



Summer provider newsletter

Supporting better care, smoother billing and stronger member connections

This summer edition includes important updates to help your practice prepare for upcoming policy and billing changes, submit accurate claims and connect Aetna Better Health® of Oklahoma members with helpful programs and resources.

In this edition, we'll cover:

Regulatory
and policy
updates

Claims and
billing

Clinical
quality

Tools and
resources

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Aetna Better Health of Oklahoma



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1. Regulatory and policy updates

Prepare now for upcoming maternity care billing changes

The American Medical Association (AMA) is introducing new maternity care service codes that will change how providers bill for maternity services. OHCA will implement the new codes and related billing changes for dates of service beginning January 1, 2027. Under the new approach, maternity services will be billed separately instead of through bundled or global obstetrical care codes.

Beginning September 1, 2026, providers should use individual evaluation and management (E/M) codes for new patients beginning prenatal care. This will support the transition to the mandatory billing changes taking effect January 1, 2027.

For antepartum services provided before January 1, 2027:

- One to three visits: bill individual E/M codes.
- Four to six visits: bill CPT code 59425 for the first block of visits, then use individual E/M codes for additional visits.

- Seven or more visits: bill CPT code 59426. Do not bill additional E/M visit codes for services provided before December 31, 2026.
- Deliveries before January 1, 2027: providers may continue using current bundled maternity codes.
- Prenatal care in 2026 with delivery in 2027: bundled delivery codes cannot be used.

Apply the TH modifier to E/M codes when billing for antepartum or postpartum care to support proper claims processing and help prevent denials.

OHCA plans to provide additional guidance and educational opportunities before implementation. Keep an eye out for updates from OHCA and Aetna Better Health.



Action needed

Review your maternity billing workflows now and begin preparing billing staff and affected clinicians for the September 1, 2026, transition period.

The new coding structure better reflects today's team-based maternity care and supports improved transparency, data quality and performance measurement.

[Learn more from the AMA here](#)



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of Oklahoma

Work requirements begin January 1, 2027

Work Requirements Screener

How do I know if I have to do the work requirements?
Starting in January 2027, a new law says some SoonerCare members must work or help in their community to keep their health coverage.

What should you do next?
Answer a few short questions to see if this rule may apply to you. This is only an estimate. It is not an application or a final decision. We do not save or use your information.



Work requirements begin January 1, 2027 for certain expansion adults ages 19 through 64 who do not qualify for an exemption. Affected members will generally need to complete at least **80 hours per month** through employment, education, community service or another qualifying activity—or demonstrate the required minimum monthly income.

Not every member will be subject to the requirements. Exempt groups include certain pregnant and postpartum members, parents and caretakers, individuals with qualifying medical or behavioral health conditions, individuals receiving certain forms of treatment and other populations identified by OHCA. Click the image to access the work requirements screener.

How providers can help now

- Encourage members to update their address, phone number and email at **MySoonerCare.org**.
- Remind members to read and respond to communications from OHCA.
- Document relevant medical and behavioral health conditions completely and accurately.
- Watch for additional guidance about provider documentation, claims information and processes that may help OHCA identify members who qualify for an exemption or short-term hardship exception.
- Direct members with eligibility questions to OHCA for assistance.

Claims information may support work requirement reviews

Certain diagnoses, services or other information submitted on a claim may help identify members who could qualify for additional review related to SoonerSelect work requirements.

Complete and accurate claims information will be especially important as the January 1, 2027, implementation date approaches. Providers should:

- Report all applicable diagnosis and procedure codes.
- Code services to the highest appropriate level of specificity.
- Make sure the medical record supports all information reported on the claim.
- Avoid selecting a code solely to obtain an eligibility outcome.
- Continue monitoring communications from OHCA and Aetna Better Health for confirmed coding instructions.

Additional provider guidance will be shared as it becomes available.

During appointments, encourage members to:



Update their contact information



Check their mail and email for messages from OHCA.



Respond promptly when additional information is requested.

2. Claims and billing

Improve provider matching and help prevent claim denials

Accurate provider information helps Aetna Better Health and OHCA match a claim to the correct provider record.

Provider matching relies on National Provider Identifier (NPI), taxonomy codes, ZIP code and contract information. These elements may be used individually or together when one NPI is associated with more than one SoonerSelect provider record.

If the provider information submitted on the claim does not match the information in OHCA's system, the claim may deny because the NPI could not be matched to the correct provider ID.

Before submitting a claim

- Confirm that the billing and rendering NPIs are correct.
- Submit the taxonomy associated with the provider's registered specialty and the services performed.
- Use the physical service location's ZIP+4 when required.
- Make sure provider enrollment and affiliation information is current with OHCA.
- Verify that claim data matches the provider's OHCA enrollment record.

Providers can initiate or verify enrollment through the OHCA provider enrollment portal.

Taxonomy codes are required on claims

Aetna Better Health requires applicable billing and rendering taxonomy codes to be included on claims. The taxonomy must be consistent with the provider's registered specialty and the services rendered.

Click the image for more taxonomy information.

Aetna Better Health® of Oklahoma
777 NW 63rd Street, Suite 100
Oklahoma City, OK 73116



May 9, 2024

Notice of Aetna Better Health® of Oklahoma SoonerSelect claims and encounters front end edits

This letter is being shared with you to ensure your medical office is aware of current compliance edits. Together, we can reduce the impact and disruption to your billing operations.

The Oklahoma Health Care Authority is required by the 42 CFR § 438 Subpart H to verify that all providers, provider groups, and affiliations who wish to provide services to SoonerSelect members have their enrollment verified. This requirement applies to contracted Managed Care Organizations (MCOs), as well [aligns to rules 438.6 (b)(1) and 438.6(b)(2)]. In Oklahoma, the Oklahoma Health Care Authority requires contracted MCOs to verify that all providers, provider groups, and their affiliates who wish to provide Medicaid services are actively enrolled in the program prior to rendering services to SoonerSelect members.

Aetna Better Health has prepared clean claim edits to ensure compliance with the Oklahoma Health Care Authority rules and edits. Aetna Better Health began enforcement of these edits on April 1, 2024. **The clean claim edits will deny EDI claims and paper claims when a unique effective Medicaid ID cannot be found on the SoonerSelect registry for any of the following provider categories:**

Professional claims - 837P or CMS-1500	Institutional claims - 837I or UB04
Billing provider 2010AA/Box 33A	Billing provider 2010AA or Box 56
Rendering provider 2310B/2420A or Box 24J	Rendering loop 2310D/2420C or Box 79 with 82 Qualifier
Referring provider 2310A/2420F or Box 17B with DN Qualifier	Referring Loop 2310F/2420D or Box 79 with DN Qualifier
Ordering/prescribing provider 2420E or Box 17B with DK Qualifier	N/A
Supervising provider 2310D/2420D or Box 17B with DQ Qualifier	N/A
N/A	Attending provider 2310A or Box 76

Providers are responsible for resolving any State registration issues and are not

EPSDT billing fundamentals

Preventative codes

Use the appropriate preventive service CPT codes for well-child visits. These codes should align with the age of the child and the services provided during the visit. A complete screening service includes: a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests, and health education including, anticipatory guidance.

EPSDT identifiers

Apply required modifiers and EPSDT indicators on claims. These identifiers signal to the payer that the services were provided as part of the EPSDT program and may trigger different coverage rules than standard adult Medicaid services. This is especially important because the EPSDT statute provides an exception to comparability, meaning services under the EPSDT program are not required to be provided to other program eligibles outside of the EPSDT benefit.

Documentation

Ensure visit notes support medical necessity for all services billed. The statute requires that services be necessary to correct or improve defects and physical and mental illnesses and conditions discovered by the screening services. Provider documentation must clearly establish this medical necessity or the service is at risk of being delayed or denied.

Common billing pitfalls

Avoid missing modifiers, incorrect age ranges, and incomplete documentation. Also, be aware that appropriate limits may be placed on EPSDT services based on medical necessity, but the amount, duration, or scope of EPSDT services may not be denied or reduced solely because of the diagnosis, type of illness, or condition.

For more detailed information, please refer to the provider manual and the coding for pediatric preventative care (which outlines all EPSDT relevant CPT and Identifier codes).

3. Clinical quality

Screen early. Intervene sooner. Earn incentives.

Complete Screening, Brief Intervention and Referral to Treatment (SBIRT) for members ages 12 and older and earn available incentive payments while helping identify substance use risks early.

Substance use disorder screening is an important part of whole-person care. Annual screening can help providers identify concerns, support the management of chronic conditions and connect patients with appropriate services before substance use leads to more serious health concerns.

Quick tips

- Make screening part of every annual wellness visit.
- Add an approved screening tool to routine intake workflows.
- Document the screening and any follow-up intervention.
- Refer members for additional assessment or treatment when appropriate.
- Download the SBIRT resource toolkit [here](#).
- For OHCA SBIRT questions, contact ProvReimb@okhca.org



Note: Incentive payments may be available for completing eligible SBIRT services. Review applicable program requirements before submitting claims.

Make every well-child visit count

Regular well-child visits help identify health and developmental concerns early and provide opportunities to address preventive care needs.

A school or sports physical may also count as a well-child visit when all required components of the comprehensive preventive visit are completed and documented.

Providers should:

- Review the child's comprehensive health and developmental history.
- Complete and document the required physical examination.
- Review immunization status.
- Complete age-appropriate screenings.
- Provide health education and anticipatory guidance.
- Use the appropriate preventive service code and applicable EPSDT identifiers.

Refer to the provider manual and applicable pediatric preventive coding guidance for complete requirements.





Help new mothers stay connected to primary care after delivery

A [recent study](#) found that proactively connecting postpartum women to primary care reduced non-emergency emergency department utilization.

The study focused on women who had at least one chronic condition or health risk such as:

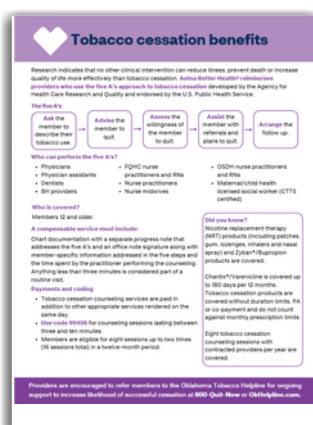
- Obesity
- Anxiety or depression
- Diabetes
- Pregnancy-related hypertension
- Chronic hypertension

Participants were automatically scheduled for a primary care visit within the first four months after delivery and received reminders about the appointment and the importance of ongoing primary care.

Researchers found the approach was associated with a 10 percentage point reduction in non-emergency emergency department visits.

What providers can do

- Encourage postpartum members to establish or reconnect with a primary care provider before delivery.
- Schedule primary care follow-up appointments whenever possible before the postpartum period ends.
- Reinforce the importance of managing chronic conditions after pregnancy.
- Coordinate care between obstetric and primary care teams.
- Connect members with available care management and support programs when additional assistance is needed.



Tobacco cessation support

Help members take the next step toward better health. Tobacco cessation counseling and quit-smoking medications are covered for eligible members. Bill CPT 99406 (3-10 minutes) or 99407 (more than 10 minutes) for eligible counseling services.

To learn more, click the image. You'll be to be directed to the provider manual. Tobacco cessation can be found in chapter five.

4. Tools, programs and resources

Join us for weekly provider office hours

When: Thursdays

Time: 10:00 – 10:30 AM CT



Availity reminder

Make sure the email address associated with your Availity account is accurate and monitored regularly.

A current email address can help your office receive important account notifications and avoid missing time-sensitive information. Each user should maintain an individual account and review their profile information regularly.

Availity provides access to provider tools and transactions, including claims, authorizations, referrals and other administrative functions.

[Access Availity here](#)

Need a member dismissal form?

Providers should follow the established process when requesting that a member be reassigned or dismissed from the practice. Complete the member dismissal form and include all required information and supporting documentation. Do not tell the member that the dismissal or reassignment has been approved until the request has been reviewed through the appropriate health plan process.

Continue providing necessary care during the review and any required transition period, consistent with contractual, ethical and regulatory obligations.

[Find the PCP-initiated member dismissal form here](#)



The Member REACH program can help connect eligible members with additional support and resources.

Providers can play an important role by identifying members who may need help beyond the clinical setting and referring them to the Member REACH team.

Consider a referral when a member needs:

- Financial, food or housing assistance
- Educational service
- Legal services
- Baby supplies
- Clothing, or other items that impact their overall wellness.

Call **1-833-316-7010** for more information.

Medication management support through Arine

Aetna Better Health is working with Arine to support safer, more effective medication management.

Arine uses medication data and clinical information to identify members who may be at increased risk of medication-related concerns.

When an eligible member is identified, an Arine pharmacist completes a comprehensive medication review and sends the prescribing provider recommendations for consideration.

Click the image to learn more.

The infographic features the Aetna and Arine logos at the top. It includes a photo of an elderly woman on a phone. Key statistics shown are '>20% Reduction in emergency room visits' and 'Up to 15% Reduction in total cost of care'. It lists 'Providers' and 'For Health Plans' as beneficiaries. A section titled 'Working Together for Better Patient Outcomes' describes the partnership. Another section, 'Introducing Arine: A Comprehensive Medication Management Platform', lists benefits like drug appropriateness, potential adverse reactions, adherence challenges, and dosing optimization. A 'Real-World Impact' section mentions 'Fewer hospitalizations and ER visits' and 'Better population health outcomes'. A 'Provider Engagement' section states that 'Advanced AI models analyze broad datasets to identify with the highest risk and greatest potential for impact members'. It also mentions that 'Identified patients receive a comprehensive review from an Arine pharmacist that generates specific optimization'. A final section says 'You'll receive a fax with changes to consider or each recommendation documentation'. At the bottom, it says 'Recommendations if appropriate and medication changes are recommendations based on your clinical judgment and via fax response'. Contact information for Aetna Better Health of Oklahoma is provided: 1-844-365-4385. A hand icon points to the contact information.



Transportation may be available to help eligible members attend covered health care appointments

When transportation is a barrier:

- Encourage the member to schedule transportation as early as possible.
- Make sure the member has the appointment date, time and address.
- Remind the member to ask about applicable scheduling requirements.
- Help the member identify whether special transportation accommodations are needed.

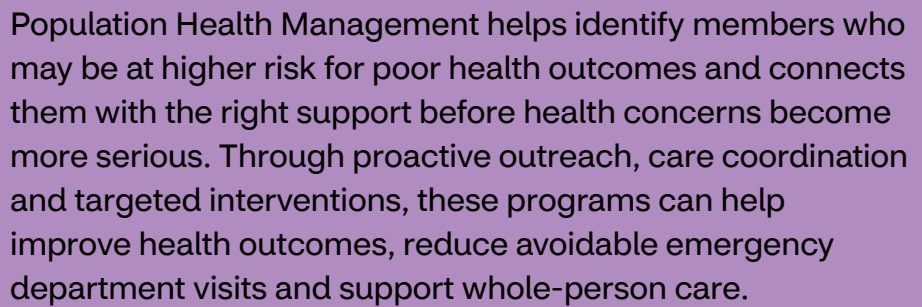
Providers can also help by discussing transportation barriers during appointment scheduling and follow-up outreach. [Learn more here.](#)



Thank you to our FQHC partners!

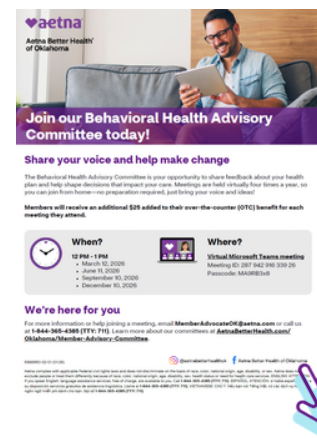
This summer we packed 34,000 items into 2,750 hygiene kits and 1,000 menstrual kits for members across the state.

This annual distribution partnership helps us fortify health care beyond the clinic and support whole person wellness.

[illegible]

December 3 from 12:00 – 1:00 PM

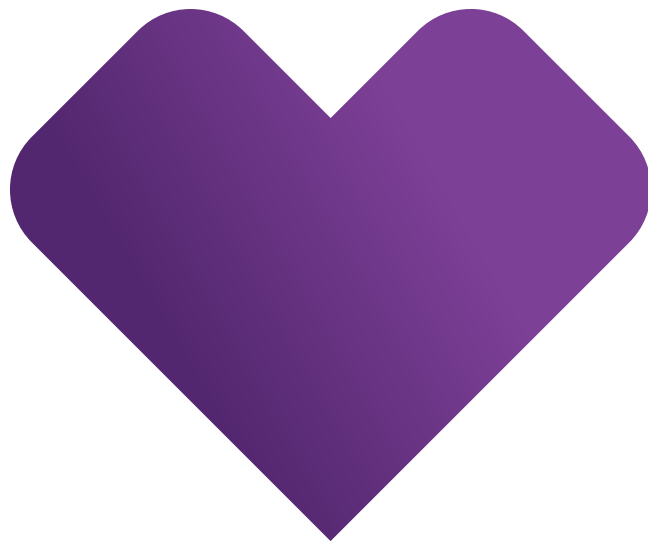
December 10 from 12:00 – 1:00 PM



Tribal advisory committee

October 8 from 12:00 – 1:00 PM





Thank you