Aetna Better Health® Kids

Provider Manual

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

aetna®
Aetna Better Health® Kids
A CHIP Health Plan

86.05.804.1-PA (Rev 08/2024)

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Chapter 1

Introduction

Healthier Happens Together.

At Aetna Better Health® Kids, we are committed to ensuring a positive provider experience and a mutually beneficial relationship by supporting our valued providers as we work together to achieve positive health outcomes for your patient, our member.

Aetna Better Health Kids is a managed care organization serving the Commonwealth for the Children's Health Insurance Program (CHIP). The Commonwealth of Pennsylvania Department of Human Services (DHS) offers this program to Children's Health Insurance Program (CHIP) members.

Our ability to serve our members well depends on the quality of our provider network. As part of our network, you provide the children of Pennsylvania with quality health care and access to medically necessary services. We're grateful for your participation and we're confident this manual will serve as a helpful resource to you and your office staff.

Use this manual as an extension of your participating Provider Agreement, a communication tool and reference guide. While the provider manual contains basic information about the Commonwealth of Pennsylvania Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS), make sure you fully understand and apply DHS and CMS requirements when administering covered services; refer to **DHS.pa.gov** and **cms.hhs.gov**. You can also find information about the CHIP program at **chipcoverspakids.com**.

Our team is in your community. Our Provider Engagement representatives are dedicated liaisons who are here to help you. In addition, our Community Outreach team works with local organizations to build health awareness, promote our exclusive value added Enhanced Benefits and connect our members to care. And with a phone call to our provider support staff, your office will receive quick and courteous response to questions or concerns you may have.

Sincerely,

Jerry Mammano
Interim CEO
Aetna Better Health Kids

About Aetna Better Health Kids

Aetna Better Health Kids is a wholly owned subsidiary of Aetna Health, Inc., which is a wholly owned subsidiary of Aetna Inc. We combine the financial and administrative strength of Aetna with the depth of Medicaid experience and expertise of our Aetna Medicaid Business Unit. Aetna has more than 150 years of experience in meeting individuals' health care needs.

Aetna brings 30 years of experience managing and serving the CHIP enrollees in the Commonwealth of Pennsylvania since CHIP began here in 1993. Visit aetnabetterhealthkidspa.com for more information about us.

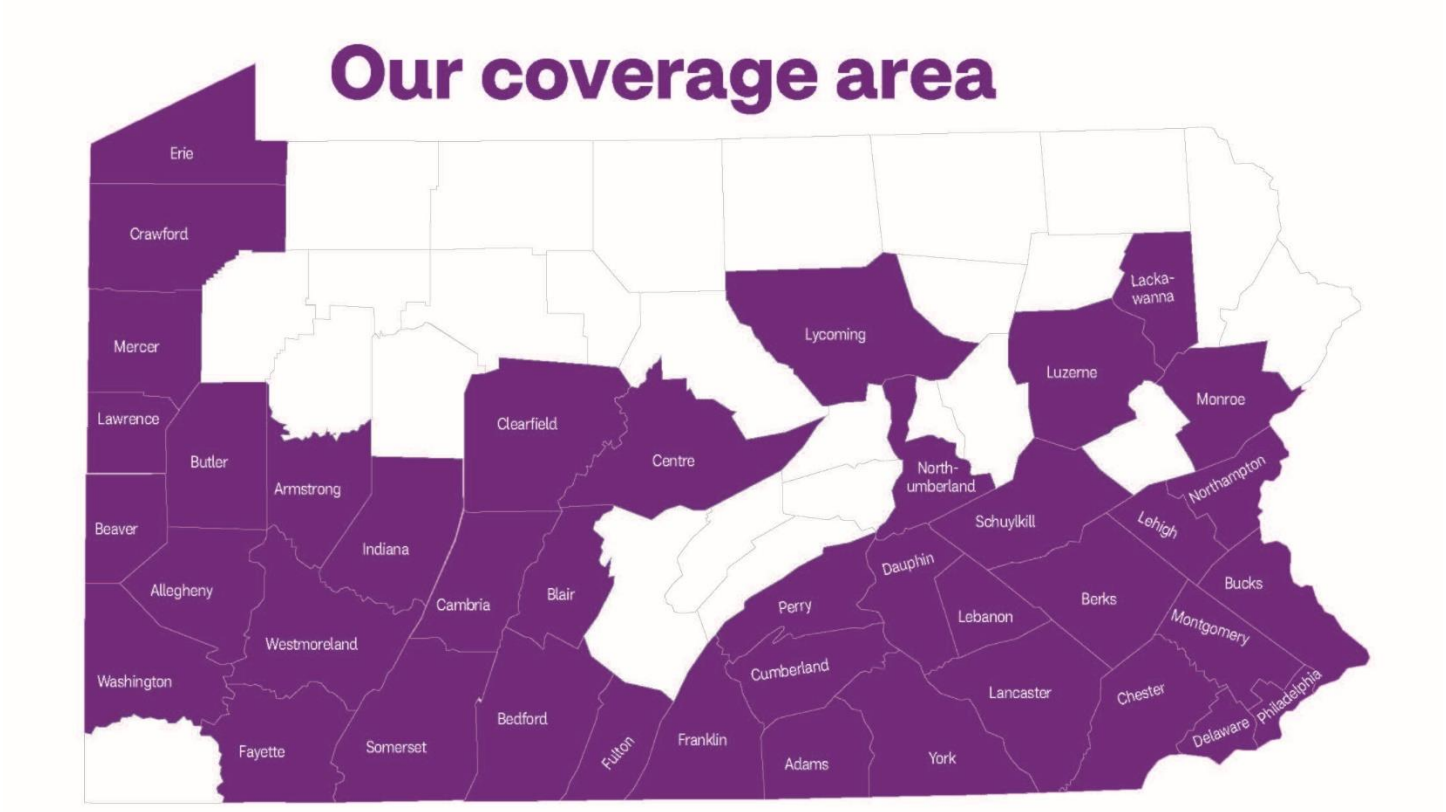
About the Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is a state and federally funded program offering health insurance to all uninsured children and teens, up to age 19, who are not eligible for or enrolled in Medical Assistance. CHIP is brought to you by Aetna Better Health Kids and we are committed to providing quality care to all eligible uninsured children and teens in our service area. Effective December 15, 2015, the administration of CHIP was moved from the Pennsylvania Insurance Department to the Department of Human Services.

Through CHIP, children and teens are able to receive high-quality medical care from a wide network of providers. Services include doctor's office visits, preventive care, prescription drugs, dental care, vision care, diagnostic testing and more.

Aetna Better Health Kids offers CHIP coverage in the following Pennsylvania counties:

Adams
Allegheny
Armstrong
Bedford
Berks
Beaver
Blair
Bucks
Butler
Cambria
Centre
Chester
Clearfield
Crawford
Cumberland
Dauphin
Delaware
Erie
Fayette
Franklin
Fulton
Indiana
Lackawanna
Lancaster
Lawrence
Lebanon
Lehigh
Luzerne
Lycoming
Mercer
Monroe
Montgomery
Northampton
Northumberland
Perry
Philadelphia
Schuylkill
Somerset
Washington
West Moreland
York



Aetna Better Health Kids Subcontractors

Dental

SKYGEN USA

skygenusa.com

Authorizations
SKYGEN USA
PO Box 628, Milwaukee, WI 53201
Claims
SKYGEN USA
PO Box 1352, Milwaukee, WI 53201
Corrected Claims
SKYGEN USA
PO Box 541, Milwaukee, WI 53201

Member Services
CHIP: **1-800-822-2447**
Provider Services
1-800-508-4892
or
1-866-638-1232

SKYGEN USA provides dental services to CHIP members under the Aetna Better Health Kids contract.

Vision

Superior Vision
superiorvision.com

Mailing and Claims
Superior Vision
939 Elkridge Landing Rd.
Suite 200
Linthicum, MD 21090

Member Services
1-800-428-8789
Provider Services
1-866-819-4298

Superior Vision provides vision services to CHIP members under the Aetna Better Health Kids contract.

Pharmacy

CVS caremark™

For questions about pharmacy, call Aetna Better Health Member Services at **1-800-822-2447**.

Language Line Services (Interpretation Services)

Aetna Better Health Kids provides telephonic interpretive services in more than 175 languages. Personal interpreters can also be arranged in advance. All interpreter services are provided free of charge for Aetna Better Health Kids members. CHIP members can call **1-800-385-4104** for language line services.

Chapter 2

Contact information

We are always responsive to your needs.

This section includes resources to better serve our members, enhance our provider relationships and increase office efficiency.

Key contact information
Aetna Better Health Kids Administrative Office:
1425 Union Meeting Road
Blue Bell, PA 19422
1-866-638-1232
AetnaBetterHealth.com/Pennsylvania

Submit paper claims to:
Aetna Better Health Kids Claims Submissions
Aetna Better Health Kids
P.O. Box 982973
El Paso, TX 79998-2973

Aetna Better Health Kids Department	Contact	Hours of Operation (ET) Excluding state holidays
Member Services Eligibility Verification Complaints & Grievances	**1-800-822-2447**	8 AM - 5 PM, Monday - Friday
Medical prior authorization **UM After Hours:**	**P: 1-800-822-2447 F: 1-877-363-8120**	8 AM - 5 PM, Monday - Friday
Pharmacy prior authorization	**P: 1-866-638-1232**	8 AM - 5 PM, Monday - Friday
Pharmacy prior authorization	**F: 1-877-309-8077**	24 hours a day, 7 days a week
Provider Relations	**1-866-638-1232**	8 AM - 5 PM, Monday - Friday
Claim Inquiry Claim Review	**1-866-638-1232**	8 AM - 5 PM, Monday - Friday
Special Needs Unit	**1-855-346-9828**	8 AM - 5 PM, Monday - Friday
Peer to Peer Review Request	**1-833-459-1998**	8 AM - 5 PM, Monday - Friday

Website

Our health plan website, **AetnaBetterHealth.com/Pennsylvania**, is available 24 hours a day, 7 days a week, for easy access to forms, resources, tools and more. Registered providers can also access our **Availity secure web portal** via our website at **AetnaBetterHealth.com/Pennsylvania/providers/portal.** The Availity secure web portal allows Aetna Better Health Kids to communicate health care information directly to practitioners and providers. Eligibility and claims information can also be accessed via the portal.

Additional information regarding the website and secure web portal is included in Chapter 3: Provider Resources and Responsibilities.

Important Contacts to Know

Contact Information/ Help for CHIP Providers	Contact	Hours of Operation Eastern Standard Time (EST) (Excluding state holidays)
Child Line	**1-800-932-0313**	24 hours a day, 7 days a week
ABH Kids Behavioral Health Crisis Line	**1-855-346-9828**	Monday-Sunday, 24 hours 7 days a week
CHIP Provider Compliance Hotline (formerly Fraud and Abuse Hotline)	**1-866-379-8477**	9 AM-4 PM, Monday-Friday
Provider Inquiry Hotline	**1-800-537-8862**	8 AM-4:30 PM, Monday-Friday
Medical Assistance Provider Enrollment: Applications In Process (Inpatient and Outpatient Providers)	**1-800-537-8862**	8:30 AM-12 PM, 1–3:30 PM, Monday-Friday
Outpatient Providers Practitioner Unit	**1-800-537-8862**	8 AM-4:30 PM, Monday-Friday
Pharmacy Services	**1-800-537-8862**	8 AM-4:30 PM, Monday-Friday

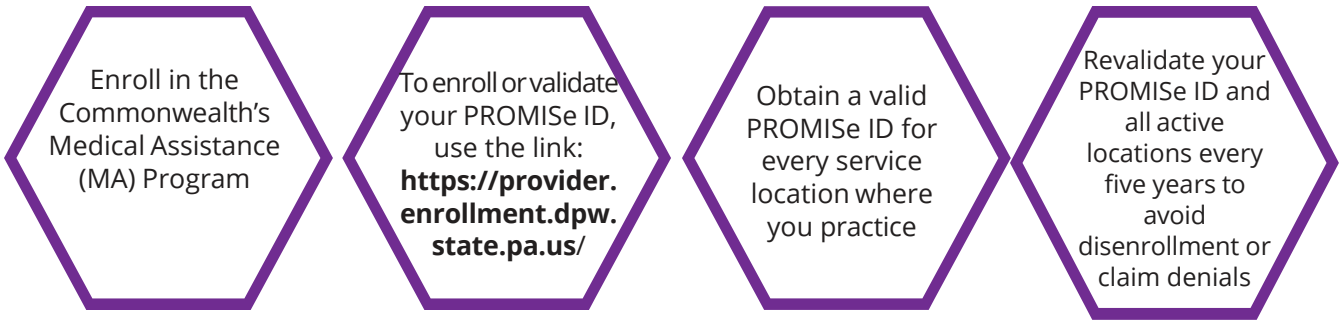
Chapter 3

Provider resources and responsibilities overview

This section outlines general provider responsibilities; additional responsibilities are included throughout this manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws.

Provider enrollment

Providers that render services to Aetna Better Health Kids members, including ordering, rendering and prescribing providers are required comply with the following state-mandated requirements:



CHIP providers who are contracted with Aetna Better Health Kids and rendering services to CHIP beneficiaries, yet not enrolled for all service locations, need to enroll immediately. Provider responsibilities include, but are not limited to, the responsibilities outlined in the provider contract and in this manual. For more information regarding PROMISe enrollment, please visit the Aetna Better Health Kids or DHS website.

Adherence to the Provider Agreement

Providers are contractually obligated to adhere to and comply with all terms of the Provider Agreement with Aetna Better Health Kids, including all requirements in this manual. We may or may not specifically communicate such terms in forms other than the Provider Agreement and this manual. Aetna Better Health Kids and all contracted network providers must comply with all governing federal and state requirements.

Documentation

Providers must document and maintain in the member's medical record all office visits, referrals, contacts, patient education, family planning counseling, and follow-up with members, including referrals for behavioral health and dental services.

Where applicable and required by regulatory agencies, providers must make all medical records available. Notations regarding follow-up of canceled and missed appointments should also be evident. Records must be signed, dated and legible.

We'll conduct routine audits of medical records to ensure that documentation meets standard requirements.

Providers must supply copies of records within 14 days of the receipt of a request, where practicable and in no event later than the date required by any applicable law, regulatory authority or government agency with jurisdiction over Aetna Better Health Kid's operations (a "Government Sponsor"). Except as required by applicable state or federal law, Aetna Better Health Kids (including Aetna Better Health Kid's authorized designee), Government Sponsors and Aetna Better Health Kids members shall not be required to reimburse providers for expenses related to providing copies of patient records or documents.

Primary care practitioner (PCP) responsibilities

A primary care practitioner (PCP) is a specific physician, physician group or certified registered nurse practitioner (CRNP) operating under the scope of their licensure. The primary role of the PCP is to help manage the health care of members.

We can assist members in establishing a source of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. Every member chooses or is assigned to a PCP. We work with PCPs to ensure members receive timely, medically necessary and appropriate services.

The PCP is the member's initial and most important point of contact regarding health care needs. The PCP is responsible for:

- Maintaining continuity of care on behalf of the CHIP member
- Locating, coordinating and monitoring other medical care and rehabilitative services
- Supervising, prescribing and providing primary care services
- Providing primary and preventive care
- Acting as the member's advocate by providing, recommending and arranging for care
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DHS data specifications
- Maintaining continuity of each member's health care, including as appropriate, transitioning young adult members from pediatric to adult providers beginning no later than the member's 18th birthday, if PCP does not accept patients over the age of 18.

- Making referrals for specialty care and other medically necessary services both in-and out-of-plan
- Maintaining a current medical record for the member, including documentation of all services provided to the member by the PCP as well as any specialty or referral services
- Using sign language interpreters for those who are deaf or hard of hearing, and oral interpreters for those with limited English proficiency (LEP) when needed by the member. Services are free of charge to the member

Preventive services
The PCP is responsible for providing appropriate preventive care for eligible members. These preventive services include, but are not limited to:

- Age-appropriate immunizations
- Disease risk assessment
- Age-appropriate physical examinations
- Well-child care
- Bright Futures evaluations and screenings

Members who are women may:

- Go to any Aetna Better Health Kids contracted obstetrician/gynecologist (OB/GYN) for all women's care services. Neither a referral nor prior authorization is required
- Receive family planning services from an in- or out-of-network provider without a referral or prior authorization

Member assignment to a practice

Upon enrollment, members may choose a PCP for themselves and any other eligible family members. We'll automatically assign a contracted PCP for any member who does not select a PCP within 10 calendar days of enrollment. If the member is dissatisfied with the auto-selection assignment or wishes to change their PCP for any reason, they can choose an alternative participating PCP at any time by calling Member Services at **1-800-822-2447**. We'll grant the request and process the PCP change in a timely manner.

We manage each PCP's panel to automatically stop accepting new members after the limit of 1,000 members has been reached. If the PCP/PCP site employs certified registered nurse practitioners then the provider/provider site will be permitted to add an additional 1,000 members per provider to the panel. We require providers to attest to their panel size annually.

PCPs who wish to close their panel must submit a written request to Provider Relations. Panel closure requests will be reviewed by the plan and a decision will be communicated to you by your Network Relations Manager

A provider can request the change of a member's PCP if the provider is having difficulty getting the member to comply with their care plan or there are other significant conflicts. Call Provider Relations at **1-866-638-1232** for more information.

Non-adherent members

It's important to manage your patients' care in a way that motivates them to comply with treatment plans and attend scheduled appointments. Make every effort to do this rather than transferring non-adherent patients to another provider. If you have non-adherent patients who aren't responding to reasonable efforts, you can refer them to our Care Management team. Just call our Special Needs Unit at **1-855-346-9828**.

Maintain accurate provider rosters, service locations and contact information

Network providers who have demographic changes should send them to **paabhproviderrelationsmailbox@aetna.com** You will receive a case number directly once this is submitted, that you can use as a reference for any follow up.

Providers may view and verify their demographic data at any time using the "real-time" provider network directory at **AetnaBetterHealth.com/PA/ find-provider.**

REMINDER: Providers must have a PROMISe ID at each of their service locations.

Access to specialty care

The PCP is responsible for initiating, coordinating and documenting referrals to specialists within Aetna Better Health Kids, including our behavioral health network providers and dentists. Members may request a second opinion from providers within the contracted network. If there is not a second provider with the same specialty in the network, members can request a second opinion from a provider out of network at no charge to the member with prior authorization.

When members need a referral to another provider, specialists must coordinate with the provider accordingly. Upon request, you must share records with the appropriate providers and forward at no cost to the plan member or other providers.

Specialists as PCPs

Members may qualify to select a specialist to act as their PCP if they have a disease or condition that is life-threatening, degenerative or disabling. Providers credentialed as specialists and approved to act as PCPs must meet all standards for credentialed PCPs and specialists. The specialist as a PCP must agree to provide or arrange for all primary care and routine preventive care consistent with our preventive care guidelines. They must also provide the specialty medical services consistent with the member's "special need" in accordance with our standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist acting as a PCP also must have admitting privileges at a hospital in our network.

PCPs are responsible for initiating and coordinating member referrals for medically necessary services beyond the scope of their contract of practice. In addition, PCPs and specialists must monitor the progress of the referred member's care, and specialists must see that members are returned to the PCP's care as soon as medically appropriate.

School - based services

School districts often provide an array of medically necessary health services performed by licensed professionals that may include, but are not limited to, immunizations, well-childcare and screening examinations. Our provider relations team or Special Needs Unit can assist you in finding services in your area.

Behavioral health services for CHIP members

CHIP members are eligible for behavioral health services through Aetna Better Health Kids. The provider is responsible for arranging medically necessary Behavioral Health Services by appropriate referrals to a participating behavioral health provider for CHIP members, in accordance with the specifications of the Provider Agreement.

Some members diagnosed with severe mental illness or severe emotional disturbance (e.g., schizophrenia or autism spectrum disorder) that significantly affects a child's behavioral health may be eligible for a broader range of services. Call Member Services at **1-800-822-2447** if you have questions about your patient's eligibility for certain mental health services. CHIP covers the following benefits/services:

- Inpatient psychiatric hospital services, except when provided in a state mental hospital
- Inpatient drug and alcohol detoxification
- Psychiatric partial hospitalization services
- Inpatient drug and alcohol rehabilitation
- Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol dependence/addiction
- Emergency department evaluations for voluntary and involuntary commitments pursuant to the Mental Health Procedures Act of 1976, 50 P.S. 7101 et seq

- Psychiatric outpatient clinic services, licensed psychologist and psychiatrist services
- Behavioral health rehabilitation services (BHRS) for individuals under the age of 19 with psychiatric, substance abuse or mental retardation disorders
- Residential treatment services for individuals under the age of 19 whether treatment is provided in facilities with or without Joint Commission for the Accreditation for Healthcare Organizations (JCAHO) accreditation
- Outpatient drug and alcohol services, including methadone maintenance clinics
- Methadone when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services provider
- Laboratory studies ordered by behavioral health physicians and clozapine support services
- Crisis intervention with in-home capability
- Targeted mental health care management (intensive care management and resource coordination)

Except in the case of an emergency, Behavioral Health Services must be provided by participating providers and facilities, unless the use of a non-participating provider or facility is preauthorized
A referral from a PCP is not required to see a participating provider. A member (14 years of age or older) or a parent or guardian may self-refer.

If your patient needs self-referral assistance, needs help finding a participating provider in their area, has difficulty scheduling an appointment with a participating provider or has questions about behavioral health benefits, call Aetna Better Health Kids Member Services at **1-800-822-2447**. This number is also listed on your patient's Aetna Better Health Kids ID card.

Self-referrals /direct access

Members can access care without a referral from their PCP:

To self-refer, the member must receive the self-referred services from a network provider. Family planning services do not require prior authorization or referral. Members may access family planning services from any qualified provider. Family planning services include, but are not limited to:

- Health education
- Diagnostic screens, biopsies, cauterizations, cultures and assessments
- Breast and cervical cancer screening services
- Counseling necessary to make an informed choice about contraceptive methods
- Contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies and condoms (male and female)
- Norplant, injectables, intrauterine devices and other family planning procedures
- Long-acting reversible contraceptive services (LARC)
- Pregnancy testing

Members have direct access to OB/GYN services. They also have the right to select their own OB/GYN provider, which includes nurse midwives in our network. Members can receive maternity and gynecological care without prior approval from a PCP.

Care includes:

- Selection of a provider to give an annual well-woman gynecological visit
- Primary and preventive gynecology care
- Pap smear and referrals for diagnostic testing related to maternity and gynecological care and medically necessary follow-up care
- Perinatal and postpartum maternity care

In situations where a new (and pregnant) member already receives care from an out-of-network OB/GYN specialist at the time of enrollment, the member can continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery.

Appointment standards and follow-up

We work with providers to reach out to members concerning appointments for medically necessary care, preventive care and scheduled screenings and examinations. Contracted providers are responsible for adhering to the appointment availability standards. Providers must monitor the adequacy of their appointment processes and reduce unnecessary emergency department visits.

Condition	Members Types	Provider	Standards
Emergency	CHIP	PCP or specialist	Members must be seen immediately or referred to an emergency facility
Behavioral health emergency	CHIP	PCP or specialist	Immediately seen or referred to emergency room
Urgent	CHIP	PCP or specialist	Appointments must be scheduled within 24 hours
Behavioral health non-life threatening	CHIP	PCP or specialist	Appointments must be scheduled within 6 hours
Behavioral health urgent – no immediate danger	CHIP	PCP or specialist	Appointments must be scheduled within 48 hours
Routine (physical and CHIP behavioral)	CHIP	PCP	Appointments must be scheduled within 10 business days wait time less than 30 minutes

Specialists		Specialist: • Dentist • Dermatology • Orthopedic surgery • Otolaryngology • Pediatric allergy and immunology • Pediatric endocrinology • Pediatric gastroenterology • Pediatric general surgery • Pediatric hematology • Pediatric infectious disease • Pediatric nephrology • Pediatric neurology • Pediatric oncology • Pediatric pulmonology • Pediatric rehab medicine • Pediatric rheumatology • Pediatric urology	Appointments must be scheduled within 15 business days
All other specialty pediatric general surgery		Specialist	Appointments must be scheduled within 10 business days
Health assessment	CHIP	PCP	Appointments must be scheduled within 3 weeks of enrollment
General physical examination	CHIP	PCP	Appointments must be scheduled within 3 weeks of enrollment
First physical examination	CHIP	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

Condition	Members	Provider Types	Standards
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
Bright Futures screening	All under the age of 19	PCP	Appointments must be scheduled within 45 days (about 1 and a half months) of enrollment unless the child is already under the care of a PCP and current with screens

Hours of operation/appointment availability

Aetna Better Health Kids requires that providers' hours of operation offered to CHIP members be no less than those offered to commercial members. Appointment availability standards are shown above.

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.

PCP waiting times

Waiting time standards for PCPs require that members, on average, should not wait in a PCP office for more than 30 minutes for a routine care appointment. Under certain emergent circumstances – for example, if a physician encounters an unanticipated urgent visit or treats a member with a difficult medical need – the waiting time may be extended to one hour.

These access and appointment standards are physician contractual requirements. We monitor compliance with appointments and waiting time standards. We will work with providers to ensure that they meet these standards.

Appointment notification and follow-up

The PCP, dentist or specialist must conduct affirmative outreach to a member when that member misses an appointment. Providers must make three outreach attempts, taking the member's language and literacy capabilities into consideration when making the outreach attempt. At least one attempt must be a follow-up telephone call. You must record the date and type of outreach attempt in the member's medical record.

Communication with the enrollee may include, but is not limited to:

- Written attempts
- Telephone calls
- Home visits

Examinations to determine abuse or neglect

When the County Children and Youth Agency system notifies us of a potential case of child neglect and/or abuse of a CHIP member, we work with the Agency and the PCP to ensure that the enrollee receives timely physical examinations for the abuse or neglect, in accordance with the Child Protective Services Law, 23 Pa . C. S . 6301 et seq. and department regulations.

If the PCP determines that the enrollee needs a mental health assessment, the PCP must inform the member or the County Children Youth Agency representative of how to access mental health services. They must also coordinate access to these services, when necessary.

In addition to conducting physical examinations, providers are legally required to proactively report suspected abuse and/or neglect of MA or CHIP enrollees. Providers can report abuse to the DHS Child Line at **1-800-932-0313 (TDD: 1-866-872-1677)**.

The Child Line accepts calls from the public and professional sources 24 hours a day, 7 days a week. The Child Line also provides information, counseling and referral services for families and children to ensure the safety and well-being of the children of Pennsylvania.

Professionals who have reasonable cause to suspect that a child has been abused are required to file a report. The individual may remain anonymous. Each call to the Child Line is answered by a trained intake specialist who will interview the caller to determine the most appropriate course of action.
Actions include:

- Forwarding a report to a county agency for investigation as child abuse or general protective services
- Forwarding a report directly to law enforcement officials
- Referring the caller to local social services (such as counseling, financial aid and legal services)

For more information on how to help children and families, visit the Child Welfare Services section of the DHS website at **keepkidssafe.pa.gov**.

Americans with Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a physician's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity
- Denial of the benefits of services, programs or activities of a public entity
- Discrimination by any such entity

Physicians should ensure that their offices are as accessible as possible to persons with disabilities. They should also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. We offer sign language and over-the-phone interpreter services at no cost to the provider or the member. Call Provider Relations at **1-866-638-1232** for more information.

Member education

Providers are responsible for educating members about:

- Their unique health care needs, health status, medical care or treatment options including any alternative treatment that may be self-administered
- The importance of physical examinations
- Potential treatment options, side effects, management of symptoms, disease prevention and the importance of regular health maintenance
- The member's right to choose the final course of action among clinically acceptable options
- How to access emergency and urgent care providers

Urgent care/emergency care

Urgent care

We are focused on reducing unnecessary emergency department visits. As such, we continually educate our members that their healthcare needs are best served by their personal physician – their medical home. We remind them about the importance of scheduling an annual visit with their PCP and that their PCP is someone who gets to know them and their specific situation well. We acknowledge the quality health care services our providers give our members during regular office hours. However, the incidence of members seeking non-emergency services after hours continues to grow, often resulting in medically unnecessary trips to hospital emergency rooms.

Aetna Better Health Kids encourages members to seek treatment at urgent care centers, after-hours and walk-in centers in our network as an alternative to using an emergency department.

These facilities can provide treatment for most mild to moderately acute conditions. They're typically open when practitioners' offices are closed or when members cannot wait for an appointment.
You should make your patients aware of the proper utilization of the PCP office and urgent care facilities outside of your office hours in lieu of hospital emergency departments.

You can refer patients to an urgent care facility in our network if you cannot see the patient immediately. You can find a complete list of centers on our website at **AetnaBetterHealth.com/Pennsylvania**.

In addition to our own network of urgent care centers, we have written policies and procedures requiring PCPs to offer after-hours care or on-call arrangements with qualified providers 24 hours a day, 7 days a week. This helps ensure that members with emergency or urgent care needs can receive timely treatment. Our policies and procedures detail how providers and members can make contact to receive instructions for treatment.
Providers offering after-hours care are not permitted to sign off to the emergency department or to use an answering machine in lieu of a live response.

Emergency care
If a member requires emergency services, they should immediately be sent to the nearest emergency department or urgent care center. Members can go to the nearest emergency department or urgent care without prior authorization.

Post-stabilization services

Aetna Better Health Kids covers post-stabilization services under the following circumstances without prior authorization, whether or not the services are provided by a network provider. Services are administered to maintain an enrollee's stabilized condition within one hour of provider's request for pre-approval of Post-stabilization services.

- Services have been pre-approved by an Aetna Better Health Kids Utilization Management care manager.
- Services are administered to maintain, improve, or resolve an enrollee's stabilized condition when the MCO does not respond to a pre-approval request within one hour, when the provider cannot reach Aetna Better Health Kids, or when Aetna Better Health Kids and the treating physician cannot reach agreement concerning an enrollee's care and, an Aetna Better Health Kids physician is not available for consultation.

Aetna Better Health Kids' financial responsibility for Post-stabilization services that have not been pre-approved ends when: a network physician with privileges at the treating hospital assumes responsibility for the enrollee's care; a network physician assumes responsibility for the enrollee's care through transfer.
Aetna Better Health Kid's financial responsibility for post-stabilization services without pre-approval ends when:

- a network physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- a network physician assumes responsibility for the enrollee's care through transfer;
- Aetna Better Health Kids and treating physician reach agreement as to the enrollee's care; and upon the enrollee's discharge.

Provider administrative responsibilities

Enrollment with the Pennsylvania Department of Human Services (DHS)
In order to participate with Aetna Better Health Kids, all providers must first enroll with the DHS and have a valid Medicaid (PROMISe) ID. To be eligible to enroll:

- Practitioners in Pennsylvania must be licensed and currently registered by the appropriate state agency
- Out-of-state practitioners must be licensed and currently registered by the appropriate agency in their state, and they must provide documentation that they participate in that state's Medicaid program
- All other providers must be approved, licensed, issued a permit or certified by the appropriate state agency and, if applicable, certified under Medicare

To enroll, providers must complete a base provider enrollment form and submit any applicable addenda documents dependent on the provider type. To access enrollment forms and to find other information about how to register with the commonwealth, visit **provider/promise/enrollmentinformation/S_001994**.

The Affordable Care Act (ACA) requires states to revalidate the enrollment of Medicaid providers every five years. Aetna Better Health Kids follows DHS requirements that participating providers revalidate their PROMISe ID and service locations every five years. **Failure to complete the revalidation process will result in nonpayment of claims and possible termination with Aetna Better Health Kids**.

Provider screening of employees and contractors against exclusion databases

In accordance with the requirement stated in 42 CFR §455 .436 and MAB #99-11-05, providers must screen employees against exclusion databases. Providers should:

- Develop policies and procedures for screening of all employees and contractors (both individuals and entities)
    - At time of hire or contracting
    - On an ongoing, monthly basis
- Determine if they have been excluded from participation in federal health care programs, using the following databases:
    - Pennsylvania Medicheck List
    - List of Excluded Individuals/Entities (LEIE)
    - Excluded Parties List System (EPLS)
    - National Plan and Provider Enumeration System (NPPES)
    - Social Security Administration's Death Master File (SSA)

If an employee is discovered to be excluded, immediately self-report to the Bureau of Program Integrity.

Member eligibility verification

The provider is responsible for verifying a member's current enrollment status before providing care by:

- Understanding that we will not reimburse for services provided to patients who are not enrolled with Aetna Better Health Kids
- Calling Provider Services at **1-866-638-1232** or by accessing our Availity secure provider portal at **AetnaBetterHealthkidspa.com** to verify member eligibility

Refer to Chapter 5: Eligibility and enrollment for further details regarding eligibility verification. Providers are responsible for complying with all administrative procedures.

Prior authorization for services and referrals

A PCP or an independently licensed health care professional who participates in the CHIP Program must request prior authorization for certain medically necessary services. Unauthorized services will not be reimbursed. Please note that authorization is not a guarantee of payment. Call your Provider Relations Representative for further information. All out-of-network services must go through Prior Authorization. Providers are strongly encouraged to submit prior authorization requests via the secure **Availity web portal**. Prior authorization requests can also be submitted by fax. Routine prior authorization requests will not be accepted by telephone.

You can find a current list of services that require prior authorization via our secure provider web portal by clicking on the "Prior Authorization" tab at **AetnaBetterHealth.com/PA/ providers/guidelines**.

Practitioner and provider requirements

Generally, a member's PCP or treating practitioner/provider is responsible for initiating and coordinating a request for authorization; however, specialists and other practitioners/providers who use our secure web portal may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting practitioner or provider is responsible for complying with prior authorization requirements, policies and request procedures along with obtaining an authorization number to facilitate reimbursement of claims.

A prior authorization request must include the following:

- Current, applicable codes:
    - Current Procedural Terminology (CPT)
    - International Classification of Diseases, 10th Edition (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 practitioner or treating practitioner's name, address, phone and fax number
- Name, address, phone and fax number and signature, if applicable, of the referring care provider or practitioner
- Name, address, phone and fax number of the consulting provider or practitioner
- Problem/diagnosis, including the ICD-10 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.

Medical records request

Aetna Better Health Kids may request medical records from the provider when researching complaints, grievances and requests for a DHS Fair Hearing or addressing quality of care issues. It's important that you respond to these requests promptly. You can act on behalf of a member with written consent. Refer to Chapter 14: Member complaints, grievances and DHS Fair Hearings for more information about member complaints, grievances and requests for a DHS Fair Hearings.

Health care providers must supply copies of records within 14 days of the receipt of a request, where practicable and in no event later than the date required by any applicable law, regulatory authority or government agency with jurisdiction over our operations (a "Government Sponsor"). Except as required by applicable state or federal law, Aetna Better Health (including Aetna Better Health Kids' authorized designee), Government Sponsors and Aetna Better Health Kids members shall not be required to reimburse health care providers for expenses related to providing copies of patient records or documents.

Submitting medical records

When submitting medical records solicited by Aetna Better Health Kids, please include a cover sheet with the following information:

- Provider information (NPI or provider ID)
- Patient information (name, DOB, health plan identification number)
- Applicable claim information (claim number and date of service) The medical records can be submitted via:
    - Secure Availity web portal accessible via our website, or
    - Mail to Aetna Better Health, P.O. Box 62198, Phoenix, AZ 85082-2198

For information on submitting medical records and supporting documentation via the secure web portal, please review the step-by-step guide for adding attachments on our website under Portal (secure web portal). Our Provider Relations team is also available to assist. Please call **1-866-638-1232**.

Compliance with federal regulations

You must comply with regulatory requirements under Title 55, Chapter 1101 of the Pennsylvania Public Welfare Code. To access the most current regulatory requirements, review the Medical Assistance Manual, Chapter 1101 (General Provisions) online at **pacode.com/secure/data/055/055toc.html**.
All providers contracting with Aetna Better Health Kids must adhere to all federal and state rules and regulations. To access more information about the commonwealth's regulations, guides and handbooks, visit the provider information section of the DHS website at **www.dhs.pa.gov/docs/For-Providers/Pages/default.aspx**.

If you want a hard copy of these regulatory requirements, call Provider Relations at **1-866-638-1232**. To ensure that you have the most updated version of these regulations, visit the DHS website.

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. Culture competency is also the ability to translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members should receive covered services regardless of race, ethnicity, national origin, religion, gender, age, gender identification, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.

We expect contracted providers to treat all members with dignity and respect as required by federal law. 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.

Cultural competency training

We've developed effective provider education programs that:

- Encourage respect for diversity.
- Foster skills that facilitate communication within different cultural groups.
- Explain the relationship between cultural competency and health outcomes.

These programs provide information related to our members' diverse backgrounds. They also address the cultural, racial and linguistic challenges members face in navigating the various components of our health care system.

We have also developed and implemented methods and techniques that are useful for both the member and provider in responding to these challenges.

You can directly contact our Special Needs Unit at **1-855-346-9828** to discuss diversity practices. We'll help you respond to the diverse needs of our members by providing training and information through our Quality Practice Liaisons or Network Relations Consultants.

Our Provider Liaisons schedule regular visits to in-network provider offices to discuss various topics, including cultural competency and the specific needs of our members.

In addition, we promote and encourage regularly scheduled and ad hoc interaction between Medical Management and our network providers. These interactions present a valuable opportunity for our Quality Practice Liaisons to discuss and help resolve specific cultural, racial or linguistic challenges that may arise.

Most importantly, to the extent possible, we strive to meet member needs by developing and maintaining a provider network that mirrors the racial, ethnic and linguistic composition of our members.

Provider education on cultural competency is required. Our Network Relations Consultants will conduct initial cultural competency training during provider orientation meetings. In addition, providers are encouraged to access the U .S . Department of Health and Human Services website course series online. This course is designed to help you:

- Improve the quality of health care services provided to diverse populations
- Gain more awareness of your own cultural beliefs and be more responsive to those of your patients
- Develop changed beliefs and positive attitudes that can translate into better health care delivery

To access the online cultural competency course, please visit **https://thinkculturalhealth.hhs.gov/education.**

To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ Program. Aetna Better Health Kids supports the Ask Me 3 ™ Program, believing it to be an effective tool to improve health communication between members and providers. Link:
https://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx

Limited English proficiency and alternate methods of communication
Our policies conform to the federal government's limited English proficiency (LEP) guidelines. These guidelines state that programs and activities normally provided in English must be accessible to LEP persons at no cost. Services must be provided in a culturally effective manner to all members, including those:

- With LEP or reading skills
- With diverse cultural and ethnic backgrounds
- Who are deaf or hard of hearing
- Who are homeless
- With physical and mental disabilities

To ensure members' privacy, you must not interview members about medical or financial issues within hearing range of other patients.

Compliance with federal and state requirements
We make certain that LEP members and members who are deaf or hard of hearing have access to health care and benefits by providing a range of language assistance services at no cost to the member or the provider. We offer translation and interpreter services including American Sign Language to providers and members free of charge.

We strongly encourage using professional interpreters, rather than family or friends, as the member may wish to keep their state of health and treatment plan private. In addition, using a family member or friend doesn't ensure an accurate translation and could lead to multiple office visits.

We offer interpretation services to CHIP members through the Language Line®. The Language Line employs trained and qualified professionals who are well versed in medical terminology. They provide telephonic interpretation in more than 175 languages. You can make arrangements in advance for personal interpreters.

Call **1-866-638-1232** to learn more about these services. In addition, we have bilingual staff to assist LEP members. Member materials, such as the member handbook, are available in English and Spanish. Members can also request materials in another language or format.

You can use Language Line services in the following scenarios:

- If a member requests interpretation services, Member Services representatives will assist the member via a three-way call to the Language Line to communicate in the member's native language
- For outgoing calls, Member Services staff dials the Language Line and uses an interactive voice response system to conference with a member and the interpreter
- For face-to-face meetings, our staff (e.g., Care Managers) can conference in an interpreter to communicate with a member in their home or another location
- When you need interpreter services and cannot access them from your office, call us to connect with a Language Line interpreter

Upon member request, we'll make all written materials accessible to visually or hearing-impaired members, including:

- Braille
- Audiotapes
- Large print
- CD or DVD
- Sign language interpreters
- TTY services or Pennsylvania Telecommunication Relay Service at 711. We include appropriate instructions on all materials about how to access or receive assistance with accessing desired materials in an alternate format

As a reference, refer to Medical Assistance Bulletin 991711 (effective 8/11/2017) regarding limited English proficiency requirements. The bulletin lists the requirements for providers in order to be compliant with the federal and state regulations, including the 1557 tag line.

HIPAA and confidentiality

HIPAA Notice of Privacy Practices

We maintain strict privacy and confidentiality standards for all medical records and member health care information, according to federal and state standards. You can access up-to-date Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices on our website at **AetnaBetterHealth.com/Pennsylvania** .

This includes explanations of members' rights to access, amend and request confidential communication of request privacy protection of, restrict use and disclosure of and receive an accounting of disclosures of protected health information (PHI).

Confidentiality requirements

You must comply with all federal, state and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements.

You're also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential provider and member information, whether oral or written in any form or medium.

The HIPAA Privacy Rule applies to all "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). "Individually identifiable health 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
- 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)

The Privacy Rule 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.

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.
Release of data to third parties requires advance written approval from the Department of Human Services, 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.

Member privacy rights

Our privacy policy assures that all 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 our 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 our 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 laws:

- Make a privacy complaint
- Receive a copy of all or part of their 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

The member or member's authorized representative must submit a privacy request through our Member Services Department. Members can call Member Services at **1-800-822-2447** (PA Relay: 711). 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, members or a member's representative must submit requests to us in writing.

Privacy process requirements
Our processes for responding to member privacy requests include components for the following:

Verification
If the requester is the member, we'll verify the member's identity. Verification examples include asking for:

- Member's ID number
- The last four digits of member's Social Security number
- Member's address
- Member's date of birth

If the requester is not the member, we require the member to complete an Authorization for Use or Disclosure form to verify the requester's authority to obtain the member's information. If the requester identifies him/herself as a member's authorized representative, we require a health care Power of Attorney (POA) or comparable document for a representative to act on behalf of the member. These materials can be obtained by calling Member Services at **1-866-638-1232**.

Review, disposition and response
Our review of privacy requests complies with applicable federal, state and local laws and regulations and applicable contractual requirements, including those that govern use and disclosure of PHI. Responses to privacy requests conform to guidelines prescribed by HIPAA, including response time standards. They'll also include a notice of administrative charges, if any, for granting the request.

Use and disclosure guidelines
We're required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations
A privacy request may be subject to specific limitations or restrictions as required by law. Limitations to a privacy request made include the following conditions:

- We don't maintain the records containing the PHI
- The requester is not the member and we're unable to verify his/her identity or authority to act as the member's authorized representative
- The documents requested are not part of the designated record set (e.g., credentialing information)
- Access to the information may endanger the life or physical safety of or otherwise cause harm to the member or another person
- We're not required by law to honor the particular request (e.g., accounting for certain disclosures)
- Accommodating the request would place excessive demands on us or our time and resources

Provider Relations and Support

Claims Inquiry & Claims Research (CICR) team

The CICR team can assist you with claim related questions and concerns. Their enhanced broad service model includes, but is not limited to, calls related to:

- Billing or contractual-related questions
- Claim status inquiries (note: this function is also available via the secure web portal)
- Handling claims adjustment requests
- Stop payments or other check related inquiries
- Coordination of benefits (COB) claim issues

The CICR staff is available to assist 8 AM-5 PM, Monday-Friday. by calling **1-866-638-1232**.

Network Relations Manager
Aetna Better Health Kids assigns every participating provider a Network Relations Manager by territory. Your Network Relations Manager serves as a liaison between you and the health plan and will be your single point of contact for services such as:

- Visiting your practice
- Training your staff on Aetna Better Health Kids policies and procedures
- Providing ongoing education resources such as the secure provider portal and Provider Manual
- Resolving operational issues to improve health care delivery
- Being available to answer your questions

They'll answer questions and assist you in meeting requirements and obtaining necessary information. You can also find your provider relations contact information on our website at https://prev.aetnabetterhealth.com/pennsylvania/providers/index.html

Additionally, our Quality Practice Liaisons serve as a valuable resource concerning quality matters. More specific information regarding their role can be found in the Quality Management section of this manual starting on page 97. For further information, call the Provider Relations Department at **1-866-638-1232**.

Provider Relations technology:

- Secure provider portal
- Administrative functions: Claims submission electronic data interchange (EDI), electronic funds transfer (EFT), electronic remittance advice (ERA)

Provider training and education

We provide a variety of training opportunities for network providers, including, but not limited to:

- Orientation sessions
- Distribution of written materials through mailings and on our website
- Ongoing site visits
- Regularly scheduled provider training forums and meetings
- In-person training sessions at provider offices
- Webinar training sessions for providers
- Annual updates to the Provider Manual

Provider orientation

We provide initial orientation for newly contracted providers within one month after joining our network. We conduct the orientation either through group sessions or during visits to individual provider offices, clinics or group practice locations. Sessions cover such topics as:

- Covered benefits along with member and provider responsibilities
- Cultural competency
- Provider tools, such as the Provider Manual, website and newsletters
- Process for checking eligibility
- The role of the PCP and appropriate use of the emergency department
- Provider responsibilities for compliance with the Americans with Disabilities Act and how to access health plan interpretation and sign language services
- Methods used to update providers on program and health plan changes
- The role of Care Managers and related activities

- Reporting requirements, including encounter data submission requirements
- Medical records documentation requirements
- The provider complaint and appeals process
- Medical Management processes, including:
    - Referrals to specialists and out-of-network providers
    - Prior authorization
    - Care and Disease Management
    - Pharmacy drug list
    - Evidence-based clinical guidelines
- Appointment availability standards, including wait times and after-hours availability
- Pay-for-performance opportunities and supporting tools, such as provider profiles
- Members' rights and responsibilities, including the right to file a grievance, complaint or request a DHS Fair Hearing and how a provider can assist members in this process
- Member resources (e. g., Language Line, community resources)
- Claims payment, including the availability of electronic funds transfer (EFT)
- Coordination of benefits
- Provider responsibility for compliance with commonwealth and federal laws
- Contact information for provider relations and other departments

Site visits
A Provider Relations Manager will contact a new provider within the first 90 days to conduct an initial site visit. Following the initial site visit, our provider relations staff may conduct scheduled or unscheduled site visits to assess physical location, office hours, adherence to regulatory requirements, provide training or to conduct joint discussions with you and your office staff.

Provider Education Resources
Visit our website to access Provider Experience Educational Resources to help you learn more about important processes, procedures and educational tools that will assist you and your staff in your roles. Information includes, but is not limited to:

- Billing and claim Information
- PROMISe billing requirements
- Complaints, appeals and grievances
- Bright Futures
- Pharmacy information
- Program initiatives
- Provider reference material
- Webinars and virtual and in person forums

Provider webinars and forums
We conduct provider webinars and virtual and in person forums for continued education including:

- Individualized provider training on select topics (e.g., website navigation)
- Group training sessions on select topics (e.g., claims coding, member benefits health forum)
- HEDIS Improvement webinars
- Provider enrollment process webinar
- Provider Availity portal (e.g., authorizations, claims and remittance search)

We annually update this Provider Manual, which serves as a primary resource for educating new and existing network providers about our policies and procedures. We also notify providers of important revisions through newsletters, provider bulletins, fax blasts, and regularly scheduled and ad hoc communications with our staff and on our website.

Availity secure web portal
The Availity secure web portal is a web-based platform that allows us to communicate member health care information directly with providers. Learn about Availity.

Providers can perform many functions within this web-based platform. The following information can be attained from the Availity secure web portal:

- Member Eligibility Search: Verify current eligibility of members
- Application Submission:
    - Submit online provider credentialing applications. Applications can also be submitted via email or fax
- 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 (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 codes are valid, expired, a covered benefit, have prior authorization requirements and any noted prior authorization exception information

    - Run data reports and export results and information to Excel
    - Ensure staff accesses the most up-to-date information on current prior authorization requirements
    - Submit email inquiries to the Provider Relations staff
- Submit authorizations: Submit an authorization request on-line. All nonparticipating providers must receive prior authorization for any treatment. These types of authorizations are available:
    - Medical inpatient services including surgical and non-surgical, rehabilitation and hospice
    - Outpatient surgery
    - Home-based services including hospice
    - Therapy
    - Durable medical equipment: rental
    - Non-par providers must receive prior authorization for all treatment
- Pennsylvania 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.

Member Care Information
You can also access:

- A real-time listing of your patients
- Information on your practice
- Secure email capability with Care Managers

You can access the Secure Web Portal Navigation Guide located on our website for additional information. Our Provider Relations representatives are also available to assist you. Please call **1-866-638-1232**.

Provider Network Management
Our Network Management staff negotiates contracts with hospitals, physicians, ancillary and other provider types to ensure a broad range of network providers to accommodate our members' health care needs.

Network Managers collaborate with the Utilization Management Department in negotiating rates for non-participating providers and facilities when services have been determined medically necessary and are approved by the health plan for Single Case Agreements. They also work with Network Relations Consultants to answer questions about participating provider contracts.

Provider termination

Suspended, disbarred from services
We follow termination procedures as set forth in the Provider Agreement. We receive notice from DHS if a participating provider is suspended or terminated from participation in the Medicaid or Medicare Programs. Upon notification, we must immediately act to terminate the provider from participation.

Terminations for loss of licensure and criminal convictions must coincide with the CHIP effective date of the action.

Termination without cause
Provider Agreements may be terminated by either Party via prior written notice given to the other Party with at least 90 calendar days' notice. In addition to the foregoing, the physician may terminate this Agreement in accordance with the provisions of Section 5.1 of the Provider Agreement.

Termination for breach of contract
The Provider Agreement may be terminated at any time by either party, upon at least 60 calendar days prior written notice of such termination to the other party upon material default or substantial breach by such party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within 60 calendar days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such 60-calendar-day period, any termination pursuant to the Provider Agreement Termination Provision will be ineffective for the period reasonably necessary to cure such 60-calendar-day period.

Chapter 4
Credentialing overview

Provider credentialing overview
We use the CHIP Policy and Procedure Manual and current National Committee for Quality Assurance (NCQA) standards for the review, credentialing and recredentialing of providers. We also use the Council for Affordable Quality Healthcare (CAQH®) Universal Credentialing Data Source for all provider types. The Universal Credentialing Data Source was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing Data Source is the leading industry-wide service to address the credentialing application process.

The Universal Credentialing Data Source program allows practitioners 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 the health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the practitioners obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the practitioner for the same standard information. Practitioners update their information on a quarterly basis to ensure data is maintained in a constant state of readiness.

CAQH gathers and stores detailed data from more than 600,000 practitioners nationwide. Practitioners may not treat members until they become credentialed.

Initial credentialing individual practitioners
Initial credentialing is the entry point for practitioners to begin the contract process with the health plan. New practitioners (with the exception of hospital-based providers), including practitioners joining an existing participating practice with Aetna Better Health Kids, must complete the credentialing process and be approved by the Credentialing Committee.

Recredentialing individual practitioners
Practitioners must recredential at least every 3 years to ensure they continue to meet health plan standards of care. Additionally, practitioners must meet legislative/regulatory and accrediting bodies (NCQA and Utilization Review Accreditation Commission) requirements (as applicable to the health plan). Termination of the provider contract can occur if a provider does not recredential.

Facilities recredentialing
As a prerequisite for participation or continued participation in our network, all applicants must be contracted under a facility agreement and satisfy applicable assessment standards. Prior to participation in the network and every three years thereafter, Aetna Better Health Credentialing will confirm that each organizational provider meets assessment requirements.

Ongoing monitoring

Ongoing Monitoring consists of monitoring practitioner and or provider sanctions or loss of license to help manage potential risk of substandard care to our members.

Provider credentialing process

1. As a participant with the CAQH, we utilize the web based CAQH uniform provider application. If the provider doesn't have a complete CAQH application, online registration is required. Please visit **www.caqh.org** and enroll through the Enroll Hub link on the right side of the page.
2. Once the registration is complete, create a personal ID and password to ensure the privacy and accuracy of your confidential information.
3. Utilize your ID and password to access the secure website to complete the online application. You can request a paper copy of the application by calling CAQH. If a CAQH number already exists, it must be active to move forward with the credentialing process.
4. You must provide proof of your valid and current Promise ID number at the time of credentialing
5. When you identify your provider type and state(s) of practice, the system automatically leads you through the application. Some fields may be pre-populated from information provided by health care organizations and/or hospitals with which you are affiliated.
6. The system allows you to complete the application over time.
7. Once the application is complete, a system audit is conducted to identify errors and/or omissions.
8. Once the corrections are made, you'll review and attest to the accuracy of the information.
9. Fax the requested supporting documents to the designated secure site.
10. The application is complete ONLY when ALL supporting documents are received AND you have attested to the accuracy of information.
11. The credentialing process at Aetna Better Health will begin once the CAQH application is complete.
12. You can access and submit the provider credentialing online application on our website under "Join Our Network" Online Application Form.
13. Alternatively, a paper application can be completed. When you complete the application in full, you can email your application to **paabhproviderrelationsmailbox@aetna.com.**
14. We will review your application for accuracy and completeness.
15. Once a clean application is received, an acknowledgment email notification will be sent within 10 calendar days.
16. If your application is incomplete an email notification will be sent within 10 days.
17. If your application is still undergoing the credentialing process 30 days after receipt of a clean application, a second notification will be sent.
18. You will be notified of your credentialing status within 60 days of receipt of the clean application.

All providers must comply with the state-mandated requirements to enroll and revalidate their PROMISe ID and all active and current service locations. Providers who do not complete the revalidation process every five years may have their provider participation disenrolled and their claims denied. You must have an active PROMISe ID in order to complete the credentialing process.

Recredentialing
All providers must comply with the state-mandated requirements to enroll and revalidate their PROMISe ID and all active and current service locations. Providers who do not complete the revalidation process every five years may have their provider participation disenrolled and their claims denied. You must have an active PROMISe ID in order to complete the credentialing process.

1. A notification will be sent via email or fax every 3 years to re-attest to the accuracy of your information and to fax updated supporting documents, if applicable.
2. Failure to re-attest or provide updated documents in a timely manner may negatively impact your five-year recredentialing cycle. This may result in termination from our network.

Please fax all completed documents to Aetna Better Health Kids at **1-800-754-5435**. Or mail to:
Aetna Better Health Kids
Attn: Provider Relations
PO Box 818047
Cleveland, OH 44181-8047

Credentialing decision notification
Once all information and supporting documents have been verified, the credentialing files are presented for committee decision. We notify all applicants of initial credentialing decisions and recredentialing denials.

Between credentialing cycles
If participation requirements, such as unrestricted DEA or state mandated CDS certification, are not met, we'll notify you in writing, via certified mail, that your participation with Aetna Better Health Kids is being terminated in accordance with the specific terms identified from the Agreement.

If you respond within 30 calendar days of the date of the notice correcting any factual discrepancies or correctable deficiencies, the Chief Medical Officer or designee has the discretion to overturn the determination.

If your license isn't current or has been encumbered (e.g., license status of probation, suspension or revocation), you'll be terminated and notified by certified mail of the termination. The notice will inform you to contact the Chief Medical Officer or designee noted in the letter within five calendar days if the information is erroneous.

Call your Provider Relations Representative with questions about our provider credentialing application or participation process at **1-866-638-1232**.

NPI/PROMISe ID enroll and revalidate
The Affordable Care Act (ACA) requires states to revalidate the enrollment of CHIP providers every five years. Aetna Better Health Kids follows DHS requirements that participating providers revalidate your NPI and PROMISe IDs, along with your service locations, every five years. Failure to complete the revalidation process may result in nonpayment of claims.

Chapter 5
Eligibility and Enrollment overview

Who is eligible for CHIP?
To qualify and enroll in CHIP, a child must be:

1. Under the age of 19
2. A U.S. citizen, a U.S. National or a qualified alien
3. A resident of Pennsylvania
4. Uninsured
5. Not eligible for medical assistance

What CHIP options are available?
Depending on family size and income, a child may qualify for free, low-cost, or full-cost CHIP coverage. Free coverage doesn't require monthly premium payments or co-payments.

Low-cost and full-cost coverage requires a monthly premium payment and copayments for certain services. If a child qualifies for low-cost or full-cost coverage, detailed instructions and a monthly bill that must be returned with their payment in order for the child to remain enrolled in CHIP. A child may lose coverage if the monthly premium isn't paid by the due date on the invoice.

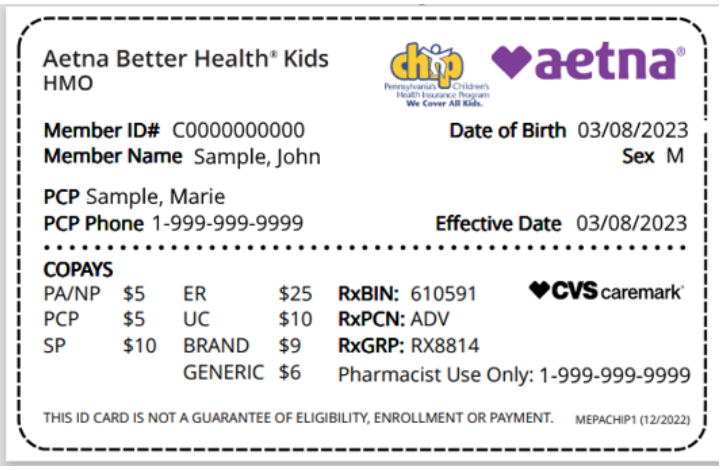
What changes do enrollees need to report during the benefit year?
All changes in a family's circumstances after a child has been enrolled. If changes are not reported promptly, the child may lose coverage. These changes can include:

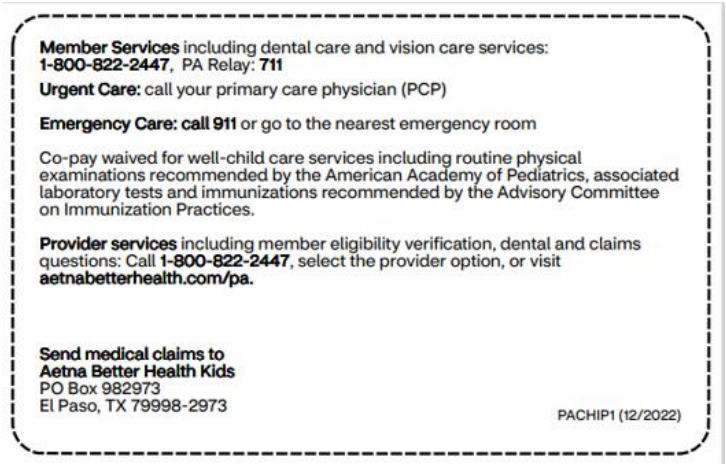
1. Family size
2. Address
3. Phone number
4. Household income or employment status
5. Coverage under a private or employer sponsored plan or Medical Assistance

Aetna Better Health Kids ID Card

CHIP enrollees will receive an Aetna Better Health Kids Identification Card. Members/Enrollees should present their Aetna Better Health Kids ID at the time of service.

This card includes information on where to submit claims. A sample Aetna Better Health Kids ID card is shown here:





Enrollment procedures

CHIP eligibility is reviewed as another form of healthcare along with Medical Assistance (MA) by DHS. CHIP enrollees and potential enrollees will engage in a process for eligibility and communication through DHS. CHIP families will see changes in the following areas:

- CHIP applications and renewals are processed by caseworkers at local DHS County Assistance Offices (CAOs).
- Questions about eligibility and application processing can be addressed by calling the Statewide Customer Service Center at **1-877-395-8930** or **215-560-7226** in Philadelphia.
- Communications about eligibility for CHIP and application processing comes from DHS, including but not limited to eligibility notices, renewal packets, and verification requests.
- The appeal process for eligibility determinations and appeal communications will come from DHS.
- CHIP families will use a record number instead of their Unique Family Identifier (UFI) number for easy identification in DHS systems and their MyCOMPASS Account.
- CHIP families will utilize the myCOMPASS PA mobile application: upload verifications, leave messages for the caseworker, review correspondence, and choose paperless communications

Changing PCPs

If an enrollee is dissatisfied with the auto-selection assignment or wishes to change their PCP for any other reason, the enrollee can choose an alternative PCP at any time by calling Member Services at **1-800-822-2447**. We'll grant the request and process the PCP change in a timely manner. Enrollees will receive a new ID card indicating the new PCP's name.

We maintain policies and procedures allowing members/enrollees to select or be assigned to a new PCP when:

- The member/enrollee requests a change
- A PCP is terminated from the network
- A PCP change is required as part of the resolution to a grievance or complaint proceeding
- A provider requests the change of a PCP for reasonable cause

In cases where a PCP has been terminated for reasons other than cause, we'll immediately inform members assigned to that PCP so that they can select another PCP before their current PCP's effective termination date. In cases where a member enrollee fails to select a new PCP, we'll reassign the enrollee to another compatible PCP before the PCP's termination date and notify the enrollee of the change in writing.

(CHIP) Newborn Enrollment

A child enrolled in CHIP who is identified during her 12-month term of eligibility as being pregnant will remain in CHIP for the duration of the 12-month term.

A child who is identified as being pregnant at the time of renewal will be subject to the usual screening and referral processes to determine eligibility for MA.

A child born to a CHIP enrollee is guaranteed one year of coverage through either MA or CHIP. The newborn will be covered under the mother's CHIP insurance for the first 31 days from birth using the mother's identification number. A separate CHIP application or eligibility determination is not required.

Member rights under Rehabilitation Act of 1973 and the ADA 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 services programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities and 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 oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks and learning. Some examples of impairments, which may substantially limit major life activities, even with the help of medication or aids/devices, are 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.

Americans with Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a physician's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity
- Denial of the benefits of services, programs or activities of a public entity
- Discrimination by any such entity

Physicians should ensure that their offices are as accessible as possible to persons with disabilities. They should also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. We offer sign language and over-the- phone interpreter services at no cost to the provider or member.

Providers treating enrollees in the CHIP program 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 barrier

We will work with you to ensure that qualified individuals with disabilities have access to all medically necessary benefits and services.

Chapter 6

Member rights and responsibilities

We treat our members with respect and dignity. We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression or sexual orientation.

We do not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression or sexual orientation. Parents or guardians of CHIP members have responsibilities too. Together, we can advise members of their rights and responsibilities. Review the member rights and responsibilities below.

Communication with enrollees and participating providers

Aetna Better Health Kids' enrollee's rights and responsibilities are listed in the Member Handbook and in this Provider Manual. You can access the most current Member Handbook and Provider Manual on our website at **AetnaBetterHealth.com/Pennsylvania**. Enrollees can request the Member Handbook in print or in another language or format. We notify them by mail when we update the handbook.

We also send written notification if we reduce, suspend, deny or terminate a covered service. Included with this notification is a description of the member's right to appeal such actions, the timeframe for filing an appeal and the process for submitting the appeal.

Member rights

As the parent or guardian of a CHIP member, you have the right to:

1. Get information about your child's rights and responsibilities
2. Get information about all the benefits, services and programs offered by CHIP, brought to you by Aetna Better Health Kids
3. Know about policies that can affect your child's membership
4. Basic information about doctors and other providers who participate with Aetna Better Health Kids
5. Choose from Aetna Better Health Kids' network of participating providers and refuse care from specific doctors
6. Request that a specialist serve as your child's primary care provider if your child has certain special medical needs or diagnoses
7. Be treated with respect and due consideration for your child's dignity and privacy
8. Expect that information you give to Aetna Better Health Kids and anything you or your child discuss with your child's doctor will be treated confidentially, and will not be released to others without your permission
9. Have all records pertaining to your child's medical care treated as confidential unless sharing them is required to make coverage decisions or is otherwise required by law
10. See your child's medical records unless access is specifically restricted by reason of law or by the attending physician for medical reasons, to keep copies for yourself and to ask to have corrections made if needed
11. Get clear and complete information from your child's doctor about your child's health condition

and treatment including what choices you have and what risks are involved

12. Get information about available treatment options and alternatives, regardless of cost or benefit coverage
13. Be a part of any decisions made about your child's health
14. Refuse to have your child receive any drugs, treatment, or other procedure by Aetna Better Health Kids or offered by its providers to the extent permitted by law
15. Be informed by a physician about what may happen if you refuse drugs, treatments or procedures
16. Refuse to allow your child to participate in medical research projects
17. Give informed consent before the start of any procedure or treatment
18. Ensure your child receives timely care in case of an emergency
19. Question decisions made by Aetna Better Health Kids or its participating providers, and to file a complaint or grievance regarding any medical necessity or administrative decisions you disagree with
20. Make recommendations regarding Aetna Better Health Kids' members' "rights and responsibilities" policy
21. Exercise your rights without adversely affecting the way Aetna Better Health Kids, its providers and state agencies may treat you

Member responsibilities

Parents or guardians of CHIP members have a duty to:

- Understand how CHIP, brought to you by Aetna Better Health Kids, works by reading this handbook and other information available.
- Follow the guidelines in this handbook and in other information available to you and ask questions about how to access health care services appropriately
- Inform Aetna Better Health Kids and your child's providers about any information that may affect your child's membership or right to program benefits, including other health insurance policies your child becomes covered under
- Supply up-to-date medical information to Aetna Better Health Kids and its providers so they can give your child appropriate care
- Be sure that your primary care provider has all of your child's medical records, including those from other doctors
- Contact your child's primary care provider first for all medical care except in the case of a true emergency
- Consent to the proper use of your child's health information
- Treat your child's providers with dignity and respect, which includes being on time for appointments and calling ahead if you need to cancel an appointment
- Provide a safe environment for services administered in your home
- Learn about your child's health problems and work with providers to develop a plan and mutually agreed-upon treatment goals to the degree possible, for your child's care
- Follow the instructions or guidelines you receive from the provider, such as taking medicine as directed and attending follow up appointments
- Take full responsibility for any consequences of your decision to refuse treatment on your child's behalf

Chapter 7
Covered benefits for CHIP members

Aetna Better Health Kids provides the medical, behavioral, dental and vision benefits in compliance with state and federal regulations to provide the highest quality of care to our enrollees. This Chapter will review the benefits available to CHIP enrollees and in some circumstances where medically necessary program exceptions will be considered by our medical director. The services in this section are in alphabetical order.

Program Exception process

Aetna Better Health Kids has a Program Exception process. The provider or member may request a Program Exception for medically necessary items or services that:

- Are not currently offered by CHIP benefits
- Are not included in the benefit package
- Exceed limits for items or services that are currently available for CHIP enrollees (as long as the limits are not based in federal or state rules)

Behavioral health services

Mental health benefits

Some members diagnosed with severe mental health disorders or conditions that significantly impact a child's behavioral health (i.e., schizophrenia, autism, etc.) may be eligible for a broader range of services.

What outpatient mental health benefits are covered?

There are no limits for mental health outpatient visits per benefit year. Covered services include:

- Psychological testing
- Visits with mental health providers
- Partial hospitalization
- Intensive outpatient therapy
- Medication management

Inpatient benefits for medical and behavioral health hospitalizations, medically related inpatient rehabilitation and skilled nursing services are not limited.

Except in the case of an emergency, mental health services must be provided by participating providers and facilities. Prior authorization is required for use of a nonparticipating provider or facility.

Do outpatient mental health services need to be prior authorized?

Some mental health services may require prior authorization. The child's mental health provider is responsible for getting necessary authorizations by calling the Prior Authorization department at **1-800-822-2447**.

Substance use disorder benefits
CHIP covers inpatient detoxification, non-hospital residential treatment and outpatient treatment relating to drug and alcohol abuse for our members.

The sooner a child begins treatment with a professional provider, the more likely they are to have a successful recovery.

Substance use disorder benefits do not cover tobacco abuse related services. However, Aetna Better Health Kids provides nicotine replacement therapy (NRT) and smoking cessation assistance to help a child stop using tobacco/vaping related products. NRT is covered under the member's pharmacy benefit.

Call the Special Needs Unit at **1-855-346-9828 (TTY: 711)** to obtain smoking cessation assistance for a CHIP enrollee.

Who can a child receive substance use disorder services from?
Substance use disorder services must be provided by participating providers and facilities, unless we prior authorize the use of a non-participating provider or facility.

A member doesn't need a referral from a PCP to see a participating substance use disorder provider. A member (14 years of age or older) or a parent or guardian may self-refer.

What if a member has a substance abuse emergency or crisis?
A substance use emergency is where you are considered in imminent, potentially life threatening physical danger with a need for immediate detoxification for drug withdrawal. The member should go to the nearest emergency room.

What do I need to know about inpatient detoxification?
Detoxification is the process by which a drug or alcohol intoxicated or dependent member is assisted through the period of time needed to eliminate the presence of the intoxicating substance(s) or the dependency factor(s), while keeping the physiological or psychological risk to the member at a minimum. Inpatient detoxification is used when a member's withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care with medical monitoring by medical and nursing professionals.

Inpatient detoxification services may only be provided by participating providers at participating Facilities unless the admission occurred in an emergency. If a member is admitted to a non-participating facility, the provider must contact the Utilization Management department at **1-800-822-2447** within 24 hours to notify them of the admission. Once the member's condition is determined to be non-emergent, the member may be transferred to participating facility.

What do I need to know about non-hospital residential treatment?
Non-hospital residential treatment refers to services administered at facilities where the member lives while participating in a comprehensive chemical dependency treatment program in a therapeutic environment that has met the minimum standards established by the Pennsylvania Department of Health. Members who don't require medical monitoring for

withdrawal may receive detoxification related services at these facilities as well. Admission to a non-hospital residential treatment facility for drug and alcohol rehabilitation treatment is never considered emergency treatment.

Non-hospital residential treatment services may only be rendered by participating providers at participating facilities unless Member Services at **1-800-822-2447 (TTY: 711)** preauthorizes the use of a non-participating provider or facility before your child is admitted and begins receiving services. Nonhospital residential substance use services your child receives at a non-participating facility will not be covered by your child's insurance.

What outpatient substance use disorder benefits are covered?
Covered services include:

- Psychological and laboratory testing
- Visits with substance use disorder rehabilitation providers
- Partial hospitalization
- Intensive outpatient therapy
- Residential /Inpatient services
- Medication management

Dental

Dental radiographs, exams (including emergency exams), prophies, FMDs before or after an exam and restorations are a few of the covered services. SRPs, prosthodontics, orthodontics and oral surgery are also covered services; however, prior authorization is required. Members 18 years of age and younger are eligible for all medically necessary dental services. Our subcontractor, SKYGEN USA, will provide details on all of the covered dental services.

Enrollees can find a dentist in their area by accessing **AetnaBetterHealth.com/Pennsylvania** or by calling Member Services at **1-800-822-2447**. Members do not need a referral to see the dentist.

Durable medical equipment (DME)

DME is covered for most members, but prior authorization may be required. Refer to the prior authorization grid by accessing our secure provider portal at **AetnaBetterHealth.com/Pennsylvania**. Covered DME items include, but are not limited to, the following:

- Oxygen
- Gastrostomy supplies
- Apnea monitors
- Prosthetic devices
- Bathroom and safety equipment
- Beds and accessories
- Medically necessary DME and supplies
- Monitoring equipment
- Respiratory equipment and supplies

Emergency services

Covered emergency services include:

- Emergency ambulance transportation
- Emergency department (ED)
- ED physician consultation (non-ED specialty)
- ED physician services (radiology, anesthesiology, ED and pathology)

Under Aetna policy, we will review ED claims for appropriate level severity for the diagnosis on the claim. We have posted a list of auto-pay emergency department diagnoses that will automatically allow the claim to process without severity medical record review has been posted on our website.

Family planning

Members can choose any provider for family planning services. Covered family planning services include, but are not limited to:

- Contraceptive implants/injections
- Education/counseling
- In-office visit with primary care practitioner or primary care obstetrician
- Long acting reversible contraception (LARC)
    - Physicians are reimbursed according to MA reimbursement guidelines for the professional component fee for insertion of a LARC or contraceptive implant at the time of an obstetrical delivery.

Hospitals are reimbursed separately for the cost of the device when inserting a LARC intrauterine device (IUD) or contraceptive implant at the time of an obstetrical delivery in addition to the all patient refined-diagnosis related group (APR-DRG) payment that hospitals receive for the delivery.

Health education

Some health educational services may require prior authorization to ensure appropriate utilization. Refer to the prior authorization grid by accessing our secure provider portal at **AetnaBetterHealth.com/Pennsylvania**.

Hearing

Bright Futures well-child hearing screening is covered for members under age 19 . Hearing aids are covered but require prior authorization for members under age 19.

Home health care

Home health care is a covered benefit and requires prior authorization.

Hospice care

We contract with providers certified according to 42 CFR 418.1 to offer hospice care to our members. Inpatient and outpatient hospice care are covered for those under age 21 and adults who are not on general assistance, but care does require prior authorization. Respite care may not exceed a total of five days in a 60-day-certification period.

Hospital care

The following are covered benefits for hospital care:

- Inpatient hospital stays (acute/rehabilitation).
- Outpatient maternity services and medical observation.
    - Outpatient surgery and maternity surgery.
    - Outpatient diagnostic/therapeutic services are covered for all members.
- Inpatient maternity stays are covered but require notification to us by the next business day. All rooms are semi-private unless deemed medically necessary.

Laboratory services

Laboratory services are covered if administered by a participating provider. Our preferred laboratory vendors are LabCorp and Quest Diagnostics.

Laboratory services may also be administered within the office with CLIA certification.

Maternity services

Maternity care and obstetrics (OB) services are covered.

Newborn care

Included in Bright Futures services. Refer to Chapter 8: Bright Futures for more information.

Obstetrical/gynecological (OB/GYN) care

Obstetrical and gynecological services do not require a referral but must be performed by a participating provider. In situations where a new and pregnant member is already receiving care from a non-participating OB/GYN specialist at the time of enrollment, the member may continue to receive services under the continuity of care provision from that specialist throughout the pregnancy as well as postpartum care related to the delivery.

Orthotics/prosthetics

Purchase and fitting of prosthetic devices and supplies, including customized devices, are covered as medically necessary and require prior authorization. Diabetic and non-diabetic orthopedic shoes are a covered benefit for those under age 19 with prior authorization.

Enhanced Benefits

These additional enhanced benefits are available to Aetna Better Health Kids members at no additional cost.

- **Over the Counter (OTC) Benefit**
  Members receive a $30 credit monthly and can choose from more than 900 over the counter products ranging from baby care items, oral health, and personal care and wellness items.
- **Medication Lockbox**
  Keep medications safely locked away from kids with this no cost lockbox
- **Medically Tailored Meals**
  Delivered by MANNA to members with certain conditions. **Medically Tailored Meals (MTM)** can be provided for members with chronic conditions who will benefit from a tailored meal for their

condition. Please contact our Special Needs Unit for referrals at **1-855-346-9828.**

- **Kid's Sports Physical**
  No cost sports physical exam
- **Enhanced Vision Benefit**
  Includes $180 off fashion frames
- **Enhanced Dental Benefit**
  Crowns that look like real teeth
- **Transportation by Modivcare**
  No cost rides to medical appointments, CHIP enrollees/parents or guardians have access to Lyft/Uber rides through Modivcare, Inc. Members can make a reservation by calling Ride Assist at 1-866-824-1567.
- **Pyx Behavioral Health Benefit & App**
  As an enhanced benefit we offer the Pyx program to enrollees and their guardians at no cost. Pyx Health's friendly staff and easy app support enrollees and their guardians with compassion and practical help:
    - Free, unlimited calls to trained staff who understand the challenges of caring for teens
    - Activities and tools to support teens and guardians to help them feel less alone
    - Access to resources like helplines, social resources, support groups, and more.

Enhanced Benefits are subject to change. For more information about enhanced benefits visit **https://www.AetnaBetterHealth.com/Pennsylvania/whats-covered.html**

PCP office visits

Regular and routine office visits and procedures are covered.

Prenatal/postpartum care

Maternity Care/Obstetrics is covered. We reimburse Maternity Care/Obstetrics on a fee-for service basis. Nurse midwife (OB) care is covered, including prenatal and postpartum visits. Refer to Chapter 9: Medical Management of this manual for additional Care Management information.

Preventive services

Preventive screenings like immunizations, mammograms are covered. Health and wellness services including smoking cessation classes, nicotine replacement products and nutritional counseling are covered.

Procedures

In-office or outpatient procedures (treatment and diagnostics) by PCP and specialists are covered. You can refer to **ProPAT** our CPT look up tool for prior authorization requirements.

Here are examples of procedures that are covered :

- Allergy testing
- Radiology imaging
- Cardiac catheterization

- Chemotherapy /radiation therapy
- Circumcision
- EMG/NCVs
- Nerve blocks/epidurals
- Sleep studies

Radiology (x-ray) services

Angiograms, MRI/MRA, PET scans, CT scans, discogram, myelogram, electromyography, other diagnostic radiology procedures and routine x-rays, including portable, are covered. You can refer to **ProPAT** our CPT look up tool for prior authorization requirements. These services do not require prior authorization.

Skilled nursing facility

Covered for enrollees with prior authorization based on medical necessity.

Skilled home nursing services

Covered for all enrollees with prior authorization based on medical necessity.

Specialist office visits

In-office visits to a specialist are covered. Please refer to page 12 of this manual for information about how to arrange a specialist.

Supplies

Diabetic testing supplies, asthma medical supplies, urinary catheter supplies and other medical supplies are covered for enrollees as medically necessary.

Therapy (occupational, physical and speech)

These services are covered, but they do require prior authorization. For specific prior authorization information, you can also find out if a service needs prior authorization by using **ProPAT**, our online prior authorization search tool.

Transplant (organ)

Organ donor costs, organ evaluation, transplant and transplant facility are covered, but require prior authorization. You can also find out if a service needs prior authorization by using **ProPAT**, our online prior authorization search tool.

Transportation

We cover all medically necessary ambulance transportation and all medically necessary non-emergency ambulance transportation. You can also find out if a service needs prior authorization by using **ProPAT**, our online prior authorization search tool.

Vision care

Our vision subcontractor, Superior Vision, will provide covered vision benefit services to members. Members can contact Superior Vision Member Services at **1-800-428-8789**. Benefit includes vision exams, as well as lenses and contact lenses annually.

Mental Health Services, drug and alcohol services

Some members diagnosed with severe mental health disorders or conditions that significantly impact a child's behavioral health (i.e., schizophrenia, autism, etc.) may be eligible for a broader range of services.

What outpatient mental health benefits are covered?

There are no limits for mental health outpatient visits per benefit year. Covered services include:

- Psychological testing
- Visits with mental health providers
- Partial hospitalization
- Intensive outpatient therapy
- Medication management

Inpatient benefits for medical and behavioral health hospitalizations, medically related inpatient rehabilitation and skilled nursing services are not limited.
Except in the case of an emergency, mental health services must be provided by participating providers and facilities. Prior authorization is required for use of non-participating provider or facility.

Do outpatient mental health services need to be prior authorized?

Some mental health services may require prior authorization. The child's mental health provider is responsible for getting necessary authorizations by calling the Prior Authorization Department at **1-800-822-2447.**

Substance use disorder benefits

CHIP covers inpatient detoxification, nonhospital residential treatment and outpatient treatment relating to drug and alcohol abuse for our members. The sooner a child begins treatment with a professional provider, the more likely they are to have a successful recovery.

Substance use disorder benefits do not cover tobacco abuse related services. However, Aetna Better Health Kids provides nicotine replacement therapy (NRT) and smoking cessation assistance to help a child stop using tobacco/vaping related products. NRT is covered under the member's pharmacy benefit. Call the Special Needs Unit at **1-855-346-9828 (TTY: 711)** to obtain smoking cessation assistance for your CHIP enrollee.

Who can a child receive substance use disorder services from?

Substance use disorder services must be provided by participating providers and facilities, unless we prior authorize the use of a nonparticipating provider or facility.

A member doesn't need a referral from a PCP to see a participating substance use disorder provider. A member (14 years of age or older) or a parent or guardian may self-refer.

What if a member has a substance abuse emergency or crisis?

A substance use emergency is where a patient is considered in imminent, potentially life-threatening physical danger with a need for immediate detoxification for drug withdrawal. The member should go to the nearest emergency room.

What do I need to know about inpatient detoxification?
Detoxification is the process by which a drug or alcohol intoxicated or dependent member is assisted through the period needed to eliminate the presence of the intoxicating substance(s) or the dependency factor(s), while keeping the physiological or psychological risk to the member at a minimum. Inpatient detoxification is used when a member's withdrawal signs and symptoms are sufficiently severe to require 24 hour inpatient care with medical monitoring by medical and nursing professionals.

Inpatient detoxification services may only be provided by participating providers at participating facilities unless the admission occurred as a result of an emergency. If a member is admitted to a non-participating facility, they must contact Member Services at **1-800-822-2447 (TTY: 711)** within 24 hours to notify them of the admission. Once the member's condition is determined to be nonemergent, the member may be transferred to participating facility. If you refuse to transfer your child to a participating facility after the psychiatric emergency has ended, the services your child receives at the nonparticipating facility may not be covered.

What do I need to know about nonhospital residential treatment?
Nonhospital residential treatment refers to services administered at facilities where the member lives while participating in a comprehensive chemical dependency treatment program in a therapeutic environment that has met the minimum standards established by the Pennsylvania Department of Health. Members who don't require medical monitoring for withdrawal may receive detoxification related services at these facilities as well. Admission to a nonhospital residential treatment facility for drug and alcohol rehabilitation treatment is never considered emergency treatment.

Non-hospital residential treatment services may only be rendered by participating providers at participating facilities unless Member Services at **1-800-822-2447 (TTY: 711)** preauthorizes the use of a nonparticipating provider or facility before your child is admitted and begins receiving services.

Nonhospital residential substance abuse services your child receives at a nonparticipating facility will not be covered by your child's insurance.

What outpatient substance use disorder benefits are covered?
Covered services include:

- Psychological and laboratory testing
- Visits with substance use disorder rehabilitation providers
- Partial hospitalization
- Intensive outpatient therapy
- Medication management

Contact Member Services at **1-800-822-2447** if you have questions about your patient's eligibility for certain mental health or substance abuse services or benefit limits. If you have a patient with a drug or alcohol problem, do not delay getting them the help they need. The sooner a child begins treatment with a professional provider, the more likely he or she is to have a successful recovery.

Pharmacy

Prescription drugs must be ordered by a licensed prescriber within the scope of the prescriber's practice. You should write prescriptions for drugs that are preferred on the formulary whenever possible. Also, your signature should be legible in order for the pharmacy to dispense the prescription. Non-formulary drugs are also covered when determined medically necessary through the prior authorization process. For the most current and up-to-date version of our formulary, please visit our website at **AetnaBetterHealth.com/PA/providers/pharmacy** and select Formulary (PDF) or online search tool.

You may also send your written request for a copy of the formulary to:

Aetna Better Health Kids
Attn: Pharmacy Department
P.O. Box 818047
Cleveland, OH 44181-8047

Quantity limits

Some medications have limits. This means that the member may only get a specific number of pills or dosage within a certain number of days. These limitations are noted on our website at **AetnaBetterHealth.com/PA/providers/pharmacy** and may be viewed by selecting Formulary (PDF) or online search tool.

If you wish to increase the limit for a certain medication for a member, you will need to submit a request showing it is medically necessary to have an exception to the limit(s).

Therapeutic substitution

You must receive permission for a therapeutic substitution. In order for a pharmacist to substitute a prescribed drug for the preferred formulary agent, in the same drug class, the pharmacist must contact the ordering prescriber to receive permission and the necessary new prescription.

Pharmacy prior authorization

We require pharmacy prior authorization if:

- The charge for any single prescription exceeds $9,999
- The prescription requires compounding
- Medications are designated as a specialty medication
- Prescriptions exceed recommended doses or established quantity limits
- Drugs which require certain established clinical guidelines be met before consideration for prior approval
- The prescription is a non-formulary or non-preferred drug
- Established step-therapy protocols have not been met

A complete list of all prior authorization guidelines is available at **https://prev.aetnabetterhealth.com/pennsylvania/providers/prior-authorization.html**

Procedure for obtaining pharmacy prior authorization
Submit an electronic prior authorization (ePA) through CoverMyMeds® or Surescripts or fax your pharmacy prior authorization requests to **1-877-309-8077**. Use the authorization form designed specifically for pharmacy requests, which you can find on our website at **https://prev.aetnabetterhealth.com/pennsylvania/providers/pharmacy-prior-authorization.html**

Incomplete forms will delay processing of your request. Also, remember to include any supporting medical records that will assist with the review of the prior authorization request. Please allow 24 hours to complete a request.

We will make available those drugs not on the formulary when prior authorization and/or step therapy requirements are met.

For medications that require prior authorization, we'll allow a 72-hour supply for new medications or a 15-day supply if the prescription qualifies as an ongoing medication at the time the member presents the prescription at the pharmacy.

Services requiring referral and prior authorization

The following list represents the majority of services requiring authorization. However, please refer to **ProPAT**, our code specific online prior authorization search tool.

All inpatient services

- Medical and Surgical
- Skilled nursing
- Rehabilitation
- Hospice

Outpatient services

Outpatient services vary based upon the code and are not location specific. Please check the code specific listings for details. Listed below are selected services requiring prior authorization:
Surgical services – Refer to our CPT code look up tool **ProPAT** for code specific prior authorization requirements.

- Home-based services including hospice and skilled nursing
- Therapy – All therapy services require authorization with the exception of therapy diagnostic analysis and therapy evaluations
- Angiography
- DME – Refer to code specific listing as requirements may vary. In general, the following require authorization:
    - Hospital beds
    - Wheelchairs
    - Oxygen
    - CPAP

- Injectables
- Therapy management services provided by a pharmacist – refer to code specific listing as requirements may vary
- Orthotics / prosthetics
- Implantable devices
- Electronic devices
- Implantable breast prosthetics
- Injectable bulking agents
- Other
    - Sleep studies
    - Osteopathic manipulation and chiropractic services
    - Specialized multidisciplinary services
    - Enteral feeding supply, formulas, additives, and all pumps
    - Some supply-based services
    - Some hearing and vision services
    - All unlisted codes require authorization

Emergency services
No authorization is required for emergency services. Non-emergent ambulance transportation does require authorization.

Consultations performed using telemedicine

Aetna Better Health Kids offers telemedicine services to support our members with receiving health care services remotely.

Telemedicine is the use of real-time interactive telecommunications technology that includes, at a minimum, audio and video equipment as a mode of delivering consultation services.

While face-to-face consultations with the patient are preferred whenever possible, we recognize that there are instances where face-to-face consultations are not feasible.

In these instances, telemedicine is considered an effective alternative in increasing patient access to specialist care, improving quality of care, and promoting better communication and coordination among providers.

Aetna Better Health Kids will allow two-way, real-time interactive communication while the patient is at an enrolled originating site and the licensed physician at a distant site.

A referring providers presence is not required at the originating site at the time the visit, however in situations where the referring provider or other physician, CRNP or CNM is not physically present, a nurse or other clinical professional may assist the patient.

Providers are reminded to render services face-to face wherever practical and appropriate. Providers should fully document the following information in the MA recipient's medical record, in accordance with MA regulations at 55 Pa. Code § 1101.51 relating to ongoing responsibilities of providers:

- The specific interactive telecommunication technology used to render the consultation
- The reason the consultation was conducted using telecommunication technology, and not face-to-face

For more on the telemedicine program or determining feasibility for the use of telecommunication technology, providers may reference information in the MA Bulletin:
dhs.pa.gov/docs/Publications/Documents/FORMS-AND-PUBS-OMAP/d_005993.pdf
Our Provider Relations team is also available to assist. Please call 1-866-638-1232 for further details.

CHIP Benefits and Cost Sharing

Covered benefits for CHIP members

This section lists the medical services covered by CHIP. All services must be medically necessary. The services in this section are in alphabetical order.

Under each covered service listing you will find a brief description of the benefit provided and any limits or restrictions that may apply. We reserve the right to restrict benefit coverage of medical equipment purchases to certain manufacturers and specific product types.

Except under very specific circumstances, such as in the case of an emergency, all services described in this section are covered only if provided by a participating provider. Except in the case of an emergency, preauthorization by or other specialized documentation or certifications required for a particular benefit, must be obtained before a child receives the service in order for the claim to be covered. We only cover services up to the specified benefit limits.

Autism spectrum disorder and related services
In accordance with the Pennsylvania Autism Insurance Act (Act 62), the following services, when medically necessary for the assessment, diagnosis and treatment of autism spectrum disorders are covered:

- Prescription drug coverage including over-the-counter (OTC) medications
- Services of a psychiatrist and/or psychologist
- Rehabilitative and therapeutic care

There are no benefit limits. Coverage does not include case management services. Coverage under this section is subject to copayments as identified in the CHIP handbook.

Treatment of autism spectrum disorders must be:

- Medically necessary and prescribed by a physician or other independently licensed health care professional with prescribing authority
- Identified in a treatment plan
- Provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker, licensed behavior specialist (a person licensed in Pennsylvania to provide applied behavioral analysis) or certified registered nurse practitioner

- Provided by an autism service provider or a person, entity or group that works under the direction of an autism service provider

Diabetic services

- Medically necessary diabetic treatment, equipment, medications and supplies as follows:
- Diabetic medical equipment, monitoring supplies and prescription medications
- Outpatient diabetic training and education
- Diabetic eye examinations
- Laboratory screening tests
- Routine diabetic foot care and orthotics
- Diabetic Disease Management Program
- Special Needs Unit care coordination and Case Management

Benefit is limited to one routine diabetic eye exam per benefit year. If there is a need for additional diabetic eye exams, a program exception can be requested for review by a medical director. Batteries for diabetic medical equipment are not covered. Services identified above are subject to the same benefit limits noted in the CHIP member handbook.

Diagnostic, laboratory and radiology services

Medically necessary diagnostic tests, services and materials related to the diagnosis and treatment of sickness and injury in both inpatient and outpatient settings are covered.
Certain services may require prior authorization in order to be covered. You can also find out if a service needs PA by using **ProPAT**, our online prior authorization search tool.

Durable medical equipment

Medically necessary durable medical equipment (DME) coverage applies to equipment designed to serve a medical purpose such as:

- A CHIP member has an illness or an injury.
- It is able to stand repeated use.
- It is not disposable or for a single patient use.
- It is required for use in the home or school environment. This benefit covers the cost of DME rental (or purchase, if purchase is cheaper than renting the DME over an extended period of time), delivery and installation.

We only cover the repair or replacement of DME as required with normal wear and tear when medically necessary.

DME may require prior authorization. Any DME request over $500 may require review by our medical director.

Emergency care services

CHIP members do not need pre-authorization for emergency ambulance transportation or emergency care in the hospital. Hospitals must treat CHIP members if they have a medical emergency. CHIP members should not use the emergency department for follow-up care. We may not cover follow-up care in the emergency department.

You should educate CHIP members and their parents on when it is appropriate to visit the emergency department.

Emergency transportation services
Transportation services by land, air or water ambulance are covered only when medically necessary. Services must be rendered in the following situations:

- In response to an emergency
- For the purpose of transporting an inpatient member between facilities
- When a homebound member is discharged from the hospital and for medical reasons cannot be transported by other means

We'll only cover transportation outside of the service area if the services required by the member cannot be provided within the service area.

Family planning services
Family planning services cover the professional services provided by a CHIP member's PCP or OB GYN provider related to the prescribing, fitting and/or insertion of a contraceptive.

This includes Food and Drug Administration approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants, voluntary sterilization procedures and patient education and counseling, not including abortifacient drugs, at no cost share to the member. Contraception drugs and devices are covered under the Prescription Drug benefit issued with the plan.

Gender transition services
The CHIP Program covers gender transition services such as physician's services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies, etc. when deemed medically necessary and appropriate.

Medical necessity will be determined based upon the World Professional Association for Transgender Health (WPATH) Standard of Care.

Habilitative services
Habilitative services are health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology, and other services for people with disabilities in a variety of outpatient settings.

Covered services are limited to 30 visits per benefit year for physical therapy; 30 visits per benefit year for occupational therapy; and 30 visits per benefit year for speech therapy, for a combined visit limit of 90 days per benefit year. Visit limits under this benefit are combined with visit limits described under outpatient rehabilitation therapy.

Hearing care services
If medically necessary, hearing aids and devices and the fitting and adjustment of such devices, are covered.

This benefit is limited to one routine hearing exam and an audiometric exam per 12 months, one hearing aid or device per year every 12 months. Batteries are not covered. No dollar limits apply.

Home health care services
Home health care is only covered if a CHIP member is homebound. Home health care services include medically necessary:

- Physician services
- Physical, speech and occupational therapy services
- Medical and surgical supplies and equipment, including oxygen
- Home infusion therapy (not including blood or blood products)

Home health services may require prior authorization by Aetna Better Health Kids. There are no copayments and no limitations.

Hospice services
Hospice is a special kind of care that is available to CHIP members who suffer from a terminal illness. This care will be concurrent with care related to the treatment of the condition for which the diagnosis of terminal illness was made. Members getting hospice and palliative care services may still receive covered services for other illnesses or conditions as well.

Hospice services must be prior authorized by Aetna Better Health Kids and require a certification by a physician stating that the member has a terminal illness must be provided with a written request for hospice services by either the member, if they're of legal age, or by the member child's legal guardian.

Hospital services
Inpatient, outpatient and ambulatory surgical center service
Hospital services must be provided by a participating facility on either an inpatient or outpatient basis and must be medically necessary. These services may be provided at participating facilities, such as an acute care hospital, skilled nursing facility or an ambulatory surgical center.

Inpatient benefits for medical and behavioral health hospitalizations, medically related inpatient rehabilitation and skilled nursing services are not limited. Inpatient medically related rehabilitation therapy is not limited.

Outpatient physical health services relating to ambulatory surgery, outpatient hospitalization, specialist office visits and follow-up appointments or sick visits with a CHIP member's PCP are not limited. Hospitalization related services may require prior authorization except in the case of an emergency.

Mastectomy and breast cancer reconstructive surgery services
Mastectomy and breast cancer reconstructive surgery services are performed on an inpatient or outpatient basis and for the following:

- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance
- Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof due to a mastectomy

- Physical complications of all stages of mastectomy, including lymphedemas
- Coverage is also provided for one home health care visit, as determined by the CHIP member's physician, received within 48 hours after discharge

Mastectomy services may require prior authorization.

Maternity services
A female CHIP member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Except in the case of an emergency or in accordance with the continuity of care policy, participating providers must provide maternity services at participating facilities.

Providers of maternity care services may include:

- Physicians
- Nurse practitioners
- Certified nurse midwives
- Facilities may include both acute care hospitals and free-standing birthing centers

Hospital and physician care services relating to antepartum, intrapartum, and postpartum care, including complications resulting from the member's pregnancy or delivery are covered. If the member's eligibility changes when they are in the second or third trimester of the pregnancy, they may remain through the postpartum stage with the same physician or practitioner.

Under federal law, health plans and health insurance issuers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e .g ., physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

CHIP members can also receive one home health care visit following an inpatient release for maternity care if the member is released prior to 48 hours for a normal delivery or prior to 96 for a caesarean delivery in consultation with the mother and provider or in the case of a newborn, in consultation with the mother or the newborn's authorized representative.

Home health visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. A licensed health care provider whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the provider. Home health care visits following an Inpatient stay for maternity services are not subject to copayments, deductibles, or coinsurance, if otherwise applicable to this coverage.

If a pregnant member joins Aetna Better Health in her second or third trimester and her provider is out of network, she may continue to see that provider through the pregnancy and postpartum period.
In the same way, if we end our contract with a pregnant member's doctor and the member is in her second or third trimester, she may continue to see that provider through the pregnancy and postpartum period. Delivery at a facility outside the service area will only be covered in the case of an emergency.

Medical foods
Medical foods such as specially formulated enteral feedings and supplements are covered only for the medically necessary therapeutic treatment of certain genetic disorders. This benefit isn't intended to be normal food products used in the dietary management of rare genetic metabolic disorders.

Medical foods require prior authorization and must be prescribed by a physician or nurse practitioner. Special kinds of infant formulas are not medical foods and are not covered.

Newborn coverage of infants born to CHIP members
This benefit pertains to newborn children of CHIP members who are covered from the time of birth for the first 31 days of life. CHIP members can access these services using the member's CHIP identification card. To assure no lapse in access to health care for the newborn after the first 31 days, the member must contact their respective **County Assistance Office** immediately after the child is born to begin the process of getting the newborn his or her own health care coverage.

This service ends after the CHIP member's baby turns 31 days of age. Members with newborns should follow the guidelines set forth in the CHIP member handbook to access their benefits.

Oral surgery services
Oral surgery services may be performed in either an inpatient or outpatient setting depending on the nature of the procedure and require prior authorization. Examples of covered services include:

- Extraction of partially or totally bony impacted third molars (wisdom teeth)
- Baby bottle syndrome (early childhood dental caries)
- Surgery to correct dislocation or complete degeneration of the temporomandibular joint
- Non-dental treatments of the mouth relating to medically conditions such as:
    - Congenital defects
    - Birth abnormalities
    - Surgical removal of tumors

We reserve the right to determine, based on medical necessity, what facility setting is most appropriate for the oral surgery services being provided. Anesthesia coverage varies based on the procedure and the type of facility where the service is provided. All services related to oral surgery require prior authorization.

Orthotic devices
Orthotic devices are rigid appliances or apparatuses used to support, align or correct bone and muscle injuries or deformities. This benefit covers the purchase, fitting, and necessary adjustments of covered orthotic devices. It also covers the required repair because of normal wear and tear on the device.

Replacement of an orthotic device is only covered when it is deemed medically necessary. There is no limit to this benefit.

Ostomy supplies
Ostomy supplies are medical supplies necessary for the care and drainage of a stoma. There is no limit to this benefit.

Outpatient medical therapy services
This benefit provides CHIP members with an unlimited number of medically necessary outpatient visits for the following services:

- Dialysis treatments
- Cancer chemotherapy and hormone treatments
- Respiratory therapy
- Radiation therapy

This benefit may require prior authorization. The CHIP member must have a documented diagnosis that indicates that the prescribed therapy is a medical necessity.

Outpatient rehabilitative therapy services
This benefit provides CHIP members with the following medically necessary rehabilitative services:

- Physical therapy
- Occupational therapy
- Speech therapy

Coverage is limited to 30 visits for each, physical, occupational and speech therapy, for a combined total limit of 90 days outpatient therapy. If there is a medically necessary reason to exceed the limit ,please submit a request to the UM department requesting a " program exception".

Primary care practitioner office services
Preventive and well child visits and services include the following, with no cost sharing or copays:

- Coverage will be provided for pediatric Immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services. Pediatric Immunization ACIP schedules may be found by at **cdc.gov/vaccines/schedules/index.html**.
- Influenza vaccines can be administered by a participating pharmacy for members starting at 5 years old, with parental consent, according to PA Act 80 of 2022.
- Sick and urgent care office visits including those that occur after normal office hours when medically necessary. These visits include well baby care, which generally includes a medical history, height and weight measurement, physical examination, routine diagnostic tests and counseling.
- Blood lead screening and lead testing. This blood test detects elevated lead levels in the blood.
- Oral health risk assessment, fluoride varnish for children ages 5 months to 5 years old (US Preventive Task Force Recommendation).
- Follow-up care after emergency services.
- Women's health services and family planning services (see benefit description for details).
- Genetic counseling and testing – there are no limits for this benefit.

Other preventive services
Benefits are covered for:

- All items and services recommended by the United States Preventive Services Task Force with a rating of A or B in the current recommendations, including:
    - Dental cavities prevention for preschool children
    - Healthy diet counseling
    - Oral fluoride supplementation
- BRCA risk assessment and genetic counseling and testing
- Prescribed Vitamin D
- Prescribed iron supplementation
- Chlamydial infection screening of pregnant women
- Chlamydial infection screening for non-pregnant women
- Sexually transmitted infections counseling
- Folic acid supplementation
- Tobacco use counseling and interventions
- Benefits as recommended by the Advisory Committee Immunization Practices (ACIP) of the Center for Disease Control and Prevention
- Benefits as recommended by the Health Resources and Services Administration (HRSA), including:
    - All Food and Drug Administration-approved contraceptive methods
    - Sterilization procedures
    - Breast feeding equipment
    - Patient education and counseling for all women with reproductive capacity

Prosthetic devices
Prosthetic devices replace all or part of a missing body part and are medically necessary. They're also used to help a non-functioning organ to work again. This benefit covers the purchase, fitting and necessary adjustments of covered prosthetic devices. It also covers required repair that resulted from normal wear and tear on the device.

Replacement of a prosthetic device is only covered when deemed medically necessary and appropriate due to the normal growth of the child. There is no limit to this benefit.

Restorative or reconstructive surgery services (other than mastectomy-related services)
Covered services for medically necessary restorative and reconstructive surgery include services relating to:

- Surgery to correct a deformity resulting from:
- Disease
- Trauma
- Congenital or developmental anomalies (birth defects) through the age of 18
- Infection

Surgery to correct a bodily functional defect resulting from:

- Accidental injury
- Incidental to surgery
- Surgery in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment, in order to achieve reasonable physical or bodily function

There is no limit to this benefit.

Skilled nursing inpatient facility services
Skilled nursing services are available if deemed medically necessary to children requiring around the clock skilled nursing services but not needing to be in a hospital.

Specialist physician services
Office visits, diagnostic testing and treatment by specialists are covered when provided by a CHIP network provider. There is no limit to this benefit.

Transplant services
Transplant services that are medically necessary and not considered experimental or investigative by are covered. Prior authorization is required.

Covered services for patient selection criteria (testing required by the transplant facility to make sure a child is eligible for a transplant) are covered at only one designated transplant facility except when the services are rendered as part of a second opinion that has been prior authorized by. This benefit does not provide coverage for services related to the donation of organs to non-members.

Urgent care services
As described in the urgent care section of the CHIP member handbook. There is no benefit limit.

Urological supplies
Urological supplies required for medically necessary urinary catheterization are covered only for a CHIP member that has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected for a child within three months. There is no benefit limit. Any DME request over $500 may require review by our medical director.

Women's health services
There is no cost sharing for preventive services under the services of Family Planning, Women's health and contraceptives. Well-woman preventive care includes services and supplies as described under the women's preventive services provision of the Patient Protection and Affordable Care Act. Covered services and supplies include, but are not limited to, the following:

- Pelvic exam, clinical breast exam and routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists
- Family planning services (refer to benefit described previously for further details and limitations)
- Maternity services (refer to benefit described previously for further details and limitations)
- Treatment of gynecological illness, including injury or complications that result from an elective abortion

The annual gynecological examination and associated services are limited to one per benefit year. Except in cases of an emergency, abortion services may require prior authorization.

Abortions will only be covered if a physician has certified the abortion is medically necessary to save the life of the mother or if the abortion is performed to terminate a pregnancy resulting from an act of rape or incest. The incident of rape or incest must have been reported to law enforcement authorities or child protective services, unless the treating physician certifies that in his or her professional judgment, the member is physically or psychologically unable to comply with the reporting requirement. Please submit your request with an MA-3 form (Physician certification) to the UM department at **1-877-363-8120**.

Contraception
Food and Drug Administration approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures and patient education and counseling, not including abortifacient drugs, at no cost share to the CHIP member.
Contraception drugs and devices are covered under the prescription drug benefit issued with the plan.

Mammograms
Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments do not apply to this benefit.

Breastfeeding
This benefit includes comprehensive support and counseling from trained providers; access to breastfeeding supplies, coverage for an electric breast pump; and coverage for lactation support and counseling provided during postpartum hospitalization, mother's option visits and obstetrician or pediatrician visits for pregnant and nursing women at no cost to the member. Coverage for rental of a hospital-grade breast pump requires prior authorization.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)
Coverage is provided for bone mineral density testing using a U.S . Food and Drug Administration-approved method. This test determines the amount of minerals in a specific area of the bone. It is used to measure bone strength which is the aggregate of bone density and bone quality.
Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a professional provider legally authorized to prescribe such items under law.

Pharmacy
We provide coverage for a broad range of prescription drugs. Our CHIP formulary explains which medications are covered. Typically, we won't pay for drugs not included in the CHIP formulary.

- Some medications in the formulary may require prior authorization
- Some medications may only be covered if a member has met certain criteria. Examples include having the health care provider submit documentation that the member has:
    - Certain medical conditions or diagnoses that indicate the medication is medically necessary
    - Drug allergies that limit the use of other medications a member might be treated with
    - Unsuccessful treatment of a condition or illness with a different medication without success

CHIP dental benefits
CHIP covers dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions. There are no copayments for dental services. CHIP doesn't cover dental services performed for cosmetic purposes rather than medical necessity. CHIP also doesn't cover more treatment due to noncompliance with prescribed dental.

CHIP vision / eye care benefits
covers emergency, preventive and routine vision care:

- Lenses
- Contact lenses are covered if medically necessary in lieu of a set of glasses
- Frames

Chapter 8

Bright Futures Overview

Bright Futures is based on the recommendations of the American Academy of Pediatrics (AAP), American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD). All PCPs who provide services to members under age 19 are encouraged to provide comprehensive health care, screening, and preventive services. We require our network PCPs to provide all Bright Futures services in compliance with federal and state regulations and periodicity schedules. You can find the most recent periodicity guidelines at **https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf**.

Current recommended childhood and adolescent immunization schedules can be viewed at **www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html** as well as in Chapter 16: Helpful links to forms and schedules.

Identifying barriers to care

Understanding barriers to access is essential to ensuring that members receive appropriate care including regular preventive services. We find that although most parents understand the importance of preventive care, many confront seemingly insurmountable barriers to readily complying 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 Bright Futures services. To address this, we train our Member Services and Care Management staff to identify potential obstacles for care during member communications opportunities. We also train our staff to work with family members/caregivers, PCPs, and other relevant entities to ensure access to services.

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

- Cultural or linguistic issues
- Lack of perceived need if children are not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Lack of transportation
- Difficulties with scheduling 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

Call your Provider Services Representative at **1-866-638-1232** for help arranging any of these services.

Screening, diagnosis, and treatment

You're required to make the following recommended and covered services available to Bright Futures eligible members at the ages recommended on the periodicity schedule. Providers are encouraged to complete Bright Futures screening services within 45 days of the member joining your practice.

Screening services, provided at recommended ages in the child's development, include all of the following:

- Comprehensive health and developmental history, including nutritional and developmental assessments (WIC evaluations and child abuse assessments are also included when necessary)
- Inpatient physician visits and routine inpatient and outpatient screenings provided for newborns.
- Comprehensive physical exam including unclothed
- Appropriate immunizations (in accordance with the Advisory Committee on Immunization Practices (ACIP) schedule)
- Laboratory tests, including urinalysis, hemoglobin/hematocrit count, Tuberculosis testing and lead toxicity screening
- Health education including anticipatory guidance, child development, healthy lifestyles, 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, relief of pain and infections, restoration of teeth and maintenance of dental health (oral exam by PCP should begin at age one with a referral to a dentist beginning at age three)
- Hearing services, including, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Diagnostic services, including referrals for further evaluation whenever such a need is discovered during a screening examination
- Treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services
- Developmental delay and autism spectrum screenings
- Lead poisoning prevention

Practitioners are expected to do the following in providing Bright Futures services:

- Avoid delays in pediatric screenings and services by taking advantage of opportunities (for instance, provide an immunization or screening during a sick visit or a sibling's visit)
- Give immunizations to members in accordance with federal and commonwealth standards
- Comply with our Minimum Medical Record Standards (contained in the Provider Agreement) for Quality Management, Bright Futures Guidelines and other requirements under the law
- Cooperate with our periodic reviews of Bright Futures services, which may include chart reviews to assess compliance with standards
- Report members' Bright Futures visits by recording the applicable Current Procedural Terminology (CPT) preventive codes on the required claim submission form

If you detect a suspected problem during a screening examination, you must evaluate the child as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

If you suspect developmental delay following a Bright Futures screening and the child is not receiving services at the time of the screening, you must refer the child (not over 5 years of age) to CONNECT at **1-800-692-7288** for the appropriate referral to local Early Intervention Program services.

We track treatment needs as we identify them. We also assure that appropriate follow-up is pursued and reflected in the medical record.

Omnibus Budget Reconciliation Act (OBRA) of 1989 entitles individuals under the age of 21 to receive all medically necessary health care services contained in Section 1905(a) of the Social Security Act and required providers to treat a condition diagnosed during an encounter. Any medically necessary health care procedure or service that is eligible under the federal CHIP program is covered including Behavioral Health Services. Providers are responsible for identifying members in need of behavioral health treatment services, notifying us, and assisting members by referring them to appropriate behavioral health providers.

Tracking

We track compliance with Bright Futures guidelines in the following areas:

- Initial visit for newborns. The initial Bright Futures screen is the newborn physical exam in the hospital.
- Bright Futures screenings and reporting of results.
- Diagnosis and/or treatment or other referrals for children.

We also track a variety of Bright Futures screenings and treatments including:

- Number of comprehensive screens (reported by age)
- Hearing and vision examinations
- Dental screens
- Age-appropriate screens
- Complete age-appropriate immunizations
- Blood lead screens
- Prenatal care for teen mothers
- Provision of eyeglasses to those in need of them
- Dental sealants
- Newborn home visits
- Referral of very low birth weight babies to early intervention
- Referral of members under the age of 19 with elevated blood lead levels to early intervention
- Routine evaluation for iron deficiencies
- Timely identification and treatment of asthma

Follow-up and outreach

We'll work with you to ensure that members with Bright Futures needs are identified and treated in a timely and appropriate manner.

Arranging medically necessary follow-up care for health care services is also an integral part of each provider's continuing care responsibility after a screen or any other health care contact. In cases involving a member under the age of 19 with complex medical needs or serious or multiple disabilities or illnesses, our Care Management services must be offered. You can reach our Special Needs/Care Management staff at **1-855-346-9828** to arrange these services.

We closely monitor Bright Futures metrics throughout the year to identify trends and potential opportunities for improvement. We also identify any children who have not yet received a Well-Care visit in the last 12 months as a priority for follow-up. We continuously update our interventions database that includes children with missing services and contact information for the member and the provider. Also, each month we calculate provider level HEDIS rates at the group level for the previous 12-month period. Then, we identify which members have gaps in care.

Our reminders for follow-up and outreach to members include:

- Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of members.
- Telephone calls remind members of upcoming visits and follow-up on missed appointments within a set time period.
- Help with transportation when requested so members can get necessary Bright Futures screening services. Assistance is offered prior to each due date of a child's periodic examination.
- Outreach to non-adherent members, including home visits, as appropriate.
- Outreach and follow-up to members under the age of 19 with special needs.

Our Care Managers are responsible for coordinating and tracking Bright Futures services, including services for children and adolescents with developmental disabilities, behavioral health needs and complex health problems who are enrolled in the Care Management program.

All assessments evaluate members under the age of 19 to identify if Bright Futures visits are needed and incorporate these services into the care plan. Care Managers use a variety of care management tools (e .g ., CORE 2.0 , our proprietary predictive modeling application) and assessments to identify members in need of coordination of care and schedule targeted outreach calls. They enter information gathered from these activities into Dynamo™, our customized care management tracking application. This enables Care Managers to review a member's encounter history, schedule needed appointments and plan follow-up activities.

In addition to outreach to members participating in our Care Management program, we generate reports to identify members who are due or past due for Bright Futures screenings and services. We perform targeted outreach through reminder mailings, phone calls and text to parents/guardians of children under the age of 19 who are due for a Bright Futures visit.

PCPs are required to contact new members identified in the quarterly encounter lists who haven't:

- Had an encounter during the first six months of enrollment
- Complied with scheduling requirements for screenings, testing and treatment

PCPs must also contact members identified as not complying with the Bright Futures periodicity and immunization schedules for children to set up appointments. If members don't comply within one month of being contacted by the PCP, the PCP must notify us. The PCP must document the reasons for noncompliance, where possible and document efforts to bring the member's care into compliance with Bright Futures standards.

PCPs must also contact all members who have not had an encounter during the previous 12 months or within the appointment standards timeframes established in the Provider Agreement.

On a quarterly basis, an outreach call is made to members who haven't received Bright Futures services within the recommended timeframes. If necessary, Care Managers will make up to three additional efforts to contact parents and guardians by telephone. If those attempts are unsuccessful, we'll send another letter and initiate any extra follow-up needed in order to reach the enrollee, including researching returned mail and contacting the member's PCP's office for assistance (for enrollees who are enrolled in Care Management).

If needed, a Care Manager will contact a member's PCP to inquire whether a Bright Futures visit occurred. If a Bright Futures visit did not occur, we'll ask the PCP to reach out to the parent/guardian to schedule an appointment.

Educating members and providers about Bright Futures services

We have a comprehensive strategy for educating members and providers about the importance of preventive health screenings and immunizations.

These strategies include, but are not limited to:

- Member educational materials
- Provider educational materials
- Integration of information into Care Management Programs (e .g ., care coordination, Care Management and Disease Management)

Members

We inform members about the availability and importance of Bright Futures services through:

- Our new member welcome packet
- Our Member Handbook
- Our member newsletters and bulletins
- Aetna Better Health Kids website: **AetnaBetterHealth.com/Pennsylvania**
- Our educational flyers
- Our reminder calls

- Our text messages
- Our care plan interventions for high-risk members enrolled in Care Management or Disease Management

Providers
We conduct provider educational and outreach activities designed to emphasize the importance of Bright Futures screenings and services and help you more readily identify patients overdue for services. These activities help you document preventive services and identify and resolve other issues that impede provider participation, including reimbursement. We work with you to increase compliance with Bright Futures screening and treatment standards through the following strategies:

- Providing online educational handouts and access to educational websites
- Increasing reimbursement for preventive care services
- Linking pay for performance criteria to preventive service delivery rates
- Implementing initiatives to increase immunizations, well-child visits and dental visits
- Developing clinical practice guidelines specific for Bright Futures
- Developing member profiling and provider report cards that target Bright Futures services
- Conducting on-site visits with providers to identify barriers to care
- Conducting an annual audit using HEDIS® criteria and American Academy of Pediatrics screening standards to improve compliance with Bright Futures benchmarks
- Implementing performance improvement plans that include Bright Futures, if needed

We work collaboratively with providers to stress the importance of Bright Futures screenings and services. We also closely monitor compliance with established benchmarks and produce periodic reports for PCPs showing which members need Bright Futures services. Please note that failure to submit a claim for complete Bright Futures screenings and services may result in denial of payment.

Interagency teams
For the ongoing coordination of Bright Futures services for members under the age of 19 identified with special needs, our staff will ensure coordination with community-based organizations, schools, and other appropriate entities. Our staff works collaboratively with these organizations, the member (if appropriate), the member's family/caregiver and other stakeholders to develop a comprehensive plan of care for the delivery of all medically necessary and appropriate services. This includes pediatric care and other specialized services, whether covered or uncovered and whether in- or out-of-network. As needed, we also initiate Care Management interventions for members under the age of 19 with complex and/or co-morbid conditions.

Chapter 9

Medical Management Overview

Our Medical Management Program encompasses activities directed toward prospective, retrospective, and concurrent utilization review. It also covers Integrated Care Management and Disease Management services.

Prospective Review (Prior Authorization) determines the medical necessity and appropriateness of the service before it is provided. Concurrent review determines the appropriateness of the level of care and length of stay throughout a member's inpatient stay. Retrospective review involves assessment of the appropriateness of medical services after the services have been provided.

Care Management Services assist physicians with members who have special needs, complex health problems and/or high-risk pregnancy. Our Disease Management Programs help members to manage their chronic illnesses.

Our Integrated Care Management (ICM) Program uses a bio-psycho-social model (BPS) 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 high risk of not doing well over the next 12 months. We offer them intensive Care Management Services built upon a collaborative relationship with a single clinical case manager, their caregivers, and their primary provider. This relationship continues throughout the Care Management engagement. We also offer supportive Care Management Services to members who are at lower risk. Supportive care includes standard clinical Care Management, service coordination and support.

To support our Care and Disease Management activities, we use our proprietary health risk assessment, questionnaires, and predictive modeling software. A customized Care Management application enables our Care Management team to work closely with members, their families, and providers to help improve clinical outcomes and enhance the quality of life for members. Our predictive modeling and self-report tools fully integrate physical and behavioral health conditions along with psychosocial risks and protective factors to identify members who would benefit from Care Management and then stratify them into intensive and supportive levels of service.

We use three tools to identify complex, high-risk members. We then assign them to one of these levels of Care Management Services. The tools we use to identify the right members for ICM include:

- Predictive modeling using our CORE analysis
- Self-report – Health Risk Questionnaire (HRQs) and/or their state-mandated alternatives
- Surveillance – Daily census, readmissions and other "traditional" case finding methods

The functionality of the Care Management software includes:

- Case finding tools
- Outreach questionnaire
- Integrated clinical assessments
- Integrated care plan
- Correspondence
- Condition-specific assessments
- Member satisfaction survey
- Audit tools
- Reporting (e .g ., tracking of member outcomes
- Community resource coordination

Our Utilization Management and Quality Management staff works with providers, monitoring the care provided to members and performing the following functions:

- Coordinating member services, including:
    - Detecting inappropriate patterns of care (e.g. over-or under-utilization of services, including pharmacy)
    - Identifying diagnoses or multiple co-morbidities that place members at risk for adverse health outcomes.
- Monitoring compliance with treatment protocols, including:
    - Untreated co-morbid conditions
    - Gaps in care, such as a failure to fill prescribed medications or get a flu shot based on evidence-based guidelines
    - Use of medications that are less than optimal for chronic conditions (e.g. rescue medication for asthma when controller medications would be more optimal)

- Assessing provider performance, including:
    - Adherence to evidence-based clinical guidelines, including prescribing patterns
    - The delivery of care or services which, if improved, could enhance member safety and health outcomes
    - The provision of providing preventive screenings and treatments
- Tracking and trending quality measures, including:
    - Verification that emergency and inpatient hospital services are appropriately used
    - Post hospital discharge services are adequate, including medication regiment
    - Inpatient readmissions are reduced
    - Inappropriate use of the emergency department

Medical claims review

We identify certain claims to determine whether services were delivered as prescribed and consistent with our payment policies and procedures. In these instances, our Medical Claims Reviewers:

- Determine whether the documentation provided supports the billing.
- Review whether billed charges are necessary and reasonable.
- Identify non-covered supplies and services along with inappropriate and undocumented charges. The Medical Claims Reviewers report any cases of potential fraud or abuse to our Compliance Department for review.

Medically necessary

All services provided to members must be “medically necessary” and delivered at the appropriate level of care.

A service or benefit is “medically necessary” if it is compensable under the CHIP Program and if it meets any one of the following standards:

Medically Necessary is a service, item, or medicine does one of the following:

1. It will, or is reasonably expected to, prevent an illness, condition, or disability;
2. It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability;
3. It will help a child get or keep the ability to perform daily tasks, taking into consideration both the child’s abilities and the abilities of someone of the same age.

Determination of “medically necessary” for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing.

The determination is based on individual member needs and medical information provided by the member, the member’s family/caretaker, and the PCP, as well as any other providers, programs, and/or agencies that have evaluated the member.

All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a health care service under this Agreement.

Please note: Services previously determined to be medically necessary, authorized and scheduled shall not be denied or cancelled based upon eligibility and benefits.

Prior authorization, concurrent review and retrospective review criteria

We use the MCG® criteria to ensure consistency in hospital–based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The MCG are updated regularly as each new version is published. Copies of individual guidelines are available for review upon request.

To support prior authorization, concurrent review, and retrospective review decisions, we use nationally recognized evidence-based criteria with input from health care providers in active clinical practice. We apply these criteria on the basis of medical necessity and appropriateness of the requested service, the individual member's circumstances and applicable contract language concerning the benefits and exclusions. The criteria will not be the sole basis for the decision.

For inpatient medical care reviews and for elective inpatient and outpatient medical services, the CHIP program uses the following medical review criteria. These are to be consulted in the order listed if the specific request is not addressed by that set of criteria:

- Criteria required by the State of Pennsylvania CHIP contract
- Applicable MCG
- Aetna National Clinical Policy Bulletins (CPBs)

For prior authorization of elective inpatient and outpatient behavioral health services, CHIP uses the following clinical review criteria. These are to be consulted in the order listed:

- Criteria required by applicable state regulatory agency or client contract
- Applicable MCG
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Clinical Policy Council Review

We utilize nationally researched review criteria sets annually reviewed for appropriateness for our membership needs and modify as applicable in order to reflect current medical standards. The annual review process involves appropriate practitioners in developing, adopting or reviewing criteria. Utilization clinical criteria is available via the Availity portal. Select Aetna Better Health from the Payer Spaces, navigate to the Resources tab, scroll down and Select MCG guidelines.

Clinical criteria guidelines are also available upon request by contacting our UM department by requesting a copy of the Medical Necessity Criteria by sending a written request via fax to **877-363-8120** or by mail to:

Aetna Better Health Kids
Attn: Utilization Management Department
PO Box 818047
Cleveland, OH 44181-8047

Prior authorization, concurrent review and retrospective review requests are presented to the designated medical director for review when the request does not clearly meet criteria applied as defined above. Before making a determination of medically necessary, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area.

The prescribing or treating practitioner may request a peer review to discuss a medical necessity denial with a medical director reviewer within 60 days (about 2 months) of the determination letter date unless a member grievance has been filed which would take precedent over a provider peer to peer request. Our staff will verify that no enrollee grievance has been filed prior to scheduling the peer-to-peer discussion.

Information required for prior authorization, concurrent review and retrospective review
Health care services and items must be medically necessary and provided appropriately, effective, timely and cost-efficient. A member's PCP is responsible for initiating and coordinating a request for prior authorization. The admitting or treating practitioner or provider is responsible for making the necessary information available for concurrent review. However, specialists and other participating providers may need to contact the Prior Authorization or Concurrent Review Department directly to obtain or confirm an authorization.

Providers are responsible for complying with our prior authorization policies and procedures and for securing an authorization number to ensure reimbursement of claims. Information in the prior authorization request for concurrent review must validate the medically necessary covered care and services, procedures and level of care and medical or therapeutic items. A request for authorization must also include the following information:

- Current, applicable codes
    - Current Procedural Terminology (CPT)
    - International Classification of Diseases, 10th Edition (ICD-10)
    - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
    - National Drug Code (NDC)
- Name, date of birth, gender and identification number of the member
- Primary care or treating provider
- Name, address, phone and fax number and signature, if applicable of the ordering provider
- Name, address, phone and fax number of the rendering provider
- Problem/diagnosis, including the ICD-10 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

Inpatient admission notifications received from the facility's administrative offices, including admissions, business or finance, satisfies the requirement to notify us of an admission. These notifications will be processed as an authorization once the required information to validate medically necessary outlined in this section is provided.

Decision and notification standards
We adhere to the following timeframes when notifying PCPs, prescribing clinicians and members of prior authorization, concurrent review and retrospective review decisions:

Type of Decisions	Decision	Initial Notification	Written Confirmation
Emergency/urgent admissions	Immediate, no prior authorization required	N/A	N/A
Drugs	24 hours from receipt of request	24 hours from receipt of request	24 hours from initial notification
Home Health	48 hours from receipt of request	48 hours from receipt of request	2 business days from initial notification
Request for additional information	14 calendar days from the receipt of the request		2 business days after the decision is made
Urgent precertification	24 hours from receipt of request*	24 hours from receipt of request	24 hours from initial notification
Non-urgent precertification	2 business days	2 business days from receipt of the request	2 business days from initial notification
Urgent concurrent review	1 business day	1 business day	1 business day*
Retrospective review	30 calendar days from receipt of the request	30 calendar days from receipt of the request	30 calendar days from receipt of the request

*The timeframes for decisions and notification may be extended if additional information is needed to process the request.

During non-urgent preservice requests, in circumstances where there is insufficient information to determine, the provider will be given 14 calendar days to provide additional information.
If we need more facts, documents, or information to make a decision, we will request it from the appropriate practitioner within standard review timeframes above. The practitioner has 14 calendar days to submit the additional information. We also notify members of requests for more information on the date we request it from the practitioner.

If the practitioner provides the additional information within 14 calendar days, we decide to approve or deny the service and notify the member, member's PCP and prescribing practitioner according to the timeframes in the table above.

If we do not receive the requested information within 14 calendar days, we make a decision to approve or deny the service based upon the available information and notify the member, member's PCP and prescribing practitioner according to the timeframes above.

Denial, reduction, suspension or termination of services

We notify the prescribing practitioner, member's PCP and member in writing of any decision to deny, reduce, suspend or terminate a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.

Our medical directors conduct medical review for each case identified as a potential denial of authorization. The requesting physician may be asked to submit more information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend or terminate an existing or pending service.

Clinical medical necessity determinations are based only on the appropriateness of care and service and the existence of coverage. Aetna Better Health Kids 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 inpatient denials, the attending physician and hospital staff are notified electronically when the admission or days within the confinement are denied. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending or referring physician may dispute the finding of the medical director informally by phone (peer to peer) or formally in writing. If the finding of the medical director is disputed, a provider appeal may be filed. (Instructions for provider appeal is noted in CHAPTER 18: APPEAL, GRIEVANCE AND COMPLAINT SYSTEM section)

Peer-to-peer consultation

Our medical directors participate in the utilization review process and conduct clinical review. They are available to discuss review determinations with attending physicians or other ordering providers. We'll notify practitioners/providers verbally, at the time of notification of the denial, that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer. We provide, within one business day of a request by the attending physician or ordering practitioner, the opportunity to discuss the denial decision:

- With the medical director making the initial determination
- With a different medical director if the original medical director cannot be available within one business day
- A health care provider can designate, another licensed member of the provider's affiliated or employed clinical staff with knowledge of the member's condition and requested procedure as a qualified proxy for purposes of
  completing a peer-to-peer discussion.
- Aetna Better Health Kids shall make a peer-to-peer review discussion available to a requesting healthcare provider or their designee from the time of a prior authorization denial until the internal grievance process commences.

Discharge planning coordination

Our Concurrent Review Nurses assist hospital staff in coordinating appropriate individualized discharge plans for members' post-hospital care. The concurrent review nurses assist with, but don't duplicate discharge services that Medicare, Medicaid and the Joint Commission on Accreditation of Healthcare Organization (JCAHO) require hospitals to provide.

Our post-hospital planning function is carried out under the direction of the Chief Medical Officer (CMO) by Concurrent Review Nurses who are responsible for:

- Coordinating the member's post-hospital discharge planning with facility personnel
- Documenting the member's hospital discharge plans upon the initial review and ongoing as needs are identified
- Documenting the member's discharge date and status within 24 hours of knowledge of the discharge
- Coordinates with Aetna Better Health Kids care management staff for additional follow-up with enrollee/guardians' discharge planning needs.

Designated Case Management staff members are responsible for:

- Calling the member within 3 business days of the member's discharge date if required*
- Determining whether the member obtained appropriate supplies and scheduled appointments*
- Determining whether a case and/or Disease Management case needs to be opened to further assist the member with their health care needs

*If we cannot reach the member after at least three outreach contacts, we send the member a letter on day five as an additional outreach attempt.

Care Management

Our Chief Medical Officer is responsible for directing our Care Management program with the assistance of the Director of Medical Management and the Manager of Care Management. This includes ensuring the incorporation of clinical practice guidelines into our Care Management practice and program. Our Care Managers are RNs and other independently licensed physical and behavioral health professionals. Care Managers along with other Care Management staff perform the day-to-day Care Management functions. These employees are trained on the special health care needs of the member population, Care Management approaches and motivational interviewing to improve member engagement.

Our Integrated Care Management (ICM) Program uses a bio-psycho-social model (BPS) 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 high risk of not doing well over the next 12 months. We then offer them intensive Care Management Services built upon a collaborative relationship with a single Clinical Care Manager, their caregivers and their primary care practitioner. This relationship continues throughout the Care Management engagement. We also offer supportive Care Management Services to members who are at lower risk. These include standard clinical Care Management along with service coordination and support.

ICM considers all the member's needs as they relate to their current and future health. We achieve this by evidence-based member identification and stratification. Our predictive modeling and self-report tools fully integrate physical and behavioral health conditions along with psychosocial risks and protective factors to identify members who would benefit from Care Management. The members are then stratified into intensive and supportive levels of service.

These steps are followed by assessment, case formulation and case planning. Highly skilled Care Managers interview members entering intensive Care Management to identify the root causes driving poor health and the critical barriers to improvement.

These might be related to their physical health or behavioral health conditions directly, to psychosocial issues that impact the member's ability to participate effectively in their own care or to barriers created by the health care system itself. The member and Care Manager then collaborate to identify the highest priority issues, goals important to the member and activities to reach those goals. Engaging and motivating members to make critical changes in persistent patterns of behavior and to assume greater responsibility for their health as Care Management progresses are essential skills for the Care Managers.

Members entering supportive Care Management have fewer complex-presenting issues that typically respond well to straightforward problem solving.

Members in supportive care management are more likely to be condition-specific or need coordination of different elements of the member's treatment and support services. Supportive Care Managers and Care Management Associates help members resolve these issues effectively, safely and quickly.

The final element of ICM is accountability for outcomes. We strive to measure the member's ability to achieve and sustain better health by becoming a more engaged and activated participant in their own health care and making better use of more appropriate health care resources.

ICM key components

Focus on:

- Right members
- Right people, right skills
- Individualized, relationship-based care
- Bio-psycho-social care planning
- Electronic tools
- Interdisciplinary case rounds
- Progression of care

- Outcomes accountability

We offer Care Management services to help you serve members who have special needs and/or complex health problems. Care Management services assist members in gaining access to necessary medical, behavioral, social, educational, and other services.

When a member enrolls in the Aetna Better Health Kids Care Management program, we'll assign the member to a case manager or care coordinator. The care manager or care coordinator will work with the member's primary care practitioner/specialist, community case managers or other program case managers to develop a care plan. The care plan uses a goal-oriented process that moves the member toward optimal health and wellness and encourages the member to take an active role towards self-care. The goals are to improve the member's health outcomes and the member or caregiver's ability to self-manage the condition.

If you have a member that you believe would benefit from our Care Management Program because of a special health care need, serious, chronic, disability or complex medical condition, complete the Care Management Referral form and fax to **877-683-7354**. If you have questions concerning the Care Management Program, call **1-855-346-9828**.

Disease Management

Our Disease Management (DM) program provides an integrated treatment approach that includes the collaboration and coordination of patient care delivery systems. It focuses on measurably improving clinical outcomes for a particular medical condition. This is accomplished through the use of appropriate clinical resources such as:

- Preventive care
- Treatment guidelines
- Patient counseling
- Education
- Outpatient care

It includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

Our DM program assists you in managing members diagnosed with targeted chronic illnesses. The illnesses targeted are those that have been shown to respond to coordinated management strategies. They've also been shown to frequently result in exacerbations and hospitalizations (high-risk) that require high usage of certain resources and that incur high costs. Our DM program has six components:

- Population identification processes
- Evidence-based practice guidelines
- Collaborative practice models that include physician and support-service providers
- Patient self-management education
- Process and outcomes measurement, evaluation and management
- Routine reporting/feedback loop (including communication with members, physicians, ancillary providers and provider profiling)

We identify members as candidates for the Disease Management Program through a stratification process using claims data and ICD-10 codes through our predictive modeling program. If a member is stratified and placed into the high-risk category, a representative from our program will contact the member and complete an assessment to determine enrollment in the DM program.

The DM Department also carries out day-to-day Disease Management operations, including:

- Identifying potential DM members using the predictive modeling/stratification database
- Conducting initial questionnaires of potential DM members and enrolling them in the program, if applicable
- Educating members about their disease process and effective self-management strategies
- Developing a goal-oriented plan of care for each member
- Evaluating at least monthly members' progress toward goals and the effectiveness of the program, with more frequent evaluations if the case indicates
- Communicating members' progress updates to their primary care practitioners
- Identifying members who meet criteria for referral to Care Management or Behavioral Health Care Management
- Assessing each case after six months for completion of goals and, if applicable, risk stratification to low risk
- Providing monthly reports of aggregate DM program outcome measures for each plan with an Aetna Medicaid Business Unit DM program
- Annually surveying member and provider satisfaction with the program

Plan-specific DM programs are structured to include nationally recognized, evidence-based guidelines, risk group interventions, risk scores, assessment of outcomes data and report formats.

We also use a National Committee for Quality Assurance (NCQA) Certified Disease Management Program to help members reduce the frequency and severity of exacerbations of a chronic illness. We do this by improving the members' health status and helping to appropriately self-manage their disease. We developed our programs using nationally recognized evidence-based guidelines. We distribute all DM guidelines to all contracted providers.

DM programs available to members include:

- Asthma (children and adults)
- Diabetes (children and adults)
- Sickle Cell Disease
- Behavioral Health

For our CHIP members, we developed DM programs for children with asthma and diabetes. Also, our DM programs address co-occurring physical concerns like obesity, hypertension and behavioral health conditions like depression and anxiety.

If you have a member who has one of the above listed chronic conditions, e.g. asthma, diabetes, you or your staff can make a referral to our Disease Management program at any time. To make a referral, call **1-855-346-9828** for Disease Management.

Members identified with special needs
We manage the care of members with special health care needs through our Care Management Department. The Care Management Department operates under the direction of our Chief Medical Officer and Special Needs Coordinator. The department's primary responsibility is to work aggressively to identify and assess special needs members prior to the onset of an adverse event. To this end, the Special Needs Unit:

- Provides care coordination/Case Management
- Works as an advocate for special needs members throughout Aetna Better Health
- Collaborates with others involved in each member's care (e. g., , Behavioral Health, community agencies, schools, etc.)

Our Special Needs Unit staff has direct access to the plan medical director and case managers with specialized expertise in the diverse and complex needs of members with chronic and/or complex health conditions.

To refer a patient to our Special Needs Unit, call **1-855-346-9828** Monday through Friday 8:30 am through 5pm.

Maternity Matters Care Management Services

Perinatal Care Management Services educate pregnant members on how to use the maternity care services available. They also assist those with complex clinical or social issues to obtain the support services they need. Care Managers assist members in developing a plan of care to meet their individualized needs. An individual's risk factors determine the interventions we use to overcome barriers to care and promote a healthy pregnancy that will result in healthy outcomes for the newborn and mother.

Care Managers provide an important link between members, their providers and community resources or agencies, such as health departments. As an advocate for the member, the Care Manager can coordinate care and services to focus on the specific individual member's needs.

Covered perinatal Care Management ranges from pre-conception counseling through postpartum care address both clinical and social needs. Care is also provided in a manner that accommodates members' cultural needs (e. g., for language translation). The services may include:

- Pre- and Perinatal Case Management for high-risk members
- Outreach contacts, such as telephone reminders of appointments, referrals and follow-up calls
- Maternity care services from a qualified health care professional or specialist (a participating obstetrician), a primary care practitioner experienced in maternity care, a certified nurse midwife or perinatologist
- Health risk questionnaires to identify high-risk populations and appropriate interventions
- Education, available through mailings or group classes
- Social support services to address individual risks, such as smoking cessation classes, alcohol and/or substance use disorder treatment, services to address spousal or partner abuse and emotional or mental health concerns
- Family planning services whenever appropriate

- Referrals to community resources, such as the Women, Infants and Children (WIC) Program, birthing or nutrition resources, behavioral health, or other resources to assist the member with other needs, such as housing and transportation, if applicable

Coordination with programs in the community that support the member's needs (e. g., Maternal home visiting program, high schools for teen mothers, hospital-or church-sponsored programs)

Maternity Matters Care Management Services

Perinatal Care Management Services educate pregnant members on how to use the maternity care services available. They also assist those with complex clinical or social issues to obtain the support services they need. Care Managers assist members in developing a plan of care to meet their individualized needs. An individual's risk factors determine the interventions we use to overcome barriers to care and promote a healthy pregnancy that will result in healthy outcomes for the newborn and mother. Care Managers provide an important link between members, their providers and community resources or agencies, such as health departments. As an advocate for the member, the Care Manager can coordinate care and services to focus on the specific individual member's needs.

Pregnant member education

Education of pregnant members includes the following information, presented by the Care Manager and the member's practitioners, through group classes or in mailed materials:

- Education in healthy practices is integrated into the care of all expectant members, including:
    - Education about and support for breastfeeding
    - Referral to the Women, Infants and Children (WIC) Program for supplemental nutrition
    - Special education for complex cases (e. g., diabetes)
    - Importance of folic acid to a healthy pregnancy
- Pregnancy
    - Prenatal
    - Fetal development
    - Labor and delivery
- Postpartum
    - Postpartum self-care
    - Postpartum depression
    - Family planning
- Infant care
- Availability of enhanced services such as referrals for social service or health education and referrals for:
    - Special supplemental nutrition program (WIC)
    - Dental care
    - Child health services (for other children)
    - Family planning

- Availability of testing for HIV/AIDS and other sexually transmitted diseases
- Availability of counseling if HIV/AIDS test results are positive
- Prenatal/childbirth classes

Practitioner's responsibilities

Our website includes information about the Perinatal Care Management program, how providers can refer members to the program and the maternity care standards. Visit **AetnaBetterHealth.com/Pennsylvania.** The information is found under "Health & Wellness."

- Discuss and share information with the member regarding:
- The physical changes to be expected during pregnancy
- The process of labor and delivery
- Breast feeding and other infant care information
- The importance of complying with the care plan
- Nutritional recommendations and maintaining healthy behaviors
- Complying with the standards of care recommended by the American College of Obstetrics and Gynecology (ACOG), including use of a comprehensive medical risk assessment tool and ongoing monitoring
- Coordinating the member's maternity care needs throughout the pregnancy and providing postpartum care between 21 and 56 days of delivery
- Referring members as necessary for medical specialty services, such as Perinatology or to Aetna Better Health Kids' Case Management Department for coordination of other services
- Complying with our time standards for first-time appointments and ACOG-recommended standards for return appointments (see the tables below)
- Assessing for possible depression and making appropriate referrals

First Prenatal Appointment Time Standards	
Pregnancy Status	**First Appointment Time**
First trimester	Within 10 business days of identification
Second trimester	Within 5 business days of identification
Third trimester	Within 4 business days of identification
High-risk condition	Within 24 hours of identification
Emergency condition	Immediately upon identification – 28 weeks

Prenatal Return Visit Time Standard	
Pregnancy Status	Return Visit Frequency
Through 28 weeks	Every 4 weeks
Between 29 and 36 weeks	Every 2 weeks
After week 36	Once a week
High-risk condition	According to the member's need

Emergency services

The Department of Human Services defines an Emergency Medical Condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- An emergency service is defined as covered inpatient and outpatient services that:
- Are furnished by a provider that is qualified to furnish such service under Title XIX of the Social Security Act
- Are needed to evaluate or stabilize an emergency medical condition

We'll work with you to assure that members needing emergency services receive medically necessary treatment at appropriate levels in a timely manner.

Monitoring ED utilization

We closely monitor trends in emergency department (ED) utilization and implement appropriate interventions to address identified issues. PCPs are not contractually allowed to "sign out" to the ED or leave outgoing messages on their phone lines or with their answering services instructing members to go the emergency department for after-hours care.

We employ a variety of strategies to monitor and address emergency department utilization, including:

- Reviewing claims and other relevant data to monitor utilization patterns
- Educating providers and members about the appropriate use of the emergency department
- Making referrals to Care Management for evaluating a member's access to care
- Ensuring behavioral health crisis intervention services are provided in the most appropriate setting
- Monitoring and profiling the accessibility of PCPs whose members have a high ED utilization trend

We'll work collaboratively with providers to address issues that may affect ED utilization, such as prescribing patterns (e. g., asthma controller and rescue medications). Our Medical Management staff may also conduct educational sessions for either an individual or larger group of providers who we have identified as contributing to excessive ED utilization. Also, we may require a provider to attend a special training session and/or to develop a Corrective Action Plan.

Chapter 10
Quality Management Overview

Quality Management (QM) is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness and effectiveness of care and service. This methodology is used by professional health personnel that review the degree of conformance to desired medical standards and practices and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Our Quality Assurance and Performance Improvement (QAPI) program is a continuous quality improvement (QI) process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively review our clinical and operational programs and processes to identify opportunities for continued improvement. Our continuous QM/QI process enables us to:

- Assess current practices in both clinical and non-clinical areas
- Identify opportunities for improvement
- Implement Rapid Cycle Improvement activities
- Select the most effective interventions
- Evaluate and measure on an ongoing basis the success of implemented interventions, refining the interventions as necessary

The use of encounter data, ad-hoc internal reports, member and provider complaint data, HEDIS, EQR and CAHPS in the monitoring, measurement and evaluation of quality and appropriateness of care and services is an integral component of our quality improvement process.

Our QAPI program uses an integrated and collaborative approach, involving our entire senior management team, all functional areas within the health plan and all committees from the Board of Directors to the Member Advisory subcommittee.

Our Chief Medical Officer (CMO) oversees the QAPI program. The CMO is supported in this effort by our QM Department and the Quality Management and Utilization Management (QM/UM), Service Improvement (SIC), Credentialing, Appeals/Grievance and Delegation Subcommittee and Quality Management Oversight (QMOC) Committees.

Our QM staff, under the direction of the CMO, develops and implements an annual workplan, which specifies projected Quality Management activities. Based on the work plan, we conduct an annual QAPI program evaluation. We encourage you to participate in medical committees and quality projects. If you wish to participate, call your Provider Relations Representative.

Our Quality Management department is an integral part of both Medical Management and internal operations. Through our team of Quality Management professionals, our focus is to review and trend services and procedures for compliance with nationally recognized standards and to recommend and promote improvements in the delivery of care and service to our members. Our QM, UM, and Special Needs Unit (SNU) maintain ongoing coordination and collaboration regarding Quality Initiatives, Care Management and Disease Management activities involving the care of special needs populations.

Our Quality Management includes, but is not limited to, medical record reviews, site reviews, peer reviews and provider profiling. Utilizing these tools, we, in collaboration with all participating health providers, are able to monitor and reassess the quality of care and services provided to our members.

Our highly effective Medical Management program manages monitors, evaluates and improves the care and services provided to our members.

Our Medical Management UM program is designed to:

- Educate members and providers about the appropriate utilization of care/service delivery systems
- Assess member and provider satisfaction with the processes
- Identify opportunities to optimize members' health outcomes
- Educate regarding the Pay for Quality program for eligible practices
- Identify opportunities to optimize members' health outcomes
- Manage health care costs

Our Medical Management program integrates Utilization Management, Care Management and our Quality Management program, all of which are dedicated to ensuring high quality, cost-effective, outcome-oriented health care for our members.

Quality Practice Liaison program

Our Quality Practice Liaisons (QPLs) within the Quality Management department are your single point of contact regarding quality matters. QPLs collaborate with Network Relations Consultants to ensure the delivery of a seamless experience for our providers. Some QPL responsibilities include:

- Educate on requirements of key quality measures and programs which include HEDIS, state specific performance measures and Pay for Quality.
- Educate on appropriate coding for care capture. Administrative data capture reduces the burden of medical record review.
- Provide current gaps in care reports for key HEDIS measures and assistance on how to close existing care gaps.
- Educate regarding the Pay for Quality program for eligible practices.

Identifying opportunities for improvement

We effectively identify and evaluate opportunities for quality improvement. We determine the best intervention strategies through the systematic collection, analysis, and review of a broad range of external and internal data sources. We identify opportunities for improvement by monitoring the following types of data:

Formal feedback from external stakeholder groups – We take the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (CAHPS) or focus groups with individuals such as members and families, providers, state, and community agencies.

Findings from external program monitoring and formal reviews – As a result of externally initiated review activities such as an annual external quality program assessment or issues identified through a state's ongoing contract monitoring oversight process, we're made aware of specific program activities/processes needing improvement.

Internal review of individual member or provider issues – In addition to receiving complaints and grievances and appeals from members, providers and other external sources, we proactively identify potential quality of care issues for review through daily operations (e. g., Member Services, Prior Authorization and Care Management). Through established formalized review processes (e. g., grievances, appeals and quality of care), we're able to identify specific opportunities for improving care delivered to individual members.

Findings from internal program assessments – We conduct a number of formal assessments/reviews of program operations and subcontractors that are used to identify opportunities for improvement. This includes but is not limited to ambulatory medical record reviews of contracted providers, credentialing/recredentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual Quality Management program evaluation, cultural competency assessment and assessment of provider accessibility and availability.

Clinical and non-clinical performance measure results – We use an array of clinical and non- clinical performance standards including but not limited to HEDIS and Pennsylvania specific performance measures, call center response times, claim payment statistics and satisfaction surveys to monitor and evaluate member outcomes. Through frequent monitoring and trending of our performance measure results, we are able to identify and act upon opportunities for improvement in clinical and operational functions.

Data trending and pattern analysis – With our innovative information management systems and data mining tools, we make extensive use of data trending and pattern analysis for the identification of opportunities for improvement.

Performance Improvement Projects (PIPS)

Performance Improvement Projects (PIPs), a key component of our QAPI program, are designed to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. All our PIPs follow CMS protocols.

We participate in state-mandated PIPs and select PIP topics that:

- Target improvement in areas that will address a broad spectrum of key aspects of member care and services over time
- Address clinical or non-clinical topics (e. g., care of acute conditions, member and provider satisfaction)
- Identify quality improvement opportunities through one or more of the identification processes described above
- Reflect our plan enrollment in terms of demographic characteristics, prevalence of disease, disparities, and potential consequences (risks) of the disease

Our QM Department prepares PIP proposals that are reviewed and approved by our CMO, the QM/UM Committee and the QMOC prior to submission to the Department for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health Kids, as well as from network providers who are members of our QM/UM Committee.

The QM Department conducts ongoing evaluation of the study indicator measures throughout the length of the PIP to determine if the intervention strategies have been successful. If there has been no statistically significant improvement or even a decline in performance, we immediately employ Rapid Cycle Improvement techniques and conduct additional analyses to identify why the interventions have not achieved the desired effect and whether additional or enhanced intervention strategies should be implemented to achieve the necessary outcomes. This cycle continues until we achieve real and sustained improvement.

Credentialing

All contracted health professionals are required to be credentialed by Aetna Better Health with the exception of pathologists, anesthesiologists, radiologists, emergency medicine and hospital-based providers.

Before rendering services, you must be credentialed with us. In addition, all providers must be enrolled with the Department of Human Services in the Medical Assistance program with an active, valid PROMISe ID.

New providers joining with a newly contracted practice will receive a credentialing application as part of their initial contract packet. New providers joining an existing contracted practice should submit an application as soon as they begin working at that location. Physicians and certain other health professionals are responsible for the completion of our credentialing application and for providing all supplemental documentation required. All new providers, including providers joining an existing participating practice with Aetna Better Health, must complete the credentialing process. They must also be approved by our Credentialing Committee and governing body as the final phase of their contract. Physicians and certain other health professionals need to have a site visit completed by our Provider Relations Department before we can complete the credentialing process. Established providers will be re-credentialed at least every three years. If any documents (e. g., license, insurance, DEA, etc..) expire before the recredentialing period, you must forward the updated documents to our Credentialing department.

Other health professionals need to have a site visit completed by our Provider Relations Department before we can complete the credentialing process.

Established providers will be recredentialed at least every three years. If any documents (e. g., license, insurance, DEA, etc.) expire before the recredentialing period, you must forward the updated documents to our Credentialing Department. The Aetna Credentialing and Performance Committee is responsible for the review of the professional credentials and profile data of potential participating health professionals, facilities and certain allied health professionals. For contracted providers, profile data is reviewed along with credentials.

Physician profiles

We profile all providers who meet the minimum threshold of members in their practices, as well as the minimum threshold of members for each profiling measure. We profile all providers and all practices for multiple measures compared with their own colleagues in their specialty. Also, we profile providers to assess adherence to evidence-based guidelines for their patients enrolled in Disease Management.

We designed the Provider Profiling program to share standardized utilization data with physicians in an effort to improve the utilization and health outcomes of members. Physicians often have little access to information about how they are managing patients or about how practice patterns compare to those of their peers. The overall goal is to reduce variation in care delivery and improve efficacy of care.

The indicators that we measure in the Provider Profile include, but are not limited to:

- Frequency of individual patient visits to the PCP
- Bright Futures services for the pediatric population
- HEDIS-type screening tests and evidence-based therapies (e .g ., appropriate management of asthma linked with correct use of inhaled steroids)
- Use of medications
- ED utilization and inpatient service utilization

Semi-annually, we distribute profile reports to each practice and provider so they can evaluate:

- Potential gaps in care and opportunities for improvement
- Information relating to specific cares
- A snapshot of their overall practice

In addition, gaps-in-care reports are available via our Availity portal. Contact your Quality Practice Liaison or Network Relations Consultant to learn how to access these reports. Our CMO will meet with individual network providers when there are questions regarding their profile results and assist in reviewing those results, review quality data and discuss any new medical guidelines.

Peer review

The Credentialing and Performance Committee evaluates Peer Review Activities. You can appeal the Committee's recommendation if you get a review and disagree with the results. All you have to do is submit written appeals stating the reasons you disagree with the results.

We encourage physician participation on key QM/UM Committees. You can contact the Chief Medical Officer or inform your Provider Relations Representative if you wish to participate.

Major functions of the QM/UM Committee include:

- Review and evaluate the results of quality improvement activities
- Review and approve studies, standards, clinical guidelines, trends in quality and utilization management indicators and satisfaction surveys
- Recommend policies for development, review, and approval

Ambulatory medical records review

Providers shall retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to CHIP recipients and that meet the criteria established in this section and additional requirements established in the provider regulations. These are the minimum acceptable standards within our provider network. The following is a list of our criteria for documentation of Care Medical Record Review. Our Quality Management Initiatives require consistent organization and documentation in patient medical records to assure continuity and effective, quality patient care.

Medical records may be on paper or electronic. Records must be maintained in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

Records will be readily available for review and copying by state and federal officials or their authorized agent at the provider's place of business or upon written request and shall be forwarded without charge to the Department of Human Services. If you are subject to an annual audit, you must submit your cost reports within 90 days following the close of the requested fiscal years. If the Department of Human Services terminates its written agreement with a provider, the records relating to services up to the effective date of the termination remain subject to the requirements stated in this section. We refer you to your contract agreement concerning the requirement to make available upon request at no cost to Aetna Better Health Kids, copies of member medical records.

Records, including both medical and fiscal types that fully disclose the nature of services rendered to members and that meet the criteria established in 55 Pa . Code Section 1101 .51 (d)(e), will be retained for at least four years, unless otherwise specified in the provider regulations. The standards for records are as follows:

1. **Medical records standards** – Records must reflect all aspects of patient care, including ancillary services. We have set the following standards for medical records:
    a. **Patient identification information** – Each page or electronic file in the record contains the patient's name or patient ID number.
    b. **Personal/biographical data** – Personal/biographical data includes age, sex, address, employer, home and work telephone numbers and marital status.
    c. **Entries** – All entries will be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations of the record will be signed and dated.
    d. **Provider identification** – All entries are identified as to author.
    e. **Legibility** – The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.
    f. **Allergies** – Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location.
    g. **Past medical history** – For patients seen by you and/or other providers in your practice three or more times in a two-year period, past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.

h. **Immunizations** – For pediatric records (under 14 years of age) there is a completed immunization record or a notation that immunizations are up to date.

i. **Diagnostic tests and results** – Documentation of medical necessity of rendered, ordered, and prescribed services.

j. **Therapies, medications and other prescribed regimens** – Drugs prescribed as part of the treatment, including quantities and dosages, shall be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to the effect.

k. **Treatment plan** – Progress and changes in treatment plan are documented.

l. **Identification of current problems –** The record shall 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.

m. **Smoking/ETOH/substance abuse** – Notation concerning cigarettes and alcohol use and substance abuse is present for patients 12 years and over and seen three or more times in a two-year period.

n. **Consultations, referral, and specialist reports** – Notes from consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record and follow-up plans.

o. **Emergency care**.

p. **Hospitalizations**.

q. **Reports of operative procedures and excised tissues**.

r. **Hospital discharge summaries/disposition of the care** – Discharge summaries are included as part of the medical record for (1) all hospital admissions that occur while the patient is enrolled in Aetna Better Health Kids, and (2) prior admissions as necessary.

s. **Referrals and results thereof**.

t. **All other aspects of patient care**.

u. **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. This may include, but not limited to, purchase invoices, prescriptions, the pricing system used for services rendered to patients who are not MA members, either the originals or copies of Departmental invoices and records of payments made by other third-party payers.

v. Additional record keeping requirements for providers in a shared health facility – Practitioners and purveyors in a shared health facility shall meet the requirements set forth in 55 Pa. Code Section 1101 .51(d)(e).

2. Patient visit data – Documentation of individual encounters must provide adequate evidence of, at a minimum:

a. History and physical examination – Appropriate subjective and objective information is obtained for the presenting complaints

b. Treatment plan

c. Diagnostic tests

d. Therapies and other prescribed regimens

e. 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 PRN; unresolved problems from previous visits are addressed in subsequent visits

f. Referrals and results thereof

g. All other aspects of patient care, including ancillary services

The purpose of the review is to verify that medical records of contracted family practice, internal medicine, general practice, obstetric and pediatric physicians comply with established the Office of CHIP, NCQA and Aetna Better Health Kids medical record keeping standards. Also, OB/GYN specialists must comply with ACOG standards. We review records for completeness of documentation, coordination of care and evidence of appropriate health maintenance screenings.

Penalties for noncompliance

The Office of CHIP may terminate its written agreement with a provider for noncompliance with the record keeping requirements of 55 Pa. Code Section 1101 .51(d)(e) or for noncompliance with other record keeping requirements imposed by applicable federal and state statutes and regulations.

HEDIS requirements

The Office of CHIP requires that we produce Healthcare Effectiveness Data and Information Set (HEDIS) rates for all Medicaid reporting measures, with the exception of some of the behavioral health measures. HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) designed to reliably compare health plan performance.

HEDIS performance measures include areas such as:

- Prevention and screening
- Diabetes, musculoskeletal and behavioral health conditions
- Medication management care and coordination
- Respiratory and cardiovascular conditions
- Health plan descriptive information
- Overuse, appropriateness, and cost of care

We work with providers to assure that all Office of CHIP requirements concerning HEDIS performance measures are met on an ongoing basis, including:

- Producing rates for Medicaid reporting measures as required by the Office of CHIP.
- Following NCQA specifications as outlined in the HEDIS Technical Specifications, clearly identifying the numerator and denominator for each measure.

All HEDIS results are validated by an NCQA-licensed vendor. We assist with the HEDIS validation process by the Department's NCQA-licensed contractor and submit validated HEDIS results annually to the Office of CHIP. We then incorporate HEDIS results into the annual overall Quality Improvement Plan.

Health care providers must supply copies of records within 14 calendar days of the receipt of a request, where practicable and in no event later than the date required by any applicable law, regulatory authority, or government agency with jurisdiction over Aetna Better Health Kids' operations (a "Government Sponsor"). Except as required by applicable state or federal law, Aetna Better Health Kids (including Aetna Better Health Kids' authorized designee), Government Sponsors and Aetna Better Health Kids members shall not be required to reimburse providers for expenses related to providing copies of patient records or documents. Refer to your Provider Agreement for the requirement to provide medical records upon request.

Consumer Assessment of Healthcare Providers and Systems

Consumer Assessment of Healthcare Providers and Systems (CAHPS) are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (Child) are reporting required by the Office of CHIP. We contract with an NCQA-certified vendor to administer the child survey according to NCQA survey protocols. The survey is based on randomly selected members and summarizes satisfaction with the health care experience.

NCQA incorporates a CAHPS survey of parental experiences with their children's care. This survey is necessary because children's health care frequently requires different provider networks and addresses different consumer concerns (e .g . child growth and development). We submit results of the child CAHPS survey to the NCQA in accordance with accreditation protocols.

External Quality Review (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1902(a), (30), (c). The requirement mandates states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations. The annual review includes the evaluation of quality outcomes, timeliness, and access to services. EQR refers to the analysis and evaluation of aggregated information on timeliness, access and quality of health care services furnished to members. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.

We cooperate fully with external clinical record reviews assessing our network's quality of care, access to care and timeliness of care, as well as any other studies determined necessary by the Office of CHIP. We assist in the identification and collection of any data or clinical records to be reviewed by the independent evaluation team members. We also provide complete medical records to the External Quality Review Organization (EQRO) in the timeframe allowed by the EQRO. You may be asked to provide copies of member medical records at no cost to support the collection of data for Pennsylvania EQRO on behalf of the Office of CHIP. Refer to your Provider Agreement for the requirement to provide medical records upon request.

The results of the EQR are shared with providers and incorporated into our overall QM and UM Management programs as part of our continuous quality improvement process.

Chapter 11
Provider Incentive programs

Pay-For-Quality program (P4Q)
We fully recognize the value of structuring financial incentives to promote improvements in the delivery of effective health care services. We also know that there is a proven track record of successfully implementing pay for quality/performance (P4Q/P4P) programs that reward improvements in both processes and outcomes. P4Q/P4P initiatives include those with financial rewards, as well as those that develop partnerships with physician groups with the sole objective of improving health care outcomes. P4Q/P4P programs will be implemented as is allowed by available funding.

Monitoring provider performance
We closely monitor clinical, service, quality, and utilization factors to determine which providers are demonstrating best practices. Our experience has taught us that there are always providers whose practice profiles statistically reflect a level of service utilization above the norm. In the case of physicians who care for members with complex medical and/or behavioral health needs, these patterns may be completely expected and justified. The factors that we measure in developing provider profiles include, but are not limited to, the following:

- Frequency of individual patient visits
- Bright Futures services
- HEDIS measures
- Prescribing patterns
- Member complaints and grievances
- Provider complaints and appeals
- Emergency department and inpatient service utilization
- Adherence to evidence-based practice guidelines

We distribute provider profile results to individual providers and practitioners to enable them to evaluate their performance against their peers and identify potential gaps in care and opportunities for improvement. The profiles are available online via our secure provider portal. Also, if our Medical Management staff identifies a provider whose performance deviates significantly from the norm for his or her specialty, we will perform outreach and, if needed, require the implementation of a corrective action plan.

Chapter 12

Encounters, billing and claims

Billing instructions

Aetna Better Health uses our business application system to process and adjudicate claims. Both electronic and paper claims submissions are accepted.

To assist us in processing and paying claims efficiently, accurately and timely, we encourage providers to submit claims electronically. To facilitate electronic claims submissions, we have developed a business relationship with Change Healthcare and Office Ally.

Aetna Better Health receives electronic data interchange (EDI) claims directly from these clearinghouses, 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 24 hours of file receipt, we provide production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

PROMISe ID number requirements

All providers who provide services to CHIP members must be enrolled in the commonwealth's Medical Assistance (MA) program and possess an active PROMISe provider ID in order to bill for services. MA providers who order, refer and prescribe are required to possess an active PROMISe provider ID. For information on how to enroll in PROMISe and enrollment forms, please visit the DHS's website at **www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx.**

Practitioners who provide services to Aetna Better Health members must be enrolled in Promise Fee-for-Service (FFS) Medical Assistance (MA).

All service locations enrolled in the MA program must revalidate including group enrollments as noted in DHS Provider Quick Tips #198.

To re-enroll, please submit, as soon as possible, a revalidation application (or reactivation application if you are submitting via the Electronic Provider Enrollment Portal). You can find specific instructions and further information at **www.dhs.pa.gov/providers/Providers/ Pages/PROMISe-Enrollment.aspx.**
All claims must be submitted with the provider information exactly as they are registered with the State in order to avoid denials i.e. NPI, Taxonomy and address including the 9-digit zip code.

Ordering, referring and prescribing requirements

DHS has implemented the ACA provision which requires that physicians and other practitioners order, refer or prescribe items or services to MA beneficiaries be enrolled as participating providers.

Claims will deny if the ordering, referring or prescribing provider is not billed or billed but they are not enrolled in the CHIP program. The ordering and/or referring provider is always required for DME providers and claims with drugs being billed.

Providers who order, refer or prescribe items or services to MA beneficiaries and are not currently enrolled in the MA program should access the DHS website for information on how to complete and submit the enrollment application that corresponds to the provider's type. DHS has implemented an electronic provider application to help streamline the enrollment application process. More information can be found at **www.dhs.pa.gov/docs/Publications/Documents/FORMS-AND-PUBS-OMAP/c_224393.pdf.**

Billing and Rendering requirements

Billing Provider - The Billing provider must be registered and submitted on all claims The Billing provider address must be a physical location and not an P.O. Box. If the provider is only registered with a Tax ID, the Billing provider can be submitted without an NPI as long as the Tax ID is submitted.
Rendering Provider All prof claims require a rendering provider unless the Billing Provider is registered as an INDIVIDUAL and not a GROUP, if the billing provider is registered as a group, the rendering is required, except for these provider types 05; 06; 08; 24; 25; 26; 28; 29; 30; 47; 55/255.

Payment for medically necessary services: In accordance with Pennsylvania Code 55, Chapter 1101, the Department of Human Services will only pay for Medically Necessary services for covered benefits. A service or benefit is medically necessary if it is compensable under the Medical Assistance program AND if it meets any one of the following standards:

Medically Necessary- a service, item, or medicine does one of the following:

1. It will, or is reasonably expected to, prevent an illness, condition, or disability;
2. It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability;
3. It will help a child get or keep the ability to perform daily tasks, taking into consideration both the child's abilities and the abilities of someone of the same age.

Determination of Medically Necessary 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/caretaker and the primary care practitioner, as well as any other providers, programs or agencies that have evaluated the member. All medical necessity determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a health care service under this agreement.

Encounters and claims

Aetna Better Health Kids is required to submit to the Department of Human Services all necessary data that characterizes the covered health care service provided to a member.

- Aetna Better Health Kids is required to process claims in accordance with Medicare and Medicaid claim payment rules and regulations.
- Providers must use valid International Classification of Disease 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 subclassification for that subcategory and assign the fifth digit subclassification code for those subcategories 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 and reported.

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

Billing and claims co-payments

Certain services require a member co-payment. You should collect this amount from the member and deduct it from the amount billed to us. You must submit all claims whether or not the member made full payment. You cannot deny services to the member even if the member hasn't made full payment of their cost-sharing amounts. It's important to document on the claim submitted the amount that the member paid or the amount you billed to the member.

Billing of members

You cannot balance bill members for any amounts exceeding the contractual allowance specified in the provider agreement. All providers are prohibited from billing members beyond the member's cost sharing liability, if applicable, as defined in the patient's benefits. You cannot balance bill patients for covered services. You only bill patients for:

- Non-covered services
- Services that have not been authorized
- Services that are out-of-network

You can only bill patients for those services if you told the patient before rendering the service that it's not covered and they agree in writing to pay the cost. You can bill members for their applicable Medical Assistance copayments. However, you cannot bill members for Medicare deductibles or coinsurance.

Timely claim submission requirements

We require providers to submit claims within 180 calendar days from the date of service. Claims resubmissions must be received no later than 365 calendar days from the date of service, if the initial submission was within the 180 calendar days, whether or not the initial claim was denied. We require Clean Claim submissions for processing. A "Clean Claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the provider of service or from a third party.

Claims payment timeframes
In compliance with state regulations applicable to Medicaid Managed Care Plans, we process Clean Claims in the following timeframes. These timeframes apply to the HealthChoices Program:

- 90% of Clean Claims must be adjudicated within 30 calendar days of receipt
- 100% of Clean Claims must be adjudicated within 45 calendar days of receipt
- 100% of all Clean Claims must be adjudicated within 90 calendar days of receipt

Claims payment timeframes for CHIP claims are as follows:

- 95% of Clean Claims must be adjudicated within 30 calendar days of receipt
- 100% of Clean Claims must be adjudicated within 90 calendar days of receipt

Claims that are not paid within 45 calendar days are paid with interest in accordance with state regulations.

Acceptable claims submission types
We require all providers to use one of the following forms when submitting claims:

- A CMS-1500 02/12 (formerly CMS 1500 08/05) billing form is used to submit claims for all professional services including ancillary services and professional services billed by a hospital
- Hospital inpatient and outpatient services, dialysis services, nursing home room and board and inpatient hospice services must be billed on the CMS-1450 billing form

We will not process claims received on any other type of claim form.

Completing a CMS 1500 02/12 (Formerly CMS 1500 05/08)
The CMS 1500 02/12 (formerly CMS 1500 05/08) billing form is used to submit claims for all professional services. When submitting a CMS 1500 form, certain fields are required.

CMS-1500 documentation
Before submitting a claim, you should ensure that you include all required attachments.
All claims that involve other insurance or Medicare must be accompanied by an explanation of benefits (EOB) or a remittance advice that clearly states how the claim was paid or the reason for denial.

Completing the CMS-1450
The CMS-1450 form is used when billing for facilities services including hospital inpatient and outpatient services, dialysis services, nursing home room and board and inpatient hospice service.

CMS-1450 documentation
Inpatient, ED and outpatient hospital claims above a certain threshold require additional documentation, which may include the medical records and an itemized bill.

Completing an EDI Submission
Professional and institutional claims must be submitted in an ANSI X12-837 electronic format (current version).

EDI documentation
Coordination of benefit information can be submitted electronically. All other attachments must be submitted via paper through normal claims submission processes.

Refer to your contract for documentation requirements and/or to the provider specific billing sections of this manual.

Electronic billing
In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health Kids encourages providers to electronically submit claims through Change Healthcare or Office Ally.

Use our EDI payer number 23228, when submitting claims.

Change Healthcare also offers verification that allows you to submit claims by visiting Change Healthcare at **changehealthcare.com**.

Before submitting a claim through your clearinghouse, please verify that your clearinghouse is compatible with Change Healthcare or Office Ally.

We strongly encourage the electronic filing of claims (EDI). Electronic billing:

- Eliminates the cost of sending paper claims
- Allows you to track each claim sent
- Minimizes clerical data entry errors
- Ensures faster processing and payment of claim

We have agreements with the EDI claim clearinghouses listed below. They have software that sends pre-edited CMS 1500 02/12 and CMS-1450 claims to our Claim Department for review.

Important points to remember:

- Aetna Better Health does not accept direct EDI submissions from its providers
- Aetna Better Health 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

EDI Clearinghouses
Office Ally™ – Offers a FREE full-service HIPAA-compliant web-based clearinghouse to health care providers. You can submit professional CMS-1500 and facility CMS-1450 claims to Aetna Better Health by using either:

- Your existing software to create and submit claims electronically
- Office Ally's Online Claim Entry Tool to manually create and submit claims electronically

Go to **cms.officeally.com** and click on “Products,” then “Enroll Today” Or call **360-975-7000**, option 1 to speak to an Office Ally representative.

Paper Claims
We encourage providers to bill electronically but realize there are times where providers need to submit claims on paper.

Paper claims can be submitted to:
Aetna Better Health Kids
Claims Submissions
PO Box 982973
El Paso, TX 79998-2973

Change Healthcare – Change Healthcare is a contracted vendor Aetna Better Health uses for electronic claim submission, processing and support. You can call customer support at **1-800-845-6592**.

If you file your claims electronically, please be aware that the claim receipt acknowledgment file that we return to the clearinghouse is the only accepted proof of timely filing. If you have questions about this, contact your vendor directly.

National provider identifier (NPI)
Your submitted claims must be in compliance with HIPAA regulations regarding national provider identifier (NPI) numbers and claim forms. Claims for the HealthChoices We will return any claims that are not in compliance. The program should also contain the provider PROMISe identification number.

Compliance

- The CMS-1500 form contains fields for the NPI numbers:
- Field 17 or EDI equivalent loop and segment, requires the NPI of the referring physician, if appropriate
- Field 24J or EDI equivalent loop and segment, is available for the NPI number of the provider rendering service(s)
- Field 32 or EDI equivalent loop and segment, requires the NPI of the facility location if other than office
- Field 33 or EDI equivalent loop and segment, requires the billing provider’s NPI number The CMS-1450 form contains fields for the NPI numbers:
- Form CMS-1450 requires the NPI number of the billing provider in field 56 or EDI equivalent
- loop and segment
- The NPIs of the attending physician and the operating physician should be located in fields 76 and 77 or EDI equivalent loop and segment, respectively

If EDI claims are rejected, check with your vendor first. If you experience any issues with EDI claims, contact our Provider Relations Department at **1-866-638-1232**.

NPI/PROMISe ID enrollment and revalidation

The Affordable Care Act (ACA) requires states to revalidate the enrollment of Medicaid providers every five years. Aetna Better Health follows DHS requirements that participating providers revalidate your NPI and PROMISe IDs, along with your service locations, every five years. **Failure to complete the revalidation process may result in nonpayment of claims.**

Effective July 1, 2019, as required by the Affordable Care Act (ACA) and DHS, **all Medicaid and CHIP providers who render services for Medicaid or CHIP beneficiaries, must be enrolled with DHS and have a valid PROMISe identification number (PROMISe ID) for each service location at which a provider operates**. DHS uses the National Provider Identification (NPI) number and taxonomy submitted on claims to validate the enrollment of providers in PROMISe.

Additionally, we require all participating CHIP providers contracted with Aetna Better Health who provide services for CHIP beneficiaries and have not yet enrolled, to promptly enroll with Pennsylvania PROMISe for all service locations as soon as possible.

Remittance Advice and Electronic Fund Transfer (EFT)

Aetna Better Health 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 it 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 Services Department if you are interested in receiving electronic remittance advices.

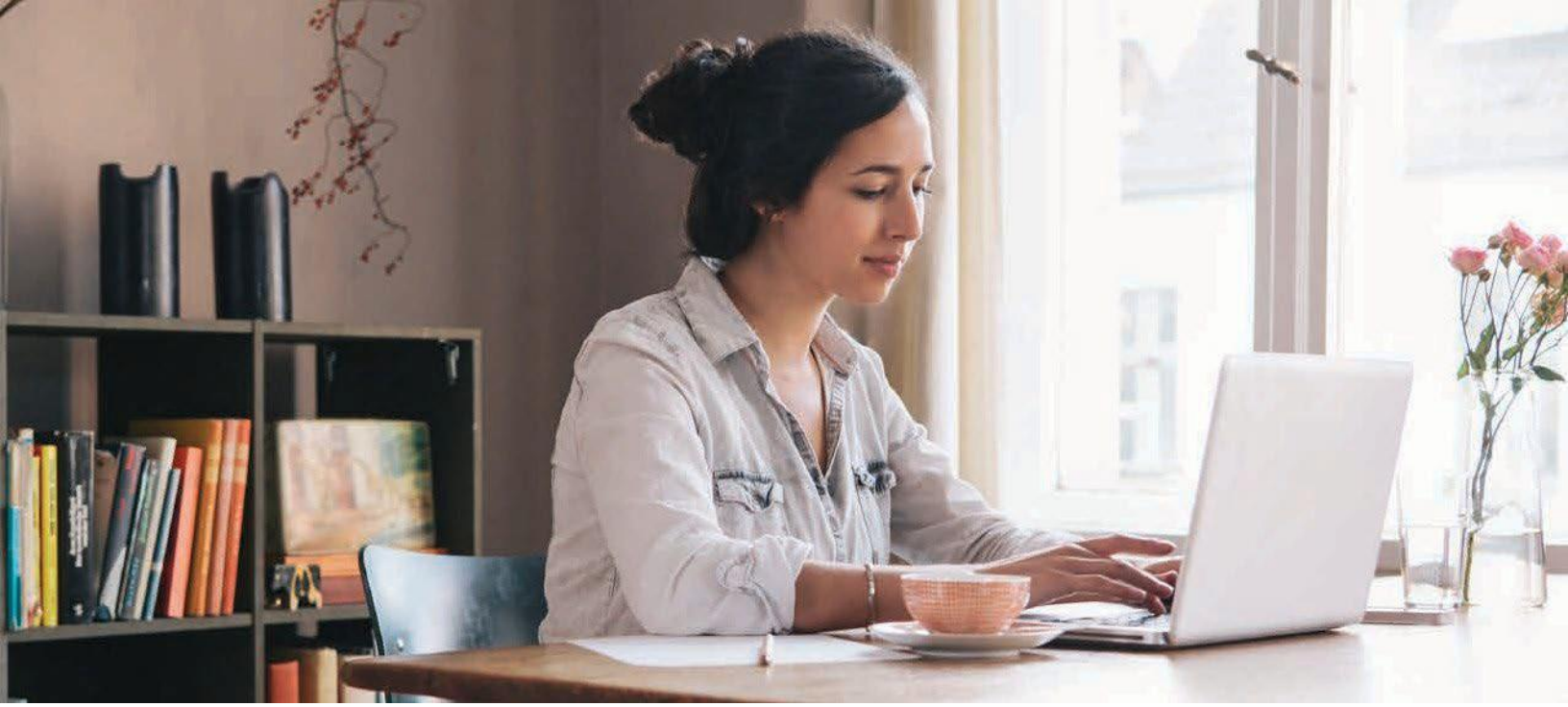
The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates. Information provided on the remit includes:

- 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 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 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 after this payment cycle. This will result in a negative amount paid.
- The check number 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 number 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.
- The 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
    - 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 the claim by EFT. You must also have the ability to receive an ERA through an 835 file.

When submitting claims, we encourage our providers to utilize EDI, EFT and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Contact our Provider Services Department for assistance with this process. To enroll in EFT and **ERA visit: AetnaBetterHealth.com/Pennsylvania/ providers/forms.** Click on the Electronic Fund Transfer (EFT)/Electronic Remittance Advice (ERA) tab.



Virtual credit card
Aetna Better Health Kids uses virtual credit cards to process provider payments. Instead of receiving paper checks for claims payments from us, virtual card payment information will be printed on your remittance advance (RA). RAs include a 16-digit card number which can be entered into your current point of sale (POS) terminal to accept the payment, similar to the manner in which you manually key in patient payments. Please note, your standard merchant fees will apply. The card information must be entered within the expiration date specified on your virtual card.

Enrollment in virtual credit card payment is automatic when you join our network. If you would like to opt out of this program and switch to electronic funds transfer (EFT), you must call **1-855-723-3475**. To sign up for EFT, follow the steps outlined in the EFT section below.

Electronic funds transfer (EFT)
You can direct funds to a designated bank account.
To enroll in EFT, go the Electronic Fund Transfer (EFT)/Electronic Remittance Advice (ERA) Sign up tab online at **AetnaBetterHealth.com/PA/providers/forms**.

Claims resubmission
Aetna Better Health must receive claims resubmission no later than 365 calendar days from the date of service if the initial submission was within the 180 calendar day time period whether or not the initial claim was denied. You can resubmit:

- Corrected claims
- Previously submitted claims to which additional information has been attached

To ensure timely and accurate processing, corrected or resubmitted claims must be:

- Submitted within the contracted timely filing guidelines
- Submitted electronically through our electronic data interface (EDI) vendors when supporting documentation is not required
- Submitted on paper to our processing center when supporting documentation is required when submitting a corrected claim, indicate on the claim whether it is a corrected claim or a resubmitted claim with appropriate supporting documentation. Providers can enter a claim resubmission form that includes required documentation via the secure web portal. Please note that this functionality is for claim resubmissions that include required documentation, not claim corrections or provider appeals.

Technical assistance
For technical assistance related to claims submissions, call Provider Relations at **1-866-638-1232**,

Claims inquiries
You can contact the Claims Inquiry Line from 8 AM to 5 PM EST each business day by calling**1-866-638-1232**. An automated telephone system allows you to speak directly with a representative or leave a detailed message regarding your inquiry. Our Claims Administration Department employs full-time claims inquiry and research representatives to respond to your questions, status inquiries and claims payment disputes. You can also check on claims status by logging on to the secure web portal.

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, excluding:
    - Corrections to prior authorization numbers – providers must call the Prior Authorization Department directly
    - Rebilling a claim – the entire claim must be resubmitted with corrections

Please be prepared to give the Claims 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

Written inquiries should be directed to the claims staff at Aetna Better Health Kids, Attn: Claims Submissions PO Box 982973 El Paso, TX 79998-2973.
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Instruction for specific claim types

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 Pennsylvania Medicaid claim processing rules.

We periodically update our policies and claims payment systems to align with correct-coding initiatives, as well as these national benchmarks and industry standards:

- Centers for Medicare & Medicaid Services (CMS) guidelines
- American Medical Association (AMA) Current Procedural Terminology (CPT)
- Health Care Common Procedure Coding System (HCPCS)
- International Classification of Diseases, 9th Edition (ICD-9) and 10th Edition (ICD-10), depending on the claim's date of service

These updates support our continuing efforts to process claims accurately.

Provider facility code requirement

Effective June 1, 2019, when a service is provided in a facility and the provider is submitting a professional claim, the service facility information must be submitted. Specific claim requirements include:

- Facility NPI and address must be submitted for professional claims billed for services rendered at a facility POS 19, 21-24, 31 & 32
- The service facility location must be populated in Loop 2310C Segment NM109
- Service facility location name, address and nine-digit zip in box 32 on the CMS 1500
- Service facility location NPI in box 32a on the CMS 1500

If the facility location information is not included on the claim, the claim will deny. If the facility number is not numeric or is missing AND the place of service (POS) is 21 – Inpatient Hospital, 22 – Outpatient Hospital, 23 – Emergency Room, 24 – Ambulatory Surgical Center, 31 – Skilled Nursing Facility or 32 – Nursing Facility, then your claim will deny. If there are any services that are not actually done at the facility for a recipient, then the POS should not be 21, 22, 23, 24, 31 or 32.

Newborn billing guidelines

Under DHS guidelines, if there is no ID set up for a newborn at the time of the inpatient claim submission, the newborn must be submitted under the mother's ID.

Listed below are guidelines for billing newborns under the mother's ID:

- There must be no available ID for the newborn at the time of claim submission
- Newborn should be billed under mother's ID with the newborn's date of birth
- The newborn's date of birth should be less than one year old at the time of claim submission
    - Claim must be billed with:
    - Admission Type 4
    - Condition Code YO

Skilled Nursing Facilities (SNF)

- Providers submitting claims for SNFs should use CMS-1450 form.
- Providers must bill in accordance with standard Medicaid requirement rules for Aetna Better Health Kids. For additional information refer to Pennsylvania Medicaid website at **www.dhs.pa.gov/docs/For-Providers/Pages/Regulations-Handbooks-Guides-and-Manuals.aspx.**

Home health claims

- Providers submitting claims for home health should use a CMS 1500 form.
- For additional information refer to the Pennsylvania Medicaid website at **www.dhs.pa.gov/docs/For-Providers/Pages/Regulations-Handbooks-Guides-and-Manuals.aspx**.

Global Maternity Bundling

Global maternity care includes pregnancy-related antepartum care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care until six weeks postpartum.

Healthy Beginnings Plus (HBP) providers are allowed to submit total obstetric care using global codes. When billing total obstetric care providers should follow the requirements listed below:

- Any time HBP providers utilize a bundled code, including maternity bundled procedures, submission of the itemization of when those services occur is also required
- Providers must submit the actual Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS) code for the service rendered in addition to the global obstetric code to receive payment
- Effective January 1, 2020, the following global and bundled procedure codes must also be accompanied by an Evaluation & Management (E&M) code to reflect the actual date of antepartum and postpartum care: 59400, 59410, 59425, 59426, 59510, 59515, 59610, 59614 and 59618

Claims will be denied if only the global code is billed. Global maternity billing is for Healthy Beginnings Plus providers only. All other providers should continue billing fee-for-service.

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
- For additional information refer to the Pennsylvania Medicaid website at **www.dhs.pa.gov/docs/For-Providers/Pages/Regulations-Handbooks-Guides-and-Manuals.aspx**

Same-day readmission claims

- Providers submitting claims for inpatient facilities should use CMS-1450 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 24 hours.

Example: Discharge date: 10/2/2023 at 11 AM / readmission date: 10/3/2023 at 9 AM

Since the readmission was within 24 hours, this would be considered a same-day readmission per above definition

Reimbursement
We reimburse providers according to our fee schedule or other contracted rates. Your contract tells you the type of reimbursement you receive and the services you can provide. If you have questions, just call your Provider Relations Representative.

Chapter 13
Appeal, Grievance and Complaint System

Member Complaint and Grievance System Overview
Members or their representative that is designated in writing can file an appeal or grievance with Aetna Better Health Kids orally or in writing. A representative is someone who assists with the complaint or grievance on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney.

Representatives must be designated in writing with the exception of a network provider requesting an expedited grievance. A network provider, acting on behalf of a member, may file an expedited appeal without written consent. In all cases, when representatives, including a provider, file a complaint or grievance on behalf of a member the case is considered a member grievance or member complaint and is subject to the member grievance or complaint timeframes and policies.

Members and their designated representatives, including providers, with written consent may also file an external appeal if internal options have been exhausted.

Aetna Better Health Kids informs members and providers of the member complaint and grievance system processes for appeals, grievances, external appeals. This information is contained in the Member Handbook and in this Manual and is available on the Aetna Better Health Kids website. When requested, we give members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, providing interpreter services, alternate formats and toll-free numbers that have adequate TTY/TTD and interpreter capability at no cost to the member.

Aetna Better Health Kids verifies that no punitive action is taken in retaliation against a member who requests an appeal or grievance or against a provider who requests an expedited resolution or supports a member's appeal or grievance. Providers may not discriminate or initiate disenrollment of a member for filing an appeal or grievance with Aetna Better Health Kids.

Aetna Better Health Kids' processes for resolving member appeals and grievances are described below.

Extensions
The decision-making timeframe on a standard or expedited grievance or on a standard complaint may be extended by fourteen (14) calendar days if the member requests the extension.

Aetna Better Health Kids will send written notice of extension within two (2) calendar days of the decision to delay and within the original standard or expedited timeframe to the affected parties.

All expressions of dissatisfaction resulting from an adverse benefit determination are automatically classified as a grievance.

Member Complaint Process

Standard Complaint

A complaint is an expression of dissatisfaction to the plan, provider, facility by a member made orally or in writing. This can include concerns about the operations of providers or the plan such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to members, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the member believes he or she is entitled. This includes quality of care concerns.

Complaints may be filed with Aetna Better Health Kids orally or in writing by the member or their designated representative at any time.

Aetna Better Health Kids responds to standard complaints within 30 calendar days. The member or their designated representative may extend the timeframe at any time.

Expedited Complaint

Aetna Better Health Kids resolves all complaints effectively and efficiently. Expedited complaints, occur in situations where the member was denied expedited processing of a prior authorization or grievance. Expedited complaints are resolved within seventy-two (72) hours of receipt.

For expedited complaints, Aetna Better Health Kids makes reasonable effort to provide oral notice of the complaint decision and follows the oral notice with written notification. Members are advised in writing of the outcome of the investigation of all complaints within the specified processing timeframe. 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.

How to File a Complaint

Complaints may be filed by calling Member Services at **1-800-822-2447** for the hearing-impaired Relay **7-1-1** or they may be submitted in writing via fax to: **1-860-754-1757** or postal mail to:

Aetna Better Health Kids
Appeal and Grievance Department
PO Box 81139
5801 Postal Rd
Cleveland, OH 44181

Member Grievance Process

Standard Grievance

Grievances are a formal request for Aetna Better Health Kids to reconsider an adverse benefit decision.

Members or their designated representative can file a standard grievance with Aetna Better Health Kids orally or in writing within sixty (60) calendar days from the date on the Aetna Better Health Kids initial decision, also called the Notice of Action (NOA).

The Aetna Better Health Kids Notice of Action (NOA) informs the member of the following:

- Our decision and the reasons for our decision
- A clear explanation of further grievance rights and the time frame for filing
- The availability of assistance in filing a grievance
- That the member may represent himself or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them at any time during the grievance process
- Their right to request an expedited resolution and the process for doing so
- The polices or procedures which provide the basis for the decision

Aetna Better Health Kids responds to standard grievances within thirty (30) calendar days. The member or their designated representative may extend the timeframe at any time.

All parties to the grievance are advised in writing of the outcome of the investigation of the grievance. The Grievance Decision letter includes the decision reached, the reasons for the decision and 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 an external appeal.

Expedited Grievance
Members or their designated representative can file an expedited grievance with Aetna Better Health Kids orally or in writing within sixty (60) calendar days from the date on the Aetna Better Health Kids initial decision, also called the Notice of Action (NOA).

Aetna Better Health Kids 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 grievances, occur in situations where the member's provider and Aetna Better Health Kids determines that waiting the standard grievance timeframe could seriously harm the member's health. A member or their designated representative, including providers, may request an expedited grievance either orally or in writing. Expedited grievances are resolved within seventy-two (72) hours of receipt.

If Aetna Better Health Kids determines that waiting the standard timeframe will not harm the member's health the member's grievance will be transferred to a standard grievance and will be decided within the normal thirty (30) calendar day timeframe. We make reasonable effort to provide oral notice that the grievance is being processed following the standard timeframe and we send written notification within two (2) business days with this information. The notification includes information that the member may file a complaint if they are dissatisfied with the denial of expedited processing time of their grievance. Post service items or services are not eligible for expedited processing.

How to File a Grievance
Grievances may be filed by calling Member Services at **1-800-822-2447**, for the hearing-impaired Relay **7-1-1** or they may be submitted in writing via fax to: **1-860-754-1757** or postal mail to:

Aetna Better Health Kids
Appeal and Grievance Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

External Grievance
Members or their designated representative, including a provider acting on their behalf, with written consent may request an External Grievance through Pennsylvania Department of Insurance. Members have fifteen (15) calendar days to file following receipt of the grievance decision letter. Information on how to submit an External Grievance is included in Grievance Decision Letter.

The request for an External Grievance must be submitted in writing to the following:

Pennsylvania Insurance Department
Bureau of Managed Care
1311 Strawberry Square / Harrisburg, PA 17120
OR
Aetna Better Health Kids
Appeal and Grievance Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

The external review organization will render the final decision and notify all parties.

Provider Appeal and Complaint System Overview
Provider's may file an appeal or complaint verbally or in writing. Verbal appeals or complaints may be required to be submitted in writing.

A network provider, acting on behalf of a member, and with the member's written consent, may file a complaint or grievance. Network providers may file an expedited grievance without written consent. In all cases, when a provider files on behalf of a member the case is considered a member grievance or complaint and is subject to the member grievance or complaint timeframes and policies.

Representatives must be designated in writing with the exception of a network provider requesting an expedited grievance. A network provider, acting on behalf of a member, may file an expedited grievance without written consent. In all cases, when representatives, including a provider, file a grievance or complaint on behalf of a member the case is considered a member grievance or member complaint and is subject to the member grievance or complaint timeframes and policies.

Aetna Better Health Kids informs providers of the provider appeal and complaint system processes in this Manual and on the Aetna Better Health Kids website.

Aetna Better Health Kids verifies that no punitive action is taken in retaliation against a member who requests a grievance or complaint or against a provider who requests an expedited resolution or supports a member's grievance or complaint. Providers may not discriminate or initiate disenrollment of a member for filing a grievance or complaint with Aetna Better Health Kids.

Aetna Better Health Kids' processes for resolving provider appeals and grievances are described below.

Provider Complaints

Both network and out-of-network providers may file a complaint verbally or in writing directly with Aetna Better Health Kids in regard to our policies, procedures, or any aspect of our administrative functions including dissatisfaction with the resolution of a claim dispute within forty-five (45) calendar days from the incident being grieved. Providers can also file a verbal complaint with Aetna Better Health Kids by calling **1-800-822-2447**. To file a complaint in writing, providers should write to:

Aetna Better Health Kids
Appeal and Complaint Department
PO Box 81040
5801 Postal Road
Cleveland, OH 44181
Fax: **860-754-1757**

Provider complaints will be acknowledged either orally or in writing within five (5) business days of receipt. Aetna Better Health Kids responds to standard provider complaints within forty-five (45) calendar days. If the
complaint requires research or input by another department, the Appeal and Complaint department will engage the affected department and will coordinate with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions and Aetna Better Health Kids' written policies and procedures, collecting pertinent facts from all parties.

Provider Disputes

Network providers may file a dispute verbally or in writing direct to Aetna Better Health Kids to resolve disputes about payment or denial of a claim related to contract issue such as coding or fee schedule set up in the operating system and other administrative disputes for any reason including but not limited to itemized bill, duplicate claim, proof of timely filing, coordination of benefits, corrected claim. The dispute will be reviewed and processed according the definitions in this document. Provider Claim Disputes do not include pre-service disputes that were denied due to not meeting medical necessity. Pre-service denials are processed as member grievances and are subject to member policies and timeframes.

Providers can file a verbal dispute with Aetna Better Health Kids by calling Provider Experience department at **1-866-638-1232**. To file a dispute in writing, providers should write to:

Aetna Better Health Kids
PO Box 982974 982973
El Paso, TX 79998-2960 2973

If the dispute is regarding claim resubmission or reconsideration, the dispute may be referred to the Claims Inquiry Claims Research (CICR) department.

Provider Appeals
A provider may file an appeal in writing if they are not satisfied with the outcome of the dispute. A provider may file an appeal related to claim denial or claim payment amount within sixty (60) days of the claim processing date unless otherwise stated in contract. Post service items/services are always standard appeals and are not eligible for expedited processing. The Provider may complete and submit the Provider Appeal Form with any appropriate supporting documentation. The Form is accessible on Aetna Better Health Kids website.

Appeals should be sent to the following:

Aetna Better Health Kids
Attention: Complaints, Grievances & Appeals,
PO Box 81040,
5801 Postal Rd,
Cleveland, OH 44181
Fax: **1-860-754-1757**

Provider appeals will be acknowledged either orally or in writing within five (5) business days of receipt. Aetna Better Health Kids responds to standard provider appeals within sixty (60) calendar days. If the appeal requires research or input by another department, the Appeal and Grievance department will engage the affected department and will coordinate with the affected department to thoroughly research each appeal using applicable statutory, regulatory, and contractual provisions and Aetna Better Health Kids' written policies and procedures, collecting pertinent facts from all parties. The appeal with all research will be reviewed for resolution and may be presented to the Appeal Committee for decision. None of the individual reviewers or members of the Appeal Committee will have been involved in any prior decision making related to the appeal. When the appeal includes a clinical issue a provider with same or similar specialty will participate.

Oversight of the Appeal and Grievance Processes
The Appeal and Grievance Manager has overall responsibility for management of the Appeal and Grievance processes and reports to the Director of Operations. This includes:

- Documenting individual appeals and grievances
- Coordinating resolutions
- Maintaining the data for all appeals and grievances in the Appeal and Grievance Application
- Tracking and reviewing grievance and appeal data for trends in quality of care or other service related issues
- Reporting all data to the Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC)

Aetna Better Health Kids' grievance and appeals processes are integrated into our quality improvement program. Our Quality Management (QM) responsibility of the grievance system processes includes:

- Review of individual quality of care grievances
- Aggregation and analysis of grievance and appeal trend data
- Use of the data for quality improvement activities including collaboration with credentialing and recredentialing processes as required
- Identification of opportunities for improvement
- Recommendation and implementation of corrective action plans as needed

This makes sure that individuals with the authority to take corrective action are actively engaged in the appeal and grievance process and that data received through member and provider appeals and grievances are routinely reviewed to identify opportunities for improvement and to apply continuous quality improvement principles.

Chapter 14
Detecting fraud, waste, and abuse

The vast majority of Medical Assistance (MA) providers and members deliver and receive care within the boundaries of applicable regulations. Unfortunately, a small number of MA members and providers may engage in practices that are fraudulent or abuse the MA program. The DHS is committed to eliminating all forms of fraud and abuse within the MA program.

We employ a variety of methods to detect potential fraud and abuse, including monitoring claim edits, prior authorization, utilization and concurrent review, Quality Management audits and provider profiling.

We have also developed algorithms to detect potential claims upcoding, with follow-up procedures for chart audits as appropriate. Also, our business software applications use historical claims information to detect and correct questionable billing practices. Claims that reach an adjudicated status of "pay" will receive a control edit, which includes, but is not limited to:

- Verification of member eligibility
- Verification of covered services
- Determining whether services are within the scope of a provider's specialty
- Valid prior authorization
- Submission of required documentation
- Excessive or unusual services based on the member's age or gender
- Duplication of services
- Invalid procedure codes
- Duplicate claims

Federal False Claims Act (FCA)

We support efforts to detect, prevent and report fraud and abuse within the CHIP system. These efforts are consistent with our mission to provide care to our members while exercising sound fiscal responsibility. Management of limited resources is a key part of this responsibility. Examples of actions that we will report to the state's investigative agencies include:

- Consistently demonstrating a pattern of submitting falsified encounters or service reports
- Consistently demonstrating a pattern of overstated reports or up coded levels of service
- Altering, falsifying or destroying clinical record documentation
- Making false statements relating to credentials
- Misrepresenting medical information to justify enrollee referrals
- Failing to render medically necessary covered services that providers are obligated to provide according to their contract
- Charging enrollees for covered services

Investigating fraud, waste, and abuse

If we receive reports of potential fraud, waste and abuse, our staff will document the information, issue a tracking number and report it to the Department of Human Services and other appropriate investigative and law enforcement agencies regardless of whether or not they are resolved internally.

Aetna's Special Investigations Unit (SIU) is responsible for the health care fraud and abuse program. With a total staff of over 170 individuals, the SIU department has CHIP-dedicated staff that support all Aetna Better Health plans, including investigators, analysts and a dedicated technology team. This staff has backgrounds in pharmacy, coding, fraud examination, Medicaid compliance, nursing, law and law enforcement. This team also has dedicated and in-state investigators as well as a dedicated senior medical director who reviews and consults on fraud, waste, and abuse issues.

To achieve the integrity objectives of the program, SIU has developed state-of-the-art systems capability to monitor our huge volume of claims data across all health product lines. We use business intelligence software to identify providers whose billing, treatment or patient demographic profiles differ significantly from those of their peers. Our SIU's internal analytics staff runs case- and scheme-specific reports using Structured Query Language, Statistical Analysis System software and Crystal reporting technology to support current investigations and identify new cases. The SIU performs an annual review of the plan to identify high-dollar specialties, providers and procedures codes. This can suggest to our SIU investigators which specialties to review for outlier behavior.

If we identify a case of suspected fraud, SIU's information technology and investigative professionals collaborate closely with external investigators to conduct in-depth analyses of case-related data.

Reporting fraud, waste, and abuse

Special Investigative Unit

Aetna's SIU has a national toll-free Fraud Hotline 1-800-338-6361 for members and providers who may have questions, seek information or want to report potential fraud-related problems. The SIU staffs the hotline 24/7/365 and callers can remain anonymous. The hotline has proven to be an effective service. We encourage HealthChoices members, providers and contractors to use it.

Pennsylvania MA Provider Self-Audit Protocol

Network providers may voluntarily disclose overpayments or improper payments of MA funds through the Department's Provider Self Audit Protocol. The protocol is available on the Department of Human Services' website at **www.dhs.pa.gov/about/Fraud-And- Abuse/Pages/default.aspx**; click on the Fraud and Abuse link.

Our Fraud and Abuse Hotline

We have a toll-free Compliance (Fraud and Abuse) Hotline **1-800-333-0119** for members and providers who may have questions, seek information or want to report potential fraud- related problems.

DHS Provider Compliance Hotline
Providers and members can also report suspected fraud and abuse directly to the DHS Provider Compliance Hotline at **1-866-DHS-TIPS (1-866-379-8477)**. Providers can also make a report online at **https://expressforms.pa.gov/apps/pa/DHS/MA-Provider- Compliance-Hotline** and filling out the MA Provider Compliance Hotline Response Form or send communications to:

Department of Human Services
Office of Administration
P.O. Box 2675
Harrisburg, PA 17105-2675.

Reported problems will be referred to the Office of Medical Assistance Program's Bureau of Program Integrity for investigation, analysis and determination of the appropriate course of action. Aetna Better Health and the DHS maintain strict confidentiality concerning the providers and members who report suspected fraud and abuse.

Fraud and abuse examples
Examples of health care provider fraud and abuse are:

- Billing or charging members for services that we cover (other than co-pays)
- Offering members gifts (other than health plan programs approved by DHS) or money to receive treatment or services
- Offering members free services, equipment or supplies in exchange for use of a member's Aetna Better Health member ID number
- Providing members with treatment or services that they do not need
- Upcoding medical billing codes in order to receive higher reimbursement
- Physical, mental or sexual abuse by medical staff

Examples of member fraud and abuse are:

- Selling or lending identification cards to other people
- Living outside Pennsylvania
- Abusing benefits by seeking drugs or services that are not medically necessary

Chapter 15
Forms

We produce a number of forms for providers to expedite and standardize administrative functions. Provider orientation includes a review of these forms. If you have any questions or would like help completing forms, contact your Provider Relations Representative at **1-866-638-1232**.
For sample forms visit **AetnaBetterHealth.com/PA/providers/forms**.

Links
Care Management Referral Form:
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/pennsylvania/provider/pdf/Blank%20CM%20referral%20form%202020.pdf

ePocrates (registration required):
online.epocrates.com/rxmain.jsp

Fee schedule:
www.humanservices.state.pa.us/outpatientfeeschedule

Immunization schedules:
www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Pharmacy formulary:
AetnaBetterHealth.com/PA/providers/pharmacy

Pharmacy Prior authorization:
https://www.aetnabetterhealth.com/pennsylvania/providers/pharmacy-prior-authorization.html

Prior authorization checklist:
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/pennsylvania/provider/pdf/Prior%20Authorization%20Checklist%2020101.pdf

Provider appeals:
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/pennsylvania/provider/pdf/abhpa_provider_appeal_form.pdf

Provider education resources:
AetnaBetterHealth.com/PA/providers/education

Provider portal:
AetnaBetterHealth.com/PA/providers/portal

Quality improvement resources:
AetnaBetterHealth.com/PA/providers/quality-improvement-resources

Chapter 16
Glossary of key terms

Abuse
Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to CHIP, or any reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or agreement obligations. Agreement obligations include those found in the Request for Proposal, Agreement, or the requirements of state or federal regulations for health care in a managed care setting. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider or entity has not knowingly or intentionally misrepresented facts to obtain payment. The abuse can be committed by the MCO, subcontractor to the MCO including providers, state employee, or an enrollee, among others. Abuse also includes enrollee practices that result in unnecessary costs to any of the following:

- CHIP
- MCO
- MCO's subcontractor
- MCO's provider

Actuarially Sound Principles- Generally accepted actuarial principles and practices that are:

- Applied to determine an aggregate utilization pattern
- Are appropriate for the population and services to be covered
- Have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board

Adult- A natural parent, stepparent, adoptive parent, legal guardian or legal custodian of an enrollee or applicant. Adult must have care and control of enrollee or applicant.

Adjudicated Claim- A claim that has been processed to payment or denial.

Adverse Benefit Determination: A Complaint or Grievance that includes one of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the Commonwealth.
- The failure of an MCO to act within the timeframes provided in this handbook regarding the standard resolution of Complaints and Grievances.
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities.

Affiliate- Any entity that controls, is controlled by or under common control of the MCO or its parent(s), whether such control be direct or indirect, all persons, holding five (5) percent or more of the outstanding ownership interests of the MCO or its parent(s), directors or subsidiaries of MCO are Affiliates. For purposes of this definition, "control" means the possession of the power to direct or cause the direction of the management or policies.

Amended Claim- A provider request to adjust the payment of a previously adjudicated claim. A provider appeal is not an amended claim.

Appeal- To file a Complaint, Grievance, or request an external review.

Applicant- A child who has filed an application or who has an application filed on their behalf.

Authorization- Approval for a service.

Business Days- Monday through Friday except for those days recognized as federal holidays or Pennsylvania state holidays.

Calendar Year- A one-year period that begins on January 1 and ends on December 31.

Capitation- A fee the Department pays monthly to an MCO for each enrollee enrolled in its managed care plan to provide coverage of medical services, whether or not the enrollee receives the services during the period covered by the fee.

Case Management Services- Services that assist individuals with chronic and complex conditions in gaining access to necessary medical, behavioral health, educational and other services.

Certificate of Authority- A document issued jointly by the Pennsylvania Department of Health (PADOH) and Pennsylvania Insurance Department (PID) authorizing a corporation to establish, maintain and operate a Managed Care Organization (MCO) in Pennsylvania.

Certified Nurse Midwife- An individual licensed under the laws of the Commonwealth within the scope of Chapter 6 of Professions & Occupations, 63 P.S. §§171-176.

Certified Registered Nurse Practitioner- An individual licensed under the laws of the Commonwealth within the scope of Chapter 7 of Professions & Occupations, 63 P.S. §§218.1218.3.

Child- A person under nineteen (19) years of age.

Children's Health Insurance Program (CHIP)- The Pennsylvania program that provides free, low-cost or full-cost health care services to children in accordance with 40 P.S. §§ 991.2301-A – 991.2309-A.

Claim- A bill from a provider of a medical service or product that is assigned a claim reference number. A Claim does not include an encounter for which no payment is made or only a nominal payment is made.

Claim Reference Number- A unique identifier assigned to a provider of a medical service or product by CHIP.

Citizen- An applicant or enrollee who is a citizen of the United States.

Commonwealth of Pennsylvania Application for Social Services (COMPASS)- Pennsylvania's online portal for applying for and renewing health and human services benefits.

Community Partner- A private or public service organization that is not part of the MCO's Provider Network with which the MCO coordinates Out-of-Plan Services for their members.

Complaint- A dispute or objection regarding a participating provider, the coverage, operations, or management policies of an MCO, which has been filed with the MCO or with the PADOH or the PID. A dispute of the medical necessity of a service is not a Complaint.

Concurrent Review- A review conducted by the MCO during a course of treatment to determine whether the amount, duration and scope of the prescribed services continues to be medically necessary or whether any service, a different service or lesser level of service is medically necessary.

Copayment- A fixed amount paid by an enrollee to the provider for a covered health care service usually when the enrollee receives the service. The amount can vary by the type of covered health care service.

Cost Sharing- The premium contributions and copayments that the enrollee's household is responsible to pay as their share of health insurance coverage.

County Assistance Office (CAO)- The county offices of the Department that administer all benefit programs on the local level. Department staff in these offices perform necessary functions such as determining and maintaining recipient eligibility for MA.

Coverage Area- The geographic area for which an MCO is contracted by CHIP to provide health insurance.

Covered Outpatient Drug- A brand name drug, a generic drug, or an over-the-counter drug which is:

- Approved by the Federal Food and Drug Administration
- Distributed by a manufacturer that entered into a Federal Drug Rebate Program agreement with the Centers for Medicare and Medicaid Services (CMS)
- Prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice
- Dispensed or administered in an outpatient setting

NOTE: The term includes biological products and insulin. The drug may be dispensed only upon prescription.

Covered Service- A service or supply for which benefits are provided.

Cultural Competency- 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.

Data Exchanges (DX)- The collection of information from various external agencies such as the Pennsylvania Department of Labor and Industry (PADLI), Social Security Administration (SSA), PADOH, Administration of Children and Families, Public Assistance Reporting Information System (PARIS), and other exchanges used for the purpose of verifying eligibility.

Deliverables- Documents, records and reports required to be furnished to the Department for review, approval, or both. Deliverables include, but are not limited to operational policies and procedures, required materials, letters of agreement, provider reimbursement methodology, coordination agreements, reports, tracking systems, required files, Quality Management (QM) and Quality Utilization (UM) documents, and referral systems.

Demographics- Social statistics about applicants, enrollees and adults that includes race, date of birth, household income, ethnicity, gender, county of residence, marital status, and occupation.

Department- Pennsylvania Department of Human Services.

Developmental Disability- A severe, chronic disability of an individual that is:

- Attributable to a mental or physical impairment or combination of mental or physical impairments;
- Manifests before the individual attains age twenty-two (22);
- Likely to continue indefinitely;
- Reflects the individual's need for special, interdisciplinary or generic services, supports or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided; and
- Manifests in substantial functional limitations in three or more of the following areas of life activity:
    - Self-care;
    - Receptive and expressive language; o Learning; o Mobility; o Capacity for independent living; and o Economic self-sufficiency.

Disease Management- An integrated treatment approach that:

- Includes the collaboration and coordination of patient care delivery systems
- Focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment
- guidelines, patient counseling, education and outpatient care
- Includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition

Disenrollment- The process by which an enrollee's ability to receive services from an MCO is terminated. An enrollee may disenroll from CHIP at any time.

Effective Date- The date an enrollee's coverage begins as shown on the records of the MCO.

Electronic Client Information System (eCIS)- The Department's online database that contains information needed to authorize TANF, Medicaid and SNAP programs.

Eligibility Period- A period of time during which an enrollee is eligible to receive CHIP benefits. An eligibility period is indicated by the eligibility start and end dates in eCIS.

Eligibility Review - Review of an eligibility decision that resulted in denied or terminated coverage, changes to the budget category, or for failure to make a timely determination of eligibility.

Eligible Child- A child who has been determined as meeting all the eligibility requirements for CHIP.

Emergency Medical Condition- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention will result in: placing the health of the individual or for a pregnant woman, the health of the woman or the unborn baby in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily function.

Emergency Services- Covered inpatient and outpatient services that are furnished by a provider qualified to provide the services and are needed to evaluate or stabilize an Emergency Medical Condition.

Encounter- Any covered health care service provided to an enrollee regardless of whether it has an associated claim.

Encounter Data- A record of any encounter, including encounters reimbursed through capitation, Fee-for-Service (FFS), or other methods of compensation regardless of whether payment is due or made.

Enrollee- A child who has been determined to be eligible for CHIP and is enrolled with an MCO.

Enrollment- The process by which an enrollee's coverage by an MCO is initiated.

Enrollment Period- A period of eligibility for CHIP which consists of twelve (12) consecutive calendar months beginning with the first month that an eligible child is enrolled.

Equity- The residual interest in the assets of an entity that remains after deducting its liabilities.

External Complaint or Grievance- A review conducted by either PADOH or PID that occurs after the exhaustion of the MCO internal Complaint or Grievance process.

External Quality Review- The analysis and evaluation of aggregated information on the quality, timeliness, and access to the health care services that are furnished to CHIP beneficiaries by an organization that qualifies as an External Quality Review Organization under 42 C.F.R. § 457.10.

Family Planning Services- Services which enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies.

Federal Data Services Hub (FDSH)- A system that allows limited access to payroll information through its TALX interface, typically called "the work number" and is provided by Equifax.

Federal Poverty Level (FPL)- A scale to judge whether a household income meets the financial needs for the basic necessities of life. New guidelines are issued every year in late January or early February to account for fiscal changes such as higher utility costs, inflation, and minimum wage levels. The FPL is determined by the United States Department of Health and Human Services (HHS).

Federally Qualified Health Center (FQHC)- An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under the above-mentioned sections of the Act.

Formulary- A listing of preferred prescription drugs and supplies approved by the Department and covered by the MCO.

Fraud- Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The Fraud can be committed by many entities, including the MCO, a subcontractor of an MCO, a provider, a state employee, or an enrollee, among others.

Free CHIP- Medical coverage provided to an eligible child whose household income is less than or equal to 208% of the FPL.

Full-Cost CHIP- Medical coverage provided to an eligible child whose household income is greater than 314% of the FPL. The enrollee or adult is responsible for the full cost of the premium.

Generally Accepted Accounting Principles- A technical term in financial accounting. It encompasses the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time.

Government Liaison- The Department's primary point of contact within the MCO. This individual acts as the day-to-day manager of agreement and operational issues and works within the MCO and with the Department to facilitate compliance, solve problems, and implement corrective action.

Grievance- A request to have an MCO or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A Grievance may be filed regarding an MCO's decision to:

- Deny, in whole or in part, payment for a service or item
- Deny or issue a limited authorization of a requested service or item including the type or level of service or item
- Reduce, suspend, or terminate a previously authorized service or item
- Deny the requested service or item but approve an alternative service or item
- Deny a request for a Benefit Limit Exemption (BLE)

Habilitation Services- Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for an enrollee who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology, and other services for people with disabilities in a variety of outpatient settings.

HealthCare Handshake (HCHS)- The process where a complete application is electronically transferred from the CAO to an MCO, or from an MCO to a CAO. All information on the application is considered verified.

Health Insurance Portability and Accountability Act (HIPAA)- The Federal standards for privacy and security of individual identifiable health information in Title II of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320 d et seq.) and its regulations (45 C.F.R. Parts 160 and 164 Subparts A and E).

Health Maintenance Organization (HMO)- A Pennsylvania licensed risk-bearing entity that combines delivery and financing of health care and which provides basic health services to enrollees for a fixed, prepaid fee.

Health Management System (HMS)- This system is used in the eligibility determination process to determine if an enrollee is covered under Medical Assistance and other health insurances.

Home Health Care- Care provided in a person's home including skilled nursing services; help with activities of daily living such as bathing, dressing and eating; and physical, speech, and occupational therapy.

Hospitalization- Care in a hospital that requires admission as an inpatient at a licensed hospital.

In-Plan Services- Services which are the payment responsibility of the MCO under CHIP.

Inquiry- An enrollee's request for administrative service, information or to express an opinion.

Interagency Team- A multi-system planning team comprised of the enrollee, when appropriate, at least one accountable adult member, a representative of the County Mental Health and/or Drug and Alcohol Program, the case manager, the prescribing physician or psychologist, and as applicable, the County Children and Youth, Juvenile Probation, Developmental Disability, and Drug and Alcohol agencies, a representative of the school district, MCO, PCP, other agencies that are providing services to the enrollee, and other community resource persons identified by the adult.

Lawfully Residing- A child that is legally present in the United States and is living in the state with the intent to reside in the state, including those without a fixed address or a member of a child's household who has entered the state with a job commitment or seeking employment (whether or not that individual is currently employed).

Legal Guardian- A person who has the legal authority and the corresponding duty to assume care, control of, and financial responsibility for another person.

Limited English Proficiency (LEP)- An individual who does not speak English as their primary language and has a limited ability to read, write, speak, or understand English. LEP individuals may be eligible to receive language assistance for a service, benefit, or encounter.

Low-Cost CHIP- Medical coverage provided to an eligible child whose household income is greater than 208% and less than or equal to 314% of the FPL, and for which the responsible adult must pay a cost sharing premium established by the Department.

Managed Care Organization (MCO)- A risk bearing entity which manages the purchase and provision of physical and behavioral health services under CHIP.

Master Client Index (MCI)- Applicant identifier that is assigned across multiple Commonwealth systems.

Master Provider Index (MPI)- A component of PROMISe™ which is a central repository of provider profiles and demographic information that registers and identifies providers uniquely within the Department.

Medicaid- Federal medical assistance program established under Title XIX of the Social Security Act.

Medical Assistance (MA)- The state program established under the Act of June 13, 1967, known as the "Human Services Code".

Medical Loss Ratio (MLR)- A basic financial measurement of the percentage of premium dollars that a health plan spends on medical claims and quality improvements, versus administrative costs.

Medically Necessary- A service, item, or medicine that does one of the following:

- It will, or is reasonably expected to, prevent an illness, condition, or disability;
- It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; or
- It will help a child get or keep the ability to perform daily tasks, taking into consideration both the child's abilities and the abilities of someone of the same age.

Medicare- A federally financed health insurance program administered by the CMS pursuant to 42 U.S.C. §§1395 et seq., covering almost all Americans sixty-five (65) years of age and older and certain individuals under sixty-five years (65) of age who are disabled or have chronic kidney disease.

Member Month- One enrollee covered by CHIP for one calendar month.

Member Services Unit (MSU) – A unit within the Office of CHIP that provides technical guidance and operational support for the maintenance of enrollee records. Provide customer support via incoming and outgoing calls.

Minimum Essential Coverage (MEC)- Coverage required to meet the individual responsibility requirement under the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

Modified Adjusted Gross Income (MAGI) – Calculated as total adjusted gross income plus tax-exempt interest income, foreign-earned income excluded from taxes, and tax-exempt social security benefits. Determined as point-in-time, projected for twelve (12) months, including predictable increases or decreases in household income.

Newborn- An infant from birth to one (1) month of age.

Network- The providers, facilities, and suppliers contracted with the MCO to provide covered services to enrollees.

Network Provider- A CHIP enrolled provider, facility, or supplier who has a written provider agreement with and is credentialed by an MCO and who participates in the MCO's provider network to serve enrollees.

Non-participating Provider- A provider facility, or supplier who is not enrolled with Pennsylvania to provide services to CHIP enrollees.

Nursing Facility- A general, county or hospital-based nursing facility, which is licensed by the DOH, enrolled in the MCO network and certified for Medicare participation. The provider types are as follows:

- General
- County
- Hospital-based
- Certified Rehab Agency

Ongoing Medication- A medication that has been previously dispensed to the enrollee for the treatment of an illness that is chronic in nature or for an illness for which the medication is required for a length of time to complete a course of treatment, until the medication is no longer considered medically necessary by the physician or prescriber, and that has been used by the enrollee without a gap in treatment. If a current prescription is for a higher dosage than previously prescribed, the prescription is for an ongoing medication at least to the extent of the previous dosage.

Out-of-Area Covered Services- Medical services provided to enrollees under one (1) or more of the following circumstances:

- An Emergency Medical Condition that occurs while outside the MCO coverage area
- The health of the enrollee would be endangered if the enrollee returned to his or her MCO coverage area for needed services

- The provider is located outside the enrollee's MCO coverage area, but regularly provides medical services to enrollees at the request of the MCO
- The needed medical services are not available in the MCO coverage area

Out-of-Network Provider- A provider, facility, or supplier who has not been credentialed by or does not have a signed provider agreement with an MCO.

Out-of-Plan Services- Services which are non-plan, non-capitated, and are not the responsibility of the MCO under the CHIP comprehensive benefit package.

Out-of-Pocket Expenses- Includes premiums and point-of-service co-payments paid by the household to MCOs or providers on behalf of the child enrolled in a Low- or Full-Cost category of CHIP for CHIP covered benefits and services only.

Participating provider- A provider, facility, or supplier who is enrolled with the Department.

Personal Property- A privately owned possession which is not real property, such as cash on hand, motor vehicles, and life insurance.

Physician Incentive Plan- Any compensation arrangement between an MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to an enrollee who is enrolled in the MCO that complies with 42 C.F.R. § 438.3(i), as incorporating 42 CFR §§ 422.208 and 422.210.

Physician Services- Health care services provided or directed by a licensed medical doctor (MD) or Doctor of Osteopathic Medicine (DO).

Pennsylvania Department of Health (PADOH)- The department which monitors health care quality within Pennsylvania.

Pennsylvania Insurance Department (PID)- The department which enforces insurance regulations within Pennsylvania.

Post-stabilization Services- Covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized to maintain the stabilized condition, or under the circumstances described in the contract, as amended and in this Handbook, to improve or resolve the enrollee's condition.

Postpartum- The 12 month period the begins at the termination of pregnancy.

Pre-Existing Condition- A condition (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or has been received prior to the effective date of coverage.

Preferred Drug List- A list of Department-approved outpatient drugs designated as preferred products because they were determined to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness and cost for the MCO enrollees by the MCO's Pharmacy and Therapeutics Committee.

Premium- The amount the adult pays to the health insurance company every month for health insurance coverage for low-cost or full-cost CHIP.

Primary Care Practitioner- A specific physician, physician group or a CRNP operating under the scope of his or her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of an enrollee.

Primary Care Provider (PCP)- The doctor or doctor's group who provides and works with an enrollee's other health care providers to make sure the enrollee gets the health care services the enrollee needs.

Prior Authorization- A determination made by the MCO to approve or deny payment for a provider's request to provide a service or course of treatment of a specific duration and scope to an enrollee prior to the provider's initiation or continuation of the requested service.

Prior Authorized Services- In-Plan Services, determined to be medically necessary, the utilization of which the MCO manages in accordance with Department-approved prior authorization policies and procedures.

PROMISE™ ID- A 13-digit number consisting of a combination of the 9-digit base MPI Provider Number and a 4-digit service location.

Provider- An individual or entity that delivers health care services or supplies.

Provider Agreement- A Department-approved written agreement between the MCO and a provider to provide medical or professional services to enrollees.

Provider Appeal- A request from a provider for reversal of a determination by the MCO, regarding:

- Provider credentialing denial by the MCO
- Claims denied by the MCO for providers participating in the MCO's Network. (This includes payment denied for services already rendered by the Provider to the enrollee)
- Provider agreement termination by the MCO

Provider Dispute- A written communication to an MCO, made by a provider, expressing dissatisfaction with an MCO decision that directly impacts the provider. This does not include decisions concerning medical necessity.

Provider Reimbursement and Operations Management Information System Electronic (PROMIS*e*™)- The Department's current claims processing and management system that supports the FFS and MA Managed Care delivery programs.

Qualified Alien- An applicant that meets the definition of qualified alien as defined by Section 431 of the Personal Responsibility and Work Reconciliation Act of 1996, P.L. 104-193 (PRWORA).

Quality Management- An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.

Real Property- Real property includes any land and related outbuildings needed to operate the home.

Reasonably Compatible- For purposes of this policy, the Department must consider information through electronic data sources, other information provided by the applicant, or other information in the records of the insurer to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the eligibility of the applicant.

Rehabilitative Services- Health care services that help to maintain, regain, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient or outpatient settings.

Reinstatement- The act of restoring an enrollee's CHIP benefit without a lapse in coverage.

Renewal- The outcome of a review of eligibility that results in an enrollee receiving another twelve (12) month enrollment period of CHIP coverage.

Renewal Due Date (RDD)- Date renewal of coverage must be completed to remain enrolled in CHIP.

Resident- An individual who is living and intends to reside in Pennsylvania, with or without a fixed or permanent address.

Resource- Real or personal property.

Retrospective Review- A review conducted by the MCO to determine whether services were delivered as prescribed and consistent with the MCO's payment policies and procedures.

Revenue- The total gross direct business premiums, for all Pennsylvania lines of business, reported in Schedule T, "Premiums and other Considerations," of the PID report. In this handbook, revenue is used for the purposes of the equity requirement calculation.

Routine Care- Care for conditions that generally do not need immediate attention and minor episodic illnesses that are not deemed urgent. This care may lead to prevention or early detection and treatment of conditions. Examples of preventive and routine care include immunizations, screenings, and physical exams.

Seasonal Worker- An individual whose ability to work directly relates to the weather or to the season. For example, individuals who work in landscaping, construction, grounds maintenance or individuals that pick fruit at an orchard work as the weather or season permits. Many of these jobs are performed for only a part of a year. The other part of the year the employee is unemployed or laid off.

Secretary- Secretary of the Pennsylvania Department of Human Services.

Skilled Nursing Services- Services provided by licensed nurses.

Social Determinates of Health (SDOH)- SDOH are the conditions in which people are born, grow, live, work, and age. They are the factors mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between different geographic locations. There are five major determinant areas:

- Economic stability (poverty, employment, food security, housing stability, transportation);
- Education (high school graduation, enrollment in higher education, language and literacy);
- Social and community context (social cohesion, discrimination, incarceration); Health and health care (accessibility and health literacy); and Neighborhood and built environment (quality of housing, safety).

Specialist- A doctor, a doctor's group, or a CRNP who focuses his or her practice on treating one disease or medical condition or a specific part of the body.

Start Date- The first date on which the MCO is operationally responsible and financially liable for the provision of medically necessary services to enrollees.

State Based Exchange (SBE)- Developed by CMS to operate in states that have chosen not to build their own Marketplace.

Step Therapy- A type of prior authorization requirement, sometimes referred to as a fail-first requirement, intended as a cost savings that begins drug therapy with the most cost-effective drug therapy, and progresses to other costlier therapies determined to be medically necessary.

Subcontract- A contract between the MCO and an individual, business, university, governmental entity, or nonprofit organization to perform part or all of the MCO's responsibilities. Exempt from this definition are salaried employees, utility agreements and provider agreements, which are not considered subcontracts for the purpose of this handbook, and, unless otherwise specified herein, are not subject to the provisions governing subcontracts.

Supplemental Security Income (SSI)- Monthly cash payments made to the aged, blind, or disabled under the authority of Title XVI of the Social Security Act, as amended, Section 1616 (A) of the Social Security Act, or Section 212 (A) of Pub. L. 93-66.

Sustained Improvement- Improvement in performance documented through continued measurement of quality indicators after the performance project, study, or quality initiative is complete.

Systematic Alien Verification for Entitlements (SAVE)- The program maintained by the United States Citizenship and Immigration Services that verifies immigration status for non-U.S. citizens.

TALX- An interface that allows limited access to payroll information; a system that allows limited access to payroll information through its TALX interface, typically called "the work number" and is provided by Equifax. See also: Federal Data Services Hub (FDSH).

Tax household- The group of persons and their income used to determine an applicant's CHIP eligibility or an enrollee's renewal based upon the MAGI rules.

Termination- Discontinuance of CHIP coverage for an enrollee who had been previously enrolled and has ended his or her relationship with an approved MCO for one of the reasons enumerated in this handbook.

Third Party Liability (TPL)- An individual entity or program (e.g. Medicare, private insurance) other than the MCO financially responsible for all or part of an individual's health care expenses.

Urgent Medical Condition- An illness, injury or severe condition which under reasonable standards of medical practice, should be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or an emergency medical condition. The term also includes services that are necessary to avoid a delay in hospital discharge or hospitalization.

Utilization Management (UM)- An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide medically necessary, timely, and quality health care services in the most cost-effective manner.

Utilization Review Criteria- Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but not limited to, level of care, place of service, scope of service, and duration of service.

Waste- The overutilization of services or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions, but rather misuse of resources.

Any questions? Call Provider Relations at **1-866-638-1232**