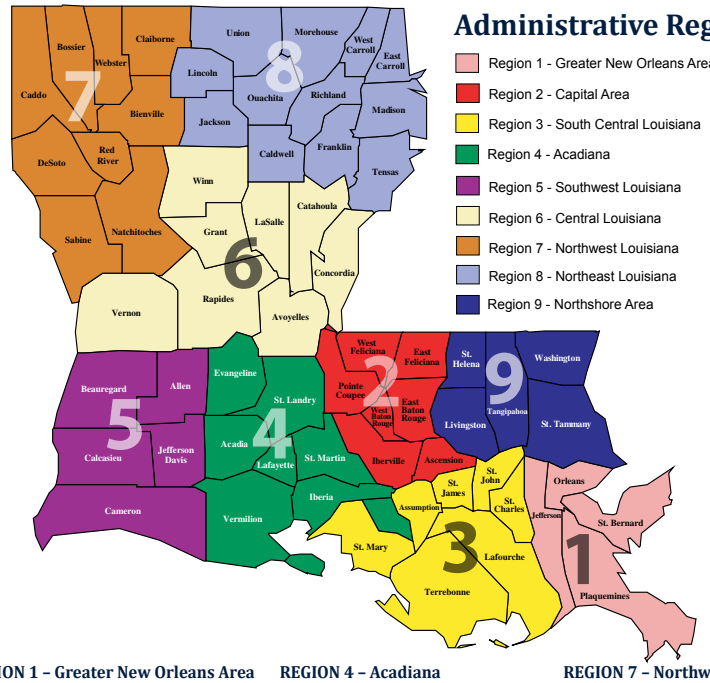
Our Provider Services Department serves as a liaison between the health plan and the provider community. Our Provider Services Representatives are available by phone at **1-855-242-0802** or e-mail to support all providers.

Some of the everyday actions we take to help you include:

- Keeping track of member updates
- Locating forms
- Reviewing member information
- Checking member eligibility
- Finding a participating provider or specialist
- Submitting a prior authorization
- Reviewing or searching the Preferred Drug List
- Notifying the plan of a provider termination
- Notifying the plan of changes to your practice
- Advising a Tax ID or National Provider Identification (NPI) number change
- Obtaining a secure web portal or member care Login ID
- Reviewing claims or remittance advice

Our Provider Services Department supports multiple functions in network development and contracting. This includes 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/e-mail blasts, website notices, and the provider orientation kit.

DEPARTMENT OF HEALTH AND HOSPITALS



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10th Floor, New Orleans, LA 70112
Mail to: P.O. Box 1521
New Orleans, LA 70004-1521
PHONE: (504) 599-0606
FAX: 1-866-853-7278

REGION 2 – Capital Area
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Baton Rouge, LA 70805
Mail to: P.O. Box 91248
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REGION 3 – South Central Louisiana
1000-C Plantation Road
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PHONE: (985) 449-5163
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REGION 4 – Acadiana
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Lafayette, LA 70508
Mail to: P.O. Box 81709
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Lake Charles, LA 70629
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Alexandria, LA 71303
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REGION 7 – Northwest Louisiana
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TTD: (318) 862-9714 or
1-888-838-2351

REGION 8 – Northeast Louisiana
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PHONE: (318) 362-3066
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REGION 9 – Northshore Area
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Region	PR Rep Assignment	PR Rep E-mail Address
1	Kelly Hebert	HebertK@aetna.com
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3	Tammy Huynh	HuynhT@aetna.com
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5	Clarence Grant	Grantjrc@aetna.com
6	Clarence Grant	Grantjrc@aetna.com
7	Da'Vida Armstrong	Armstrongd@aetna.com
8	Da'Vida Armstrong	Armstrongd@aetna.com
9	Kelly Hebert	HebertK@aetna.com

ICD-10 Frequently Asked Questions Aetna Medicaid Providers	
Q. Who should I contact if I have additional questions?	A. Please contact your provider relations representative.
Q. What is your testing strategy?	A. We are planning to conduct large scale internal testing – which started during the first half of 2013. This will be followed by targeted external testing in the latter part of 2013 and continue into 2014. We may complete an additional cycle of external testing in 2015. As part of our external testing, we plan to include Institutional and Professional claims and will be contacting those entities we plan to test with directly. We strongly encourage providers to approach clearinghouses and other business partners to initiate testing as well.
Q. When will you complete the Assessment/Gap Analysis phase to determine the impact of ICD- 10 on your business processes, systems, and trading partner relationships?	A. This is 100% complete.
Q. When will you complete your Requirements phase for impacted business processes, systems, and trading partner relationships?	A. This is 100% complete.
Q. When will you complete your process design and development for impacted business processes, systems, and trading partner relationships?	A. This is 100% complete.
Q. What phase of the ICD-10 project are you in? (Planning, Design/Remediation, User Acceptance, Partner Testing)?	A. There many modules to our project at various stages of completion, though overall we have remediated the majority of our processes, performed both user and partner testing, and implemented ICD-10 into production with 10/01/2015 effective date.
Q. What is your estimated date to start internal testing ICD-10 processing?	A. We have a staggered scheduled for the configuring and testing of health plans. Our first Plan began testing in 1Q2013, with subsequent activity throughout 2013 and 1Q2014. All Plans that were active when the new ICD-10 date was established have been tested and validated.
Q. What is your estimated date to start external testing of ICD-10 processing?	A. Provider Collaboration testing started in April 2013 with targeted providers and the clearinghouses. Testing with these targeted providers completed 4Q2014.
Q. Can we test ICD-10 claims with you?	A. Due to limited resources we are not testing with all providers, but we are testing with trading partners. We suggest that providers test with their electronic claim trading partner(s) to validate their claim generation/ submission process. Aetna Medicaid will work directly with clearinghouses on submission testing. If you require assistance in testing your submission processes, please contact your clearinghouse for direction.
Q. What approach do you intend to take to adjudicate claims with ICD-10 codes as of 10/01/15?	A. ICD Diagnosis and Procedure codes for Dates of Service and Dates of Discharge on or after the implementation date must be submitted as ICD-10.
Q. Will you accept ICD-9 codes on or after 10/01/15?	A. ICD-9 codes must be retroactively submitted for those Dates of Service and Dates of Discharge prior to implementation.
Q. When do you expect to be processing ICD-10 claims in the production environment?	A. 10/01/2015

Q. Do you anticipate any delays in claim adjudication as of 10/01/15?	A. We do not anticipate adjudication delays on appropriately submitted claims.
Q. How will Aetna Medicaid address scenarios where an initial claim is approved using ICD-9 format, and a corresponding final claim is submitted after go-live with ICD-10?	A. Claim acceptance and adjudication is based on the Date of Service/Discharge of the claim. Post go-live, we will continue to require ICD-9 codes for claims with DOS/DOD prior to 10/01/15.
Q. Does Aetna Medicaid process Worker's Compensation claims?	A. No
Q. Do you anticipate any changes in policies or delays in payments to result from the switch to ICD-10?	A. No
Q. Does Aetna Medicaid have a plan in place for addressing situations where testing demonstrates a substantial variance in payment when processing ICD-10 coded claims compared with ICD-9 coded claims today?	A. Any discrepancies identified in testing will be analyzed for root cause and addressed accordingly prior to go-live.
Q. Does Aetna Medicaid have any special requirements for providers for the ICD-10 transition?	A. Appropriate Submission of claims based on Dates of Service/Discharge and confirming individual claims do not contain a mix of ICD-9 and ICD-10 codes, will ensure proper and timely handling.
Q. Will Aetna Medicaid use a separate test database with test data or will you be using your production database for testing?	A. We are using a test environment that mirrors our production environment. Claims are coded for actual members, but the PHI will be masked.
Q. Are you planning any additional pilot testing programs with your other Payors, Providers or Hospitals?	A. We have initiated a collaborative end to end testing process with a targeted group of providers.
Q. Will you be updating your medical policies?	A. We do not anticipate any policy changes due to the ICD-10 transition. We are remediating our processes with financial and clinical neutrality as a goal to attain expected payment turnaround. Medicaid benefits and coverage are not expected to change unless established by the state.
Q. Do you have a deadline for updating the medical policies?	A. August, 2015
Q. Will your systems be ready to group DRG/APC/CMG?	A. A DRG upgrade will be managed as a separate project. Testing for that upgrade project will incorporate ICD-10.
Q. What processes are you using to update your claim edits?	A. While we cannot share details of our internal program work, we are ensuring all of our systems are ready for ICD-10 coding.
Q. What type of reimbursement changes do you think will result from the ICD-10 conversion?	A. The ICD-10 conversion was not intended to transform payment or reimbursement. However, it may result in reimbursement methodologies that more accurately reflect patient status and care.
Q. Do you plan to relax timely filing periods and appeal periods?	A. We have no such plans at this time. Appropriate Submission of claims based on Dates of Service/ Discharge, and confirming individual claims do not contain a mix of ICD-9 and ICD-10 codes, will ensure proper and timely handling. Normal timely filing rules still apply.
Q. How do you anticipate ICD-10 changes to affect your quality program reimbursement?	A. We are evaluating this as part of our overall program planning.

Q. How is your self-insured business handled? If the self-insured business uses a Payor that is someone other than your operations how are you assuring providers that the Payor and/or Third Party Administrators will be compliant with the electronic acceptance of ICD 10, the operational issues and the timely payments?	A. Our self-insured business is handled by Aetna.
Q. What are your lessons learned from the General Equivalence Mappings (GEMs) and reimbursement crosswalks?	A. We have completed a full analysis of ICD-10 codes and we are using this information to update our systems, processes, and policies as needed.
Q. What new claim status or rejection error codes are you implementing?	A. We do not anticipate any difference in our claim receipt and adjudication process.
Q. Assuming your prior authorizations drive the claim payment, how do you anticipate this to work when the authorization is obtained prior to 10/1/15 but the services are not performed until after 10/1/15?	A. ICD-9 codes should be used for prior authorizations submitted prior to compliance date (10/01/2015) and ICD-10 for prior authorizations submitted post compliance date. Authorizations will be carried over and matched to the claims.
Q. Does your entity expect to be ready to accept the new 1500 form on 04/01/2014?	A. We will be ready to accept the revised CMS- 1500 form in January 2014.
Q. Does your entity expect to have new Payor Edits related to ICD-10 and if so, when will they be available?	A. The only new edits will be the acceptance/rejection of claims submitted with incorrect ICD code based on Dates of Service/Discharge. Claims will be rejected if they contain: • Both ICD-9 and ICD-10 codes • ICD-9 codes for Dates of Service/Discharge on or after 10/01/15 • ICD-10 codes for Dates of Service/Discharge of 09/30/15 or earlier
Q. What is your plan for communication to update status, issues/concerns, testing plans and policy changes related to ICD-10 transition?	A. Use the current channel of communication.
Q. When do you plan to distribute updated policies or handbooks to providers?	A. Any additional requirements for billing will be inserted in the provider manual as needed.
Q. Will the payment that you issue be determined in any way by the ICD-10 code that was submitted to you?	A. An ICD-10 code will only determine payment after 10/01/2015 where an ICD-9 code determines payment today.

Clinical Practice Guidelines

To help provide our members with consistent, high-quality care that uses services and resources effectively, we have chosen certain clinical guidelines to help our providers. These include treatment protocols for specific conditions, as well as preventive health measures.

These guidelines are intended to clarify standards and expectations. They should not:

- Take precedence over your responsibility to provide treatment based on the member's individual needs
- Substitute as orders for treatment of a member
- Guarantee coverage or payment for the type or level of care proposed or provided

On our website, **www.aetnabetterhealth.com/louisiana/providers/guidelines**, you will find:

- Clinical Policy Bulletins
- Clinical Practice Guidelines
- Preventive Health Guidelines