AETNA BETTER HEALTH® OF PENNSYLVANIA
AETNA BETTER HEALTH® KIDS

# Provider Newsletter

FALL 2017

## URGENT PROVIDER NOTICE: Required enrollment of ordering, referring and prescribing providers

Effective January 1, 2018, as required by the Affordable Care Act (ACA) and the Department of Human Services (DHS), all providers, including those who order, refer or prescribe items or services for MA or CHIP beneficiaries, must be enrolled with DHS and have a valid PROMISe™ Identification Number (PROMISe ID). DHS uses the National Provider Identification (NPI) number submitted on claims to validate the enrollment of providers in the MA or CHIP Program.

We strongly encourage all MA and CHIP providers who order, refer or prescribe items or services for MA or CHIP beneficiaries and who have not yet registered, to enroll with the state as soon as possible. Many MA and CHIP providers have already done this. If you need to verify if you or an ordering, referring or prescribing provider are enrolled, you can access the DHS online portal.

**Note:** CHIP Only providers will not be able to validate their status via the online portal until November 2017.

Beginning January 1, 2018, claims will be denied if an ordering, referring or prescribing provider is not enrolled in the MA or CHIP Program.

### Please be advised of the following dates:

**October 1, 2017** – Aetna Better Health began issuing warning notices for claims submitted without an ordering, referring or prescribing provider or with a non-registered ordering, referring or prescribing provider.

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

## Want to know the latest?

If you want to stay on top of the latest updates for Aetna Better Health providers you can check out our provider home page at aetnabetterhealth.com/pennsylvania/providers and also click on the Notices tab on the left side of the page.

# Access & Availability Standards

We work with providers to outreach members concerning appointments for medically necessary care, preventative care, scheduled screenings and examinations. Contracted Aetna Better Health providers are responsible to:

- Adhere to the appointment availability standards listed on pages 2 and 3.
- Monitor the adequacy of their appointment processes.
- Reduce unnecessary Emergency Department visits.

We monitor network provider access and availability to ensure that the sufficiency of network meets the health care needs of our members for both primary care physicians (PCPs) and specialists, as appropriate. To monitor practionioners' Access and Availability Standards compliance, we:

- Complete Geo-mapping reports using industry-standard software and review at least annually the results of Geo-mapping reports to monitor compliance with the Access and Availability Standards.
- Review the annual results of the Consumer Assessment of Health Plans Study (CAHPS), a member satisfaction survey, to monitor compliance with our Access and Availability Standards.
- Routinely monitor member complaints.
- Routinely monitor after-hour telephone accessibility through member complaints and member and/or provider surveys, or through after-hour phone audits to ensure that the physician or an associate is available 24 hours per day, 7 days per week.

Our appointment availability standards reflect minimum requirements. We routinely monitor providers for compliance with these standards. Noncompliance may result in the initiation of a corrective action plan or further corrective actions.

| Condition | Members | Provider Types | Standards |
|---|---|---|---|
| Emergency | All | PCP or Specialist | Members must be seen immediately, or referred to an emergency facility. |
| Behavioral Emergency (CHIP only) | CHIP | PCP or Specialist | Appointments must be scheduled within 6 hours. |
| Urgent | All | PCP or Specialist | Appointments must be scheduled within 24 hours. |
| Behavioral Emergency (CHIP only) | CHIP | PCP or Specialist | Appointments must be scheduled within 48 hours. |
| Routine (Physical and CHIP Behavioral) | All | PCP | Appointments must be scheduled within 10 business days. Wait time less than 30 minutes. |
| | | All other specialty Pediatric general surgery | Appointments must be scheduled within 10 business days. |

| Condition | Members | Provider Types | Standards |
|---|---|---|---|
| Routine (Physical and CHIP Behavioral) | All | PCP | Appointments must be scheduled within 10 business days. Wait time less than 30 minutes. |
| | | Specialist:<br>– Dentist<br>– Dermatology<br>– Orthopedic surgery<br>– Otolaryngology<br>– Pediatric allergy and immunology<br>– Pediatric endocrinology<br>– Pediatric gastroenterology<br>– Pediatric general surgery<br>– Pediatric hematology<br>– Pediatric infectious disease<br>– Pediatric nephrology<br>– Pediatric neurology<br>– Pediatric oncology<br>– Pediatric pulmonology<br>– Pediatric rehab medicine<br>– Pediatric rheumatology<br>– Pediatric urology | Appointments must be scheduled within 15 business days. |
| | | All other specialty Pediatric general surgery | Appointments must be scheduled within 10 business days. |
| Health assessment | All | PCP | Appointments must be scheduled within 3 weeks of Enrollment |
| General physical examination | All | PCP | Appointments must be scheduled within 3 weeks of Enrollment |
| First physical examination | All | PCP | Appointments must be scheduled within 3 weeks of Enrollment |
| Initial appointment | HIV/AIDs members | PCP or Specialist | Appointments must be scheduled within 7 days of enrollment unless the member is already in active care with a PCP or Specialist |
| | SSI members | PCP or Specialist | Appointments must be scheduled within 45 days of enrollment unless the member is already in active care with a PCP or Specialist |
| Initial prenatal care appointment | Pregnant members | OB/GYN or Certified Nurse Midwife | |
| | First trimester | | Appointments must be scheduled within 10 business days of the member being identified as pregnant |
| | Second trimester | | Appointments must be scheduled 5 business days of member being identified |
| | Third trimester | | Appointments must be scheduled 4 business days of being identified |
| | High risk pregnancy | | Appointments must be scheduled within 24 hours of identification or immediately if an emergency exists |
| EPSDT screens | All under the age of 21 | PCP | Appointments must be scheduled within 45 days of enrollment unless the child is already under the care of a PCP and current with screens |

# Member rights & responsibilities

Aetna Better Health of Pennsylvania and Aetna Better Health Kids maintain policies and procedures that formally address a member's rights and responsibilities. The policies reflect federal and state laws as well as regulatory agency requirements.

We annually inform our members of their rights and responsibilities in the member handbook, member newsletter and other mailings. They are also posted within the For Members section on our website at aetnabetterhealth.com/pennsylvania/members.

We ensure that members can exercise their rights without adversely affecting treatment by participating providers. Member rights and responsibilities are monitored through our quality management process for tracking grievances and appeals as well as through member surveys. Issues are reviewed by our Service Improvement Committee and reported to the Quality Management Oversight Committee.

For additional information regarding member rights and responsibilities, visit our website or call your Provider Relations Representative at 1-866-638-1232.

# Know the signs of fraud, waste and abuse and how to report it

Please remember that it is your responsibility as a HealthChoices program provider (a requirement which can be subject to federal or state sanctions) to report suspected fraud, waste and abuse.

**Health care fraud** means getting benefits or services that are not approved. Fraud can be committed by a provider, member, or employee. An example of provider fraud is billing for services, procedures and/or supplies that were not provided. Suspected use of altered or stolen prescription pads is an example of member fraud.

**Abuse** is doing something that results in needless costs. Abuse is treatment or services that do not agree with the diagnosis. Hostile or abusive behavior in a doctor's office or hospital is also abuse. An example of abuse would be a member asking the transportation driver to take him or her to an unapproved location.

**Waste** goes beyond fraud and abuse. Most waste does not involve a violation of law. It relates primarily to mismanagement, inappropriate actions and inadequate oversight. Some examples are inefficient claims processing and health care administration, preventable hospital readmissions, unnecessary Emergency Department (ED) visits and hospital-acquired infections/conditions.

### Report fraud, waste, or abuse in any of these ways:

- Call the Aetna Better Health of Pennsylvania compliance hotline toll-free at 1-800-333-0119.
- Call the Medical Assistance provider compliance hotline at 1-866-379-8477.
- Use the fraud and abuse reporting form on our website and submit online.
  - Go to aetnabetterhealth.com/pa.
  - Click on "Fraud & Abuse" located in the upper right corner.

Please provide enough information to help us investigate, including:

- Name of the member or provider you suspect of fraud
- Member's ID number
- Name of doctor, hospital or other health care provider
- Date of service
- Description of the acts you suspect involve fraud or abuse.

# Vaccines for Children (VFC) Billing Guide and FAQ

This billing guide and frequently asked questions (FAQ) is meant to assist our providers with common billing and reimbursement questions related to VFC.

1. **How should VFC services be billed?**
   Submit both the appropriate vaccine CPT code(s) along with any applicable administration code.
2. **How should VFC services be billed with an EPSDT encounter?**
   Submit both the appropriate vaccine CPT code(s) along with any applicable administration code. When billing the well child evaluation and management (E&M) code, informational modifiers EP and 25 are required to avoid an incidental denial edit on the E&M or the vaccine administration fee.
3. **Can multiple units be billed on the vaccine administration code?**
   Yes, multiple units can be billed. The number of multiple units must match the number of vaccine codes listed on the claim. Administration codes should be billed on one line with multiple units wherever possible to avoid duplicate denials.
4. **Should a dollar amount be billed with the vaccine CPT code?**
   Vaccine codes can be billed with a $0.00 fee or with a dollar amount. The vaccine code will adjudicate a $0.00 fee.
5. **Are National Drug Codes (NDC) required to be billed with the vaccine code?**
   No. NDCs are not required when submitting a vaccine for children.
6. **Are the VFC billing requirements applicable to CHIP program?**
   No, VFC does not apply to the CHIP program.
7. **If my previously submitted billed claims did not contain both the vaccine CPT code(s) along with any applicable administration code, what will occur?**
   Aetna Better Health will retract any incorrectly billed claims 30 days after the date of the provider communication and the date of this FAQ.
8. **Will I have an opportunity to rebill a corrected claim before the retraction occurs?**
   Yes, a corrected claim can be resubmitted prior to the retraction project.
9. **How should a corrected claim be submitted?**
   If rebilling an electronic claim, resubmit with a Resubmission Code in box 22 of the CMS-1500 form. If rebilling a paper claim, the CMS-1500 form should be stamped or written “Corrected Claim.”
10. **What are the time limits for filing a corrected claim?**
    - We require providers to submit claims within 180 days from the date of service unless otherwise specified within the provider contract.
    - Aetna Better Health must receive claim resubmissions no later than 365 days from the date of the provider Remittance Advice or Explanation of Benefits if the initial submission was within the 180 day time period, whether or not the claim was denied on the first submission.
    - You must submit provider appeals within 60 days from the date of notification of claim denial unless otherwise specified within the provider contract.

**Please note:** An inquiry do**es not extend or suspend** the timely filing requirement.