Provider newsletter

Summer 2023

Member advocates

Our member advocate team can normally be found working with members to ensure that they have the best healthcare experience possible. In addition to providing an overview of our plan, member advocates educate our members on benefits available for STAR/CHIP/STAR Kids coverage, Texas Health Steps, renewal and Accelerated Services for Farmworker Children. Here are a few additional services our outreach team offers:

- **Questions about coverage** – Our member advocate team can assist members in obtaining answers to questions about their coverage.
- **Re-enrollment assistance** – Call **2-1-1 Texas** or visit **yourtexasbenefits.com/Learn/Home**.
- **Member Advisory Group meetings** – Our member advocate team schedules quarterly STAR Member Advisory Group meetings and welcomes all STAR members to attend.
- **Member Baby Shower program** – Our Maternity Care Program provides lots of great information to help with pregnancy. Visit: **www.aetnabetterhealth.com/texas/wellness/women/pregnancy**.
- **Diapers for Dads program** – Our Maternity Care Program also offers information to help soon-to-be fathers. Visit our website at: **www.aetnabetterhealth.com/texas/wellness/women/pregnancy**.

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- **CVS HealthHUB™ events** – Our member advocate team schedules weekly health events at local CVS HealthHUBs to provide member education on STAR/CHIP/STAR Kids coverage, Texas Health Steps, renewal, services for farmworker children and the latest on COVID-19 and vaccination incentives.

To get connected with a member advocate, members can call the number on the back of their member ID card. They can also leave a message at **1-800-327-0016** in our member advocate mailbox and we will return the call within one to two business days.

Members who are deaf or hard of hearing can call **1-800-735-2989**.

For information on our value-added services please visit:

- **What Does Medicaid Cover? | Aetna Medicaid Texas**
- **What Does STAR Kids Cover? | Aetna Medicaid Texas**
- **What Does CHIP Cover? | Aetna Medicaid Texas**

Community outreach

Our community outreach department can normally be found in the community attending health fairs and community events geared towards educating existing and potential members about our plan. In addition to providing an overview of our plan, community outreach educates our communities on CHIP/Medicaid, Texas Health Steps, and Accelerated Services for Farmworker Children. Our outreach team can also be a great asset to any provider office offering a number of services geared for members to enhance not only their experience with our plan but with the provider as well. Here are a few of the services we offer:

- **Member education** – One-on-one education session with a member that must be conducted in a private room at the provider's office. Community outreach will normally coordinate a date/time with a provider when multiple members are scheduled.
- **Re-enrollment assistance** – Members can call **2-1-1 Texas** or visit **yourtexasbenefits.com/learn/home** to renew their Medicaid benefits.
- **Provider education** – Education sessions for provider offices to assist in the identification of children of migrant farmworkers in order to help them receive the health care services their child/children may need.
- **Farmworker children** – Farmworker children have parents or guardians who meet the state definition of a migratory agricultural worker, generally defined as an individual:
  1. Whose principal employment is in agriculture on a seasonal basis.
  2. Who has been so employed within the last 24 months.
  3. Who performs any activity directly related to the production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence.
  4. Who establishes for the purpose of such employment a temporary abode.

  Source: Texas Health and Human Services Commission, Uniform Managed Care Contract Terms & Conditions, Version 1.17, p. 11
- **Farmworker children referral process** – Providers who identify farmworker children members can contact Member Services at **1-888-672-2277** so we can provide additional outreach and assistance if needed.

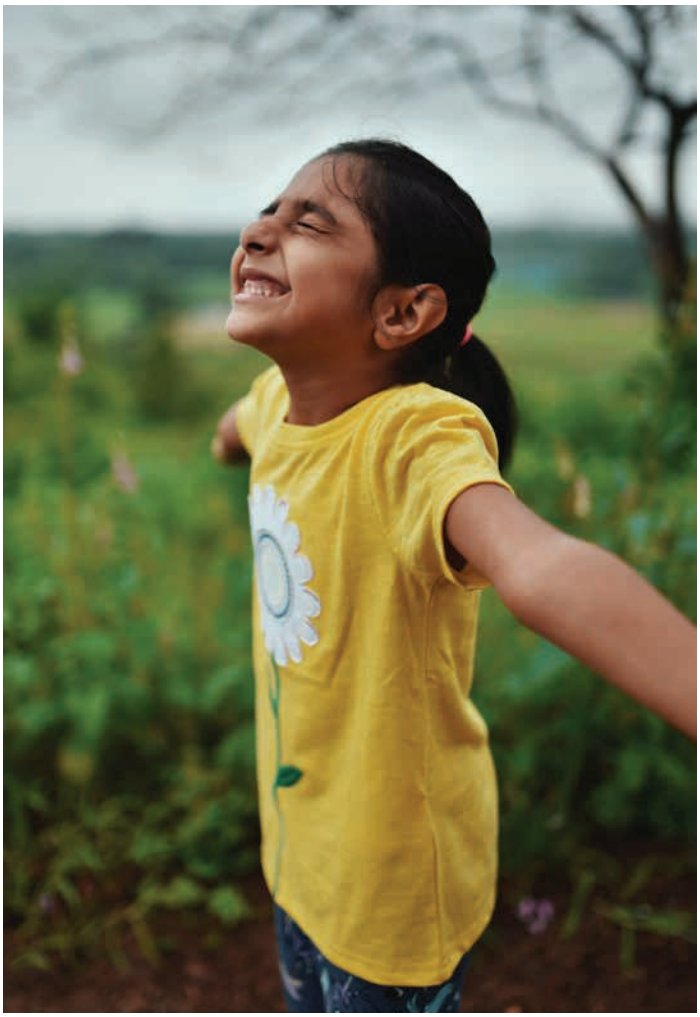
For more information on our value-added services and programs call **1-877-751-9951**.

Submitting appeals

When submitting an appeal for timely filing please review the facts below when submitting your appeal request:

Timely claim filing facts

- Claims must be received within 95 days of each date of service to be considered timely.
- Appeals must be received within 120 days of the disposition date to be considered timely.
- Claims that are filed electronically and are rejected must be corrected and resubmitted for payment consideration.
- Proof of timely filing must be submitted with the with the appeal for a claim that has denied for timely filing.
- Corrected claims or additional information needed to process a denied claim must be received within 120 days of the dispositions date. If not, the claim will still be considered past timely filing.
- Regarding coordination of benefits, the primary EOB must be received within 120 days of the disposition date on the primary EOB to be considered timely.



Service Coordination

All STAR Kids members receive an assessment, at least yearly, using the STAR Kids Screening and Assessment Instrument (SK-SAI). The assessment contains screening questions and modules that assess for medical, behavioral, and functional service. The assessment is in person with member required attendance. School notes are available for members who elect to complete the assessment during school hours.

Encourage your patients to collaborate with a Service Coordinator to complete this assessment. It is essential in determining a member's need for attendant care services, therapies, durable medical equipment, and more.

Your patients can contact our Service Coordination department at **1-844-787-5437** (select the Service Coordination option) to schedule the assessment.

Member Advisory Group meeting

STAR Kids members have the Member Advisory Group (MAG) meeting as a way to share their opinions and receive information pertinent to them.

Members who attend will receive a gift card for their participation. Meetings are held quarterly with virtual and in-person options. Dallas service delivery area meetings are held at Texas Scottish Rite for Children in Dallas on 8/9/2023 and 11/8/2023. Tarrant service delivery area meetings are held at East Regional Library in Fort Worth on 8/2/2023 and 11/1/2023.

Your patients can contact our Service Coordination department by at **1-844-787-5437** (select the Service Coordination option) for more information about MAG meetings and meeting details.

Thank you for joining us in our mission to promote optimal health for each and every one of our members.

Help us ensure that your Aetna patients have timely and appropriate access to care

We want to remind Aetna Better Health providers of the required availability and accessibility standards. Please review the standards listed below.

Level of care	Timeframe
Emergency services	Upon member presentation at the service delivery site
Urgent care appointments	Within 24 hours of request for primary and specialty care
Routine primary care	Within 14 days of request for non-urgent, symptomatic condition
Routine specialty care	Within 21 days of request for non-urgent, symptomatic condition
Adult preventive health physicals/ wellness visits for members over the age of 21	Within 90 days of request
Pediatric preventive health physicals/ well-child checkups for members under the age of 21, including Texas Health Steps services	As soon as possible for members who are due or overdue for services, in accordance with the Texas Health Steps Periodicity Schedule and the American Academy of Pediatrics guidelines, but in no case later than: • 2 weeks of enrollment for newborns • 60 days of new enrollment for all others
Prenatal care/first visit	Within 14 days of request. For high-risk pregnancies or new members in the third trimester, appointments should be offered immediately, but no later than 5 days of request.
Behavioral health visit	Initial outpatient behavioral health visit (child and adult within 14 calendar days

Appointment availability requirements

After-hours access requirements: the following are acceptable and unacceptable phone arrangements for contacting PCPs after normal business hours.

Acceptable	Unacceptable
Office phone is answered after hours by an answering service, in English, Spanish or other languages of the major population groups served, that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes. Office phone is answered after normal business hours by a recording in English, Spanish or other languages of the major population groups served, directing the patient to call another number to reach the PCP or another designated provider. Someone must be available to answer the designated provider's phone. Another recording is not acceptable. Office phone is transferred after office hours to another location, where someone will answer the phone and be able to contact the PCP or another designated medical practitioner.	Office phone is only answered during office hours. Office phone is answered after hours by a recording, which tells the patients to leave a message. Office phone is answered after hours by a recording, which directs patients to go to an emergency room for any services needed. Returning after-hour calls outside of 30 minutes.

Join us for a behavioral health informational webinar

Wednesday, June 21, 2023, 11:30 AM – 1 PM CT
Join by phone or TEAMS

Topics: TMHP, quality, behavioral health provider updates, provider relations news and updates

Email **ABHTXcredentialing@aetna.com** or your provider representative for more information

Do you have suggestions or topics you would like more information on? Email **ABHTXcredentialing@aetna.com**.

Any changes to your demographic information?

Aetna Better Health of Texas strives to ensure provider directory information is as accurate and current as possible for our members. If you are a provider or provider group and need to update demographic information, please contact us at the emails below.

Contact	Type of update
ABHTXCredentialing@Aetna.com	Adding providers, change of physical address, contracting, credentialing, copies of contract or checking credentialing/ contracting status. If you have a new provider joining your practice, you must submit: • Prospective Provider Form • W9 The application can be found at **AetnaBetterHealth.com/Texas**.
TXproviderenrollment@Aetna.com	If you have an EFT/ERA update or delegated roster update.

Help ensure your patients do not lose their coverage

As you may know, the public health emergency (PHE) related to COVID-19 ended May 11, 2023. States now have 12 months to recertify the eligibility of all Medicaid/CHIP enrollees.

Those who no longer meet eligibility requirements – or those who do not take the steps to confirm their eligibility – **will lose their coverage**.

Even before the PHE, thousands of people were disenrolled from Medicaid every month for procedural reasons. In many cases, recipients weren't even aware that they needed to recertify their eligibility.

How you can help

Remind your patients to confirm their current contact information with HHSC or caseworker. They can visit the website below for more information and to get started.

Also, **make note of the phone number, 2-1-1 Texas, for your state's Medicaid enrollment office**. Keep it handy at your front desk, billing office or anywhere staff can share with patients.

Thank you for supporting this effort. For more information, visit **yourtexasbenefits.com.**

Provider enrollment revalidation extensions ended May 11

Effective May 11, 2023, HHSC ended the flexibility of extended Medicaid provider revalidation dates that came due during the COVID-19 PHE. Per federal guidance, providers that were due for revalidation March 1, 2020, through May 11, 2023, will receive a post-PHE grace period to complete the revalidation process.

TMHP notified providers in March 2023 of their recalculated enrollment end date and will notify them again 120 days prior to their Medicaid provider enrollment end date.

Providers are encouraged to avoid potential enrollment delays by submitting revalidation applications as soon as possible within the 120-day window.

Providers can find their revalidation due dates in the Provider Dashboard in PEMS under the Revalidation Due Date field in the Enrollment Information section of the Provider Information page.

Additional information

Providers that do not complete the revalidation process by their deadline will be disenrolled from all Texas state health care programs, and all claims and prior authorization requests submitted after the revalidation deadline will be denied.

Revalidating providers may need to provide fingerprints, submit additional documentation, or complete other screening requirements. Providers can visit PEMS to view and confirm their revalidation date and enrollment information.

To speed up the application process, providers should have the following information available to ensure this information is accurate:

- First and last name
- Organization name
- Social Security number
- Date of birth
- Employer's tax identification number and legal name
- Licenses or certifications, if applicable
- Identification for the provider and any person who meets the definition of owner, creditor, principal, subcontractor or managing employee
- Documentation related to disclosures, if needed
- Additional documentation required for program participation

Providers that are revalidating an existing enrollment should continue to submit claims to meet their timely filing requirements while their revalidation is being processed.

Certain revalidating providers must pay a provider enrollment application fee. Refer to the **State of Texas Provider Types Required to Pay an Application Fee** for a list of institutional providers that have to pay the application fee.

For more information, providers can refer to the current Texas Medicaid Provider Procedures Manual, General Information, Section 1, **Provider Enrollment and Responsibilities**, call the TMHP Contact Center at **1-800-925-9126** or email: **providerenrollmentmanagementsystem@hhs.texas.gov.**

Common Texas Health Steps billing issues for medical checkups

Aetna Better Health of Texas as part of its ongoing efforts to increase Texas Health Steps (THSteps) medical checkup rates has identified some common billing errors. Understanding why claims are denied may help prevent future claims from being rejected. Please use the reference guide below to review the top claim denial trends and how to prevent the denial.

Remit reason	Denial related to	Aetna Better Health of Texas comment	Action needed to prevent denial
N77 – missing, incomplete or invalid designated provider number	THSteps provider enrollment with TMHP	See TMHP manual section: 4.2.1 THSteps Medical Provider Enrollment, federal qualified health centers (FQHC) or rural health clinics (RHC) must be enrolled in Texas Medicaid, but do not have to be enrolled separately as a THSteps provider. The following provider types must be enrolled in Texas Medicaid as a THSteps provider: • A physician or physician group • A physician assistant (PA) • A clinical nurse specialist (CNS) • A nurse practitioner (NP) • A certified nurse midwife (CNM) • A health-care provider or facility with physician supervision	Ensure that the rendering provider or group is registered with TMHP as a THSteps provider prior to submitting claims
96 non-covered charge(s)	Bundled rate or fee not found on TMHP fee schedule	See TMHP manual Section: 4.3.6 THSteps Medical Checkups Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup, with the exception of initial point-of-care blood lead testing, mental health screening for adolescents, postpartum depression screening, tuberculin skin test (TST), developmental and autism screening, vaccine administration, and oral evaluation and fluoride varnish (OEFV).	Ensure that claim is billed in accordance with the TMHP manual and THSteps Quick Reference guidelines
6 – procedure/ revenue code is inconsistent with the patient's age	Correct coding	See THSteps Quick Reference Guide **www.tmhp.com/sites/default/files/file-library/texas-health-steps/THSteps_QRG.pdf**	Ensure that the correct CPT code from the Quick Reference Guide indicated on the claim based on member age prior to submitting claim

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Common Texas Health Steps billing issues *(continued from previous page)*

Remit reason	Denial related to	Aetna Better Health of Texas comment	Action needed to prevent denial
208 – national provider identifier does not match	General provider enrollment with TMHP	Aetna Better Health of Texas is unable to reimburse claims when either the rendering or billing NPI does not have an active Medicaid enrollment or if the license expiration date has lapsed in the PEMS portal	Ensure all NPIs submitted on the claim are active with TMHP and submit any necessary license maintenance requests via the PEMS portal as soon as practitioners receive an updated license expiration date
N19 – procedure code incidental to primary procedure	Correct coding	TMHP manual guidelines, correct coding guidelines including National Correct Coding Initiative (NCCI) guidelines apply to THSteps claims	Ensure correct coding modifiers are applied if vaccines, autism screening or other distinct services are being performed in addition to the THSteps exam
Duplicate	Correct coding	A duplicate claim is defined as a claim or procedure code detail that exactly matches a claim or procedure code detail that has been reimbursed to the same provider for the same client. Duplicate claims or details include the same date of service, procedure code, modifier and number of units.	Ensure that that claim submission was accepted by Aetna Better Health of Texas for processing and review status of claim prior to generating another submission. When billing corrected claims, providers must use the appropriate billing indicator and include the original claim number
16 – claim/service lacks information needed for adjudication	Correct coding/ provider enrollment/ excludes denials	The ICD-10 code set includes notes that indicate when certain diagnosis codes are never appropriate to bill together	Ensure that coding on the claim meets all of the correct coding guidelines including the ICD-10 excluded notes guidelines

For coding tips, refer to the **Aetna HEDIS Tips for Providers** for more information. If you have questions or need additional support, please contact your Provider Relations rep or email **ABHTXCredentialing@Aetna.com**.