

Aetna Better Health[®] of Texas

Provider Manual

Updated: April 2023

To learn more, please call:

Provider Services (follow prompts)

1-800-248-7767 (Bexar) or **1-800-306-8612** (Tarrant)

1-844-STRKIDS (1-844-787-5437)

Provider Website: **AetnaBetterHealth.com/Texas**

Provider Portal: Availity **1-800-282-4548**

Bexar Service Area

Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall,
Medina, Wilson

Tarrant Service Area

Denton, Hood, Johnson, Parker, Tarrant, Wise

Dallas Service Area

Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, Rockwall



TEXAS
Health and Human
Services

TEXAS
STAR Kids
Your Health Plan ★ Your Choice

TEXAS **STAR**
Your Health Plan ★ Your Choice



AetnaBetterHealth.com/Texas

Aetna Better Health[®] of Texas

Aetna Better Health® of Texas
Medicaid (STAR), STAR Kids and CHIP/CHIP Perinate
Provider Manual

April 2023

P.O. Box 818042
Cleveland, OH 44181-8042



Table of Contents

Introduction.....	7
Background.....	7
Quick Reference Phone List	8
Objectives of program	9
Role of primary care provider/medical home.....	9
Role of specialty care provider	9
Role of Long-Term Services and Supports (LTSS) providers.....	9
Role of Aetna Better Health of Texas Service Coordinator.....	9
Role of CHIP Perinate provider	9
Role of pharmacy	9
Role of Main Dental Home.....	10
Network limitations.....	10
Covered Services	10
Medicaid Managed Care Covered Services.....	11
Attention Deficit Hyperactivity Disorder (ADHD).....	22
Prescribed Pediatric Extended Care Centers and Private Duty Nursing.....	22
STAR Kids Covered Services.....	23
Transition Plan	38
Coordination with Non-Medicaid Managed Care Covered Services.....	39
CHIP Covered Services.....	42
CHIP DME/Supplies	58
CHIP Perinate Newborn Covered Services.....	62
CHIP Perinate (unborn child) covered services.....	85
Behavioral Health	98
Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM)	103
Definition of severe and persistent mental illness (SPMI).....	104
Definition of severe emotional disturbance (SED).....	105
Member access to and benefits of MHR Services and TCM.....	105
CHIP Member Prescriptions.....	105
Quality Management	106
Practice Guidelines.....	108
Focus study and utilization management reporting requirements	110
Provider Responsibilities	111
Member information on Advance Directives	115

Reporting Abuse, Neglect, or Exploitation (ANE).....	121
Long-Term Services and Supports Provider Responsibilities.....	125
Routine, Urgent, and Emergency Services.....	128
Electronic Visit Verification.....	132
Providers of Home Health Services Responsibilities.....	136
Provider Compliance Plan.....	137
Medicaid Managed Care Provider Dispute, Complaint and Appeal Process.....	138
Documentation.....	140
CHIP Provider Complaint and Appeal Processes.....	148
CHIP Member Complaint Process.....	150
CHIP Member Appeal Process.....	151
Member Expedited Aetna Better Health Appeal.....	153
Member Independent Review Organization Process.....	154
Medicaid Managed Care Member Eligibility and Added Benefits.....	155
Added Benefits.....	158
Value-added services to Aetna Better Health STAR Kids members.....	163
CHIP Member Eligibility and Added Benefits.....	167
Verifying eligibility.....	167
CHIP Managed Care benefits and Aetna Better Health CHIP value-added services.....	169
Member Rights and Responsibilities.....	181
Member's Right to Designate an OB/GYN.....	186
Fraud Reporting.....	186
Medicaid Managed Care/CHIP Encounter Data, Billing and Claims Administration.....	187
Where to send claims/Encounter Data.....	187
Provider Portal Functionality (both online and batch claims processing).....	189
Form/Format to use.....	189
Emergency Services Claims.....	191
Cost sharing schedule for Aetna Better Health CHIP members.....	192
Billing Members.....	194
Private Pay Agreement/Member Acknowledgement.....	194
Time limit for submission of claims/Encounter Data/claims Appeals.....	194
Claims payment.....	194
Special billing.....	196
Medical Management.....	196
Utilization Management.....	197
Prior authorization.....	198
Concurrent review.....	198

Integrated Care Management services	199
Chronic Condition Management	200
Provider Portal	201
How to find a list of covered drugs.....	201
How to find a list of preferred drugs.....	201
How to find a list of PA required services and codes.....	201
Medicaid Managed Care Member Enrollment and Disenrollment from Aetna Better Health	203
CHIP Member enrollment and disenrollment	204
CHIP Perinatal member enrollment and disenrollment.....	206
Medicaid Managed Care/CHIP Special Access Requirements.....	207
General transportation and ambulance/wheelchair van.....	207
Interpreter/translation services	207
Provider coordination.....	208
Reading/grade level consideration.....	208
Cultural sensitivity	208
Standing Referrals	209
Access to telemedicine, telemonitoring, and telehealth	209
Insurance requirements, laws, rules and regulations	209
Insurance.....	209
Laws, rules and regulations.....	210
Marketing	211
Professional conduct	211
Update to Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook.....	211
Conclusion	212
Appendixes	213
Appendix A – Sample ID cards.....	213
Appendix B – Behavioral health screening tools.....	218
Appendix C – Texas Health Steps Periodicity Schedule.....	219
Appendix D – Texas Referral/Authorization Form	221
Appendix E – Request for initial outpatient therapy	222
Appendix F – Request for extension of outpatient therapy	223
Appendix G – Request for Durable Medical Equipment	224
Appendix H – Medical record criteria.....	226
Appendix I – Private Pay Agreement.....	229
Appendix J – Member Acknowledgement.....	230
Appendix K – Consent for Disclosure of Confidential Information	231

Appendix L – Texas Health Steps Quick Reference Guide..... 235
Appendix M- State Fair Hearing/External Medical Review Request Form.....236

Introduction

Welcome to Aetna Better Health. We are pleased you have decided to participate with the Aetna Better Health STAR (Medicaid), STAR Kids, the Children’s Health Insurance Program (CHIP)/CHIP Perinate Newborn and/or the CHIP Perinate (future reference is CHIP).

Background

Aetna Better Health’s Medicaid, CHIP and STAR Kids programs are dedicated to delivering quality health care to recipients eligible for State funded health care coverage.

Aetna Better Health understands the health care risks of the community we serve and the impact that these problems have on our Members’ ability to function and live productive lives. It is this understanding and focus on addressing barriers to care created by social needs that makes Aetna Better Health relevant to improving Member access to quality medical care.

Currently, we offer Medicaid, CHIP and STAR Kids benefits to eligible recipients who live in the Bexar, Tarrant and Dallas Service Areas. These Service Areas (SAs) encompass the following counties in Texas:

Tarrant service area	Bexar service area	Dallas service area
Denton	Atascosa	Dallas
Hood	Bandera	Collin
Johnson	Bexar	Ellis
Parker	Comal	Hunt
Tarrant	Guadalupe	Kaufman
Wise	Kendall	Navarro
	Medina	Rockwall
	Wilson	

This Provider Manual is a source of detailed information about programs and processes used to administer benefits to Aetna Better Health Medicaid, STAR Kids and CHIP/CHIP Perinate Members. From provider requirements, access standards, prior authorization processes and claim filing, this manual provides easily accessible information to help guide you through your day-to-day business practices with us and allows you more time to focus on what’s important to you – the health and wellbeing of your patients.

Before you use this manual, take a moment to review these important highlights for participating health care professionals.

Quick Reference Phone List

	Medicaid	CHIP	STAR Kids
Provider Relations/ Member			
Tarrant	1-800-306-8612	1-800-245-5380	1-844-787-5437
Bexar	1-800-248-7767	1-866-818-0959	
Fax	1-866-510-3710	1-866-510-3710	
Medical Management			
Tarrant	1-800-306-8612	1-800-245-5380	1-844-787-5437
Bexar	1-800-248-7767	1-866-818-0959	Acute Care Fax 1-866-835-9589
Fax	1-866-835-9589	1-866-835-9589	LTSS Fax 1-844-275-5728
Claims Administration			
Tarrant	1-800-306-8612	1-800-245-5380	1-844-787-5437
Bexar	1-800-248-7767	1-866-818-0959	
Medicaid Eligibility Verification			
STAR Help Line	1-800-925-9126 (AIS)	1-800-925-9126	1-800-925-9126 (AIS)
CHIP Help Line	1-800-964-2777	(AIS) 1-800-647-6558	
Non-emergency Ambulance Transport Services			
Access to Care (A2C)	1-866-411-8920		1-866-411-8920
TTY	711		711
Where's My Ride?	1-866-411-8920		1-866-411-8920
Behavioral Health Hotline (24 hours a day, 7 days a week)			
Tarrant	1-800-306-8612	1-800-245-5380	1-844-787-5437
Bexar	1-800-248-7767	1-866-818-0959	
Superior Vision			
	1-800-879-6901	1-800-879-6901	1-800-879-6901
	For general questions regarding prescriptions: Aetna Better Health 1-800-306-8612	1-800-245-5380	1-844-787-5437
For questions for Rx providers			
CVS Caremark Pharmacy Help desk	1-877-874-3317	1-877-874-3317	1-877-874-3317
Prior Authorization Request Line	1-855-656-0363	1-855-656-0363	1-844-787-5437
Fax	1-866-255-7534	1-866-255-7534	1-866-255-7534
For mail order prescriptions			
	1-800-875-0867	1-800-875-0867	1-800-875-0867
For dental questions or dentist info			
United Healthcare Dental	1-877-901-7321	1-877-901-7321	
DentaQuest	1-800-516-0165	1-800-508-6775	1-800-516-0165
MCNA Dental	1-800-494-6262	1-800-494-6262	1-800-494-6262
Availity provider portal	1-800-282-4548		
Change Healthcare	1-800-956-5190 Mon-Thurs 8 AM – 5 PM https://payerenrollservices.com		

Objectives of program

We have identified specific objectives to effectively manage and provide quality health care for the Aetna Better Health Medicaid, CHIP and STAR Kids Members. The program objectives are to:

- Ensure network adequacy and timely access to care
- Provide timely claim payment
- Provide comprehensive behavioral health care
- Incorporate a cultural competency program to address the diverse cultural needs of our members and provide disease management programs appropriate for the populations we serve.

Role of primary care provider/medical home

The primary care provider (PCP) is the medical home for the Member. This provider delivers appropriate preventive and other primary care services within the scope of their practice and oversees the continuity and coordination of care among all health care practitioners involved in providing services to Aetna Better Health Medicaid CHIP and or STAR Kids Members.

Role of specialty care provider

The specialty care provider can provide services after a referral has been made by the Member's primary care provider. It is the responsibility of the specialist's office to ensure that the Member has a valid referral from the primary care provider and authorization from Aetna Better Health Medical Management for services on the prior authorization list prior to rendering services. Members do not need primary care provider referrals for behavioral health, obstetrical/gynecological care, or other Plan specific services that are not on the prior authorization list. However, communication with the primary care provider is encouraged to promote continuity of care.

Role of Long-Term Services and Supports (LTSS) providers

LTSS providers will provide assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability, (i.e., personal care services, private duty nursing, Day Activity and Health Services (DAHS), Community First Choice (CFC) services, and STAR Kids MDCP services).

Role of Aetna Better Health of Texas Service Coordinator

The purpose of a Service Coordinator is to maximize a Member's health, wellbeing, and independence. Service Coordination will consider and address the Member's situation, including his or her medical, behavioral, social, and educational needs. The Service Coordinator will work with the Member's PCP to coordinate all covered services, non-capitated services, and non-covered services available through other sources.

Role of CHIP Perinate provider

A CHIP perinatal provider can be an obstetrician/gynecologist (OB/GYN), a family practice doctor or another qualified health care provider that provides prenatal care.

Role of pharmacy

The pharmacy is a place where drugs are compounded or dispensed. The pharmacist is the dispenser of prescription drugs to Aetna Better Health Medicaid ,CHIP and STAR Kids members when the physician prescribes a medication(s). Aetna Better Health contracts with CVS Caremark to manage the pharmacy network.

Role of Main Dental Home

Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is 6 months or older must have a designated Main Dental Home.

A Main Dental Home serves as the Member's main dentist for all aspects of oral health care. The Main Dental Home has an ongoing relationship with that Member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The Main Dental Home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists can serve as Main Dental Homes.

Network limitations

We have an open provider network for all Aetna Better Health Medicaid, CHIP and STAR Kids Members. We do limit a Member's selection of a primary care provider or a referral to a specialist to the Aetna Better Health Medicaid, CHIP and STAR Kids networks.

Covered Services

Texas Health Steps Services

Texas Health Steps (THSteps), formerly known as Early and Periodic Screening, Diagnosis and Treatment program, is specifically a children's program under Texas Medicaid which provides medical and dental preventive care and treatment to Medicaid clients who are birth through 20 years of age. Aetna Better Health will assist members and their parents or guardians to:

- Find a qualified Texas Health Steps provider enrolled in Medicaid
- Set up appointments to see a doctor or dentist
- Coordinate with our plan's non-emergency ambulance transport services.
- Answer questions about eligible services.

For more information about THSteps, please refer to the Texas Health Steps website at www.dshs.state.tx.us/thsteps/ or the Texas Medicaid Provider Procedures Manual (TMPPM) at www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

Please consult the Texas Medicaid Provider Procedures Manual for information regarding Texas Health Steps and Comprehensive Care Program services, including private duty nursing, prescribed pediatric extended care centers, and therapies.

Documentation of completed Texas Health Steps components and elements

Each of the six components and their individual elements, according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual, must be completed and documented in the medical record. Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening.
 - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
2. **Comprehensive unclothed physical examination** which includes measurements; height or length, weight, front-occipital circumference, BMI, blood pressure, and vision and hearing screening.
 - A complete exam includes the recording of measurements and percentiles to document growth and development including front-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.
3. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
 - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP “Recommended Childhood and Adolescent Immunization Schedule-United States,” unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
 - The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
 - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
 - Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit www.dshs.texas.gov/immunize/tvfc.
 - **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia
 - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member’s mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
 - Anemia screening at 12 months.
 - Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age
 - HIV screening at 16-18 years
 - Risk-based screenings include:
 - Dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.
4. **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and

development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.

5. Dental referral every 6 months until the parent or caregiver reports a dental home is established.

- Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional and recommended. Each checkup form includes all checkup components, screenings that are required at the checkup and suggested age appropriate anticipatory guidance topics. They are available online in the resources section at www.txhealthsteps.com.

Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

Medicaid Managed Care Covered Services

The following chart details the Member benefit package available to Aetna Better Health Plan Medicaid Members. Please refer to the current Texas Medicaid Provider Procedures Manual, found at www.tmhp.com for the listing of limitations and exclusions.

Medicaid covered services	
Hospital – (Inpatient Services)	<p>Inpatient hospital services include medically necessary items and services ordinarily furnished by a hospital under the direction of a physician for the care and treatment of inpatient members. Inpatient hospital services include the following items and services:</p> <ul style="list-style-type: none"> • Bed and board in semi-private accommodations, intensive care or coronary care unit; includes meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital’s charge for its most prevalent semi-private accommodations. Bed and board in private accommodations is covered if required for medical reasons, as certified by a physician. • Whole blood and packed red blood cells reasonable and necessary for treatment of illness or injury, unless they are otherwise available without cost. • Maternity care includes usual and customary care for all pregnant members and specialized prenatal care for women with specific problems. • Newborn care includes routine care and specialized nursery care for newborns with specific problems. <p>All medically necessary ancillary services and supplies ordered by a provider.</p>
Hospital – (All Outpatient Services)	<p>Hospital outpatient services include those services performed in the emergency room or clinic setting of a hospital.</p> <ul style="list-style-type: none"> • This includes services provided to members in a hospital setting who are not confined for inpatient care. • Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services deemed medically necessary and furnished by or under the direction of a physician to an outpatient by a hospital. • This does not include drugs or biologicals taken home by the member. • Supplies provided by a hospital supply room for use in physician’s offices in the treatment of patients are not reimbursable as outpatient services.
Inpatient Mental Health Services	<ul style="list-style-type: none"> • Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders. • Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions area benefit of the Medicaid Program and are subject to UR requirements. <p>Includes inpatient psychiatric services, up to annual limit, - ordered</p>

	<p>under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.</p> <p>Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition.</p>
<p>Outpatient Mental Health Services</p>	<ul style="list-style-type: none"> • Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders. Includes outpatient psychiatric services, up to annual limit , ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation. • Provider types include Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist (LMFT). • Covered services are a benefit for clients suffering from a mental psychoneurotic or personality disorder when provided in the office, home, SNF, outpatient hospital, nursing home or another outpatient setting. • Does not require a primary care provider referral. • Psychological and Neuropsychological testing are covered for specific diagnoses. • Psychological testing • Neuropsychological test battery • Additional services such as mental health screenings are covered under the Texas Health Steps-CCP program. • Medicaid clients age 21 years and older may receive mental health counseling provided by a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Clinical Social Worker, and a Licensed Marriage and Family Therapist.
<p>Inpatient Medical with Substance Abuse Treatment Services</p>	<ul style="list-style-type: none"> • Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition. • Admissions for a single diagnosis of chemical dependency or abuse (alcohol, opioids, barbiturates, amphetamines) without an accompanying medical complication are not a benefit.

<p>Outpatient Substance Abuse Treatment Services</p>	<ul style="list-style-type: none"> • Counseling for children and adolescents must be rendered in accordance with the DSHS Chemical Dependency Treatment Facility Licensure Standards and determined by a qualified credentialed counselor to be reasonable and necessary for a person who is chemically dependent. • Counseling is available for children and adolescents age 13-17 years. • Younger children (age 10-12 years) and young adults (age 18-20 years) may receive counseling when assessment criteria are met. • Group counseling is limited to 135 hours per client, per calendar year. • Individual counseling is limited to 26 hours per client per calendar year. • Inpatients residing in a DSHS facility are not eligible for outpatient services. • Does not require a Primary Care Provider referral.
<p>Federally Qualified Health Clinics (FQHCs)</p>	<ul style="list-style-type: none"> • Members may seek professional medical services with any Aetna Better Health contracted FQHC.
<p>Rural Health Clinic Services (RHCs)</p>	<p>The following services are benefits of Rural Health Clinics under Texas Medicaid:</p> <ul style="list-style-type: none"> • Physician Services • Advanced nurse practitioner, clinical nurse specialist, certified nurse midwife, clinical social worker, or physician assistant services • Services and supplies furnished as incidental to physician, nurse practitioner or physician assistant services • Visiting nurse services on part time or intermittent basis to home bound members in areas determined to have a shortage of home health agencies • Basic lab services essential to immediate diagnosis and treatment.
<p>Professional Services</p>	<p>Services provided by or under the personal supervision of a physician within their scope of practice are covered when reasonable and medically necessary. This includes visits in the office, home, inpatient, or outpatient location under Medicaid guidelines further identified in the most current <i>Texas Medicaid Provider Procedures Manual</i>. Services provided by advanced nurse practitioners and behavioral health services that fall under general medicine, are included in this category.</p>

OB/GYN Services	Females may seek Obstetrics and Gynecological Services from any participating network obstetrician/gynecologist (OB/Gyn) provider without a referral from their primary care provider. These care providers must perform services within the scope of their professional specialty practice. A properly credentialed OB/Gyn must practice in accordance with Section 4, Article 21.53D of the Texas Insurance Code and follow rules promulgated by the Texas Department of Insurance (TDI).
Lab and X-Ray Services	Medicaid benefits are provided for professional and technical services ordered by a qualified practitioner and provided under the personal supervision of a qualified practitioner in a setting other than a hospital (inpatient or outpatient). Medicaid does not reimburse baseline or screening laboratory studies. All laboratory testing sites providing services must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.
Podiatry Services	Podiatrists eligible to be enrolled as Medicaid providers are authorized to perform procedures on the ankle or foot as approved by the Texas Legislature under their license as DPM and when such procedures would also be reimbursable to a physician (M.D. or D.O.) under Texas Medicaid. Podiatry services are only eligible for members under the age of 21. Some of these services may be provided by the Primary Care Provider.
Vision Services	<p>Members under age 21 are limited to one examination with refractions for the purpose of obtaining eyewear once every state fiscal year (September 1 through August 31). For members under the age of 21, this can be exceeded where a school nurse or teacher requests the eye exam, or when determined to be medically necessary. Members ages 21 and over are allowed one eye exam for refractive error once every 24 months. Eye examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed above. Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction which cannot be accomplished by glasses. Vision services provided through Superior Vision.</p> <p>Additional eye health care provided by an in-network optometrist or ophthalmologist (other than surgery) can be provided without a referral from the member's Primary Care Provider. Covered surgical/laser care requires prior authorization.</p>

Ambulance Services	<p>Medicaid reimbursement is limited to basic life support ambulance services and air ambulance services (fixed wing and helicopter) and for instances of emergency and in non-emergency situations for the severely disabled only where use of an ambulance is the only appropriate means of transportation.</p> <p>Prior Authorization is needed for non-emergent Air Transport and Non-emergent Ambulance Services.</p>
Home Health Services	<p>The member must exhibit a condition where leaving their home is medically inadvisable. Benefits include fifty (50) home visits per year, selected medical supplies, durable medical equipment, and necessary repairs of this equipment. Visits beyond the 50-visit limit and additional services are allowed, if determined to be medically necessary and authorized prior to delivery.</p>
Hearing Aid Services	<ul style="list-style-type: none"> • Persons under 21 years of age should be referred to the Department of State Health Services (DSHS) Program for Amplification for Children of Texas (PACT). • Hearing aid evaluation with combined audiometric assessment is available for Medicaid members over 21 years of age.
Chiropractic Services	<p>The following chiropractic services are available only to Medicaid members under 21 years of age:</p> <ul style="list-style-type: none"> • Texas Medicaid reimburses the treatment of spinal subluxation requiring manual manipulation of the spine. Benefits include up to 12 treatments per benefit period. A benefit period is defined as 12 consecutive months, beginning with the date the member receives the first covered chiropractic treatment.
Ambulatory Surgical Center (ASC) Services	<p>Covered services are minor surgical services that normally do not require hospital admission or inpatient stay. Only the procedures specified on the Centers for Medicare and Medicaid Services (CMS) approved list and selected Medicaid- only procedures are covered services provided in an ASC. Covered services are based on CMS Ambulatory Surgical Code groupings 1 through 9 and HHSC group 10.</p>
Certified Nurse Midwife (CNM) Services	<p>Covered services include those services that are normally outside of the maternity cycle to the extent that the midwives are authorized to perform under state law. CNMs may be reimbursed for primary care services provided to women throughout the life span and newborns for the first two (2) months of life, in addition to the maternity cycle (antepartum, intrapartum, and postpartum).</p>

<p>Birthing Center</p>	<p>A Birthing Center is:</p> <ul style="list-style-type: none"> • A facility that is not administrative, organizational, or financial part of a hospital. • Organized and operated to provide maternity services to outpatients. • Complies with all applicable federal, state, and local laws and regulations. • Birthing Center services include: <ul style="list-style-type: none"> — Admission — Labor – ante partum care — Delivery — Postpartum care — Total obstetrical care
<p>Maternity Clinic Services (MCS)</p>	<p>A maternity service clinic is:</p> <ul style="list-style-type: none"> • A facility that is not an administrative, organizational, or financial part of a hospital. • Organized and operated to provide maternity services to outpatients. • Complies with all applicable federal, state, and local laws and regulations. • Maternity clinic services are those medical services provided by registered nurses and determined with or by a licensed physician to be reasonable and medically necessary for the care of a pregnant adolescent or woman during her prenatal period and subsequent 60-day postpartum period. MCS benefits do not include deliveries. Covered clinic services include, but are not necessarily limited to, risk assessment, medical services, specific laboratory/screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling, and patient education regarding maternal and child health.
<p>Family Planning Services</p>	<p>Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Covered services must include, but are not limited to:</p> <ul style="list-style-type: none"> • Family planning annual visit • Comprehensive health history and physical examination • Follow-up office visit • Member education and counseling to include preconception counseling • Laboratory tests, prescriptions and contraceptive devices • Pregnancy testing • Sterilization services (federal sterilization consent form required) • Federal law requires under §1915(b) waivers that members be allowed to retain the right to choose any Medicaid participating family planning provider.

Genetic Services	Genetic services are services to evaluate members regarding the possibility of a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders. These services must be prescribed and performed by or under the supervision of a clinical geneticist (M.D. or D.O.). Covered services include genetic history and physical examination; genetic laboratory services and echography; genetic radiological services; genetic diagnostic procedures; and genetic counseling.
Transplant Services	Transplant services include liver, heart, lung, heart/lung, bone marrow, cornea, peripheral stem cell, and kidney transplants. Coverage of organ transplants is limited to those services that are determined reasonable, medically necessary, and standard medical procedures. Coverage does not include donor expenses or services. Coverage of each type of solid organ transplant is limited to a lifetime benefit of one initial transplant and one subsequent re transplant due to rejection. Coverage for solid organ transplant includes procurement of the organ and services associated with the procurement. Benefits are not available for any experimental or investigational services, supplies, or procedures.
Respiratory Care	Covered respiratory services include oxygen, nebulizers, breathing treatments, medication for breathing treatments, and inhalers.
Adult Well-Check	Annual physical for adults ages 21 and over once per calendar year.
Texas Health Steps Medical Checkups	Texas Health Steps is federally mandated and provides basic primary care medical screening services for all Medicaid members under 21 years of age. Medical checkups are covered for persons under 21 when delivered in accordance with the periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the member's life and identifies the time period, based on the member's age, when screening services are covered.
Texas Health Steps Comprehensive Care Program (CCP)	A federally mandated program that provides for any health care service that is medically necessary and appropriate for all members under 21 years of age, regardless of the limitations of Texas Medicaid.
Renal Dialysis	Renal dialysis services are available for members with one of the following diagnosis: <ul style="list-style-type: none"> • Acute renal disease – a renal disease with a relatively short course, the cause of which is usually correctable. • Chronic renal disease (end-stage renal disease) – a stage of renal disease that requires continuing dialysis or kidney transplantation to maintain life or health. Medicaid coverage begins with the original onset date and continues until Medicare coverage begins.

<p>Total Parenteral Nutrition (TPN)/Hyperalimentation</p>	<p>TPN is a covered benefit for eligible members who require long- term support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot support nutrition. Covered services include but are not necessarily limited to:</p> <ul style="list-style-type: none"> • Parenteral hyperalimentation solutions and additives as ordered by member’s physician. • Supplies and equipment including refrigeration, if necessary, that are required for the administration of prescribed solutions and additives. • Education of the member and/or appropriate family members or support persons regarding the administration of TPN before administration initially begins. (Education must include the use and maintenance of required supplies and equipment.) • Visits by a Registered Nurse appropriately trained in the administration of TPN. • Customary and routine laboratory work required to monitor the member’s status. • Enteral supplies and equipment, if medically necessary in conjunction with TPN.
<p>Physical Therapy</p>	<p>Covered benefits include services to members suffering from an acute musculoskeletal and/or neuromusculoskeletal condition. Services provided as a result of an exacerbation of a chronic condition necessitating therapy to restore function may also be covered. The Physical Therapist must have the following on file for each member treated:</p> <ul style="list-style-type: none"> • A treatment plan established by the member’s physician and/or Physical Therapist that identifies diagnosis, modalities, frequency of treatment, expected duration of treatment, and anticipated outcomes. • A written prescription by the member’s physician for the therapy services.
<p>Occupational Therapy</p>	<p>Occupational therapy services are a covered benefit if performed in an inpatient or outpatient hospital setting and if it meets the following criteria:</p> <ul style="list-style-type: none"> • It is prescribed by the member’s physician and performed by a qualified occupational therapist. • The therapy is prescribed for an acute condition with a diagnosis involving the muscular, skeletal, and neurological body systems. • It is designed to improve or restore an individual’s ability to perform those tasks required for independent functioning. • The physician expects the therapy to result in a significant practical improvement in the individual’s level of functioning within 30 days. • For members less than 21 years of age, additional services must be provided under the Texas Health Steps – CCP Program if they are federally allowable, medically necessary, and appropriate.

<p>Speech and Language Therapy</p>	<p>Speech and language evaluations are used to assess the therapeutic needs of patients having speech and/or language difficulties as a result of disease or trauma. Speech-language pathology therapy is allowed only for acute or sub-acute pathological or traumatic conditions of the head or neck that would affect speech production. To be covered, benefits must be:</p> <ul style="list-style-type: none"> • Prescribed by a physician and provided as an inpatient or outpatient hospital service. • Prescribed by a physician and performed by or under his personal supervision. • The therapy may be performed by either a speech-language pathologist or audiologist if they are either on staff at the hospital or under the personal supervision of the physician. <p>For members less than 21 years of age, additional services must be provided under the Texas Health Steps – CCP Program if they are federally allowable, medically necessary, and appropriate.</p>
<p>Pharmacy</p>	<p>All Aetna Better Health members are entitled to a pharmacy benefit as described later in this manual.</p>
<p>Durable Medical Equipment and Supplies (DME)</p>	<p>All providers must obtain prior authorization for the member’s use of medical equipment and supplies over \$1000. The member’s Primary Care Provider/Specialist must complete the Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form) prescribing the DME and/or supplies must be signed before requesting prior authorization for DME equipment and supplies. All signatures must be current, unaltered, original and handwritten.</p> <p>Computerized or stamped signatures will not be accepted. The Title XIX form must include the procedure code and quantities for services requested. The Title XIX must be maintained by the DME provider and the prescribing physicians in the client’s medical record. The completed Title XIX form with the original signature must be maintained by the prescribing physician.</p>
<p>Emergency Services</p>	<p>Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished within the United States by a provider qualified to furnish emergency services. Emergency services includes health care provided in an in-network or out-of-network hospital emergency department or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize medical conditions. Emergency services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether or not an emergency exists.</p>

<p>Screening, Brief Intervention and Referral to Treatment Benefit (SBIRT)</p>	<p>Aetna Better Health provides for SBIRT, a comprehensive approach to the delivery of early intervention and treatment services for Members with substance use disorders and those at risk of developing such disorders. Substance use screenings performed in hospital emergency departments can be covered and reimbursed and are encouraged as a means of early identification and resolution of substance use problems. To learn more about the screening, brief intervention and referral to treatment benefit (SBIRT) and how it can be provided and billed, please refer to the following TMHP links Screening Brief intervention and Referral to Treatment Benefit for Texas Medicaid www.tmhp.com/Texas_Medicaid_Bulletin/228_M.pdf</p>
---	---

Attention Deficit Hyperactivity Disorder (ADHD)

Treatment services for children diagnosed with ADHD, including follow-up care for children who are prescribed medications, are covered as outpatient mental health care. Please refer to TMPPM for additional information about covered benefits.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A Member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A Member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the Member's medical condition, or the authorized hours are not commensurate with the Member's medical needs. Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

STAR Kids Covered Services

STAR Kids Covered Services	
<p>Hospital – (Inpatient Services)</p>	<p>Inpatient hospital services include medically necessary items and services ordinarily furnished by a hospital under the direction of a physician for the care and treatment of inpatient members. Inpatient hospital services include the following items and services:</p> <ul style="list-style-type: none"> • Bed and board in semi-private accommodations, intensive care or coronary care unit; includes meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital’s charge for its most prevalent semi- private accommodations. Bed and board in private accommodations is covered if required for medical reasons, as certified by a physician. • Whole blood and packed red blood cells reasonable and necessary for treatment of illness or injury, unless they are otherwise available without cost. • Maternity care includes usual and customary care for all pregnant members and specialized prenatal care for women with specific problems. • Newborn care includes routine care and specialized nursery care for newborns with specific problems. • All medically necessary ancillary services and supplies ordered by a provider.
<p>Hospital – (All Outpatient Services)</p>	<p>Hospital outpatient services include those services performed in the emergency room or clinic setting of a hospital.</p> <ul style="list-style-type: none"> • This includes services provided to members in a hospital setting who are not confined for inpatient care. • Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services deemed medically necessary and furnished by or under the direction of a physician to an outpatient by a hospital. • This does not include drugs or biologicals taken home by the member. • Supplies provided by a hospital supply room for use in physician’s offices in the treatment of patients are not reimbursable as outpatient services.

<p>Inpatient Mental Health Services</p>	<ul style="list-style-type: none"> • Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders. • Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions area benefit of the Medicaid Program and are subject to UR requirements. • Includes inpatient psychiatric services, up to annual limit, ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation. • Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition.
<p>Outpatient Mental Health Services</p>	<ul style="list-style-type: none"> • Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders. • Includes outpatient psychiatric services, up to annual limit, ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation. • Provider types include Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist (LMFT). • Covered services are a benefit for clients suffering from a mental psychoneurotic or personality disorder when provided in the office, home, SNF, outpatient hospital, nursing home or another outpatient setting. • Does not require a primary care provider referral. • Psychological and Neuropsychological testing are covered for specific diagnoses. • Psychological testing. • Neuropsychological test battery. • Additional services such as mental health screenings are covered under the Texas Health Steps-CCP program. • Medicaid clients ages 21 years and older may receive mental health counseling provided by a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Clinical Social Worker, and a Licensed Marriage and Family Therapist.

<p>Inpatient Medical with Substance Abuse Treatment Services</p>	<ul style="list-style-type: none"> • Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition. • Admissions for a single diagnosis of chemical dependency or abuse (alcohol, opioids, barbiturates, amphetamines) without an accompanying medical complication are not a benefit.
<p>Outpatient Substance Abuse Treatment Services</p>	<ul style="list-style-type: none"> • Counseling for children and adolescents must be rendered in accordance with the DSHS Chemical Dependency Treatment Facility Licensure Standards and determined by a qualified credentialed counselor to be reasonable and necessary for a person who is chemically dependent. • Counseling is available for children and adolescents ages 13-17 years. • Younger children (age 10-12 years) and young adults (age 18-20 years) may receive counseling when assessment criteria are met. • Group counseling is limited to 135 hours per client, per calendar year. • Individual counseling is limited to 26 hours per client per calendar year. • Inpatients residing in a DSHS facility are not eligible for outpatient services. • Does not require a Primary Care Provider referral.
<p>Federally Qualified Health Clinics (FQHCs)</p>	<p>Members may seek professional medical services with any Aetna Better Health contracted FQHC.</p>
<p>Rural Health Clinic Services (RHCs)</p>	<p>The following services are benefits of Rural Health Clinics under Texas Medicaid:</p> <ul style="list-style-type: none"> • Physician services • Advanced nurse practitioner, clinical nurse specialist, certified nurse midwife, clinical social worker, or physician assistant services • Services and supplies furnished as incidental to physician, nurse practitioner or physician assistant services <p>Visiting nurse services on part time or intermittent basis to home bound members in areas determined to have a shortage of home health agencies</p> <ul style="list-style-type: none"> • Basic lab services essential to immediate diagnosis and treatment

<p>Professional Services</p>	<p>Services provided by or under the personal supervision of a physician within their scope of practice are covered when reasonable and medically necessary. This includes visits in the office, home, inpatient, or outpatient location under Medicaid guidelines further identified in the most current <i>Texas Medicaid Provider Procedures Manual</i>. Services provided by advanced nurse practitioners and behavioral health services that fall under general medicine, are included in this category. Aetna Better Health of Texas will allow a STAR Kids Member who is receiving services for complex medical needs to remain under the care of a Texas Medicaid Enrolled Provider from whom the Member is receiving care, even if that provider is out of network with Aetna as long as there are established Member/Provider relationships, existing treatment protocols and ongoing care plans in place.</p>
<p>OB/GYN Services</p>	<p>Females may seek Obstetrics and Gynecological Services from any participating network obstetrician/gynecologist (OB/Gyn) provider without a referral from their primary care provider. These care providers must perform services within the scope of their professional specialty practice. A properly credentialed OB/Gyn must practice in accordance with Section 4, Article 21.53D of the Texas Insurance Code and follow rules promulgated by the Texas Department of Insurance (TDI).</p>
<p>Lab and X-Ray Services</p>	<p>Medicaid benefits are provided for professional and technical services ordered by a qualified practitioner and provided under the personal supervision of a qualified practitioner in a setting other than a hospital (inpatient or outpatient). Medicaid does not reimburse baseline or screening laboratory studies. All laboratory testing sites providing services must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.</p>
<p>Podiatry Services</p>	<p>Podiatrists eligible to be enrolled as Medicaid providers are authorized to perform procedures on the ankle or foot as approved by the Texas Legislature under their license as DPM and when such procedures would also be reimbursable to a physician (M.D. or D.O.) under Texas Medicaid. Podiatry services are only eligible for members under the age of 21. Some of these services may be provided by the Primary Care Provider.</p>
<p>Vision Services</p>	<p>Members under age 21 are limited to one examination with refractions for the purpose of obtaining eyewear once every state fiscal year (September 1 through August 31). For members under the age of 21, this can be exceeded where a school nurse or teacher requests the eye exam, or when determined to be medically necessary. Members ages 21 and over are allowed one eye exam for refractive error once every 24 months. Eye</p>

	<p>examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed above. Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction which cannot be accomplished by glasses. Vision services provided through Superior Vision.</p> <p>Additional eye health care provided by an in-network optometrist or ophthalmologist (other than surgery) can be provided without a referral from the member's Primary Care Provider. Covered surgical/laser care requires prior authorization.</p>
Ambulance Services	<p>Medicaid reimbursement is limited to basic life support ambulance services and air ambulance services (fixed wing and helicopter) and for instances of emergency and in non-emergency situations for the severely disabled only where use of an ambulance is the only appropriate means of transportation.</p> <p>Prior authorization is needed for non-emergent air transport and non-emergent ambulance services.</p>
Home Health Services	<p>The member must exhibit a condition where leaving their home is medically inadvisable. Benefits include fifty (50) home visits per year, selected medical supplies, durable medical equipment, and necessary repairs of this equipment. Visits beyond the 50-visit limit and additional services are allowed, if determined to be medically necessary and authorized prior to delivery.</p>
Hearing Aid Services	<p>The following chiropractic services are available only to Medicaid members under 21 years of age:</p> <ul style="list-style-type: none"> • Texas Medicaid reimburses the treatment of spinal subluxation requiring manual manipulation of the spine. Benefits include up to 12 treatments per benefit period. A benefit period is defined as 12 consecutive months, beginning with the date the member receives the first covered chiropractic treatment.
Chiropractic Services	<p>The following chiropractic services are available only to Medicaid members under 21 years of age:</p> <ul style="list-style-type: none"> • Texas Medicaid reimburses the treatment of spinal subluxation requiring manual manipulation of the spine. Benefits include up to 12 treatments per benefit period. A benefit period is defined as 12 consecutive months, beginning with the date the member receives the first covered chiropractic treatment.
Ambulatory Surgical Center (ASC) Services	<p>Covered services are minor surgical services that normally do not require hospital admission or inpatient stay. Only the procedures specified on the Centers for Medicare and Medicaid Services (CMS) approved list and selected Medicaid-only procedures are covered services provided in an ASC. Covered services are based on CMS Ambulatory Surgical Code groupings 1 - 9 and HHSC group 10.</p>

Certified Nurse Midwife (CNM) Services	<p>Covered services include those services that are normally outside of the maternity cycle to the extent that the midwives are authorized to perform under state law. CNMs may be reimbursed for primary care services provided to women throughout the life span and newborns for the first two (2) months of life, in addition to the maternity cycle (antepartum, intrapartum, and postpartum).</p>
Birth Center	<p>A Birth Center is:</p> <ul style="list-style-type: none"> • A facility that is not an administrative, organizational, or financial part of a hospital. • Organized and operated to provide maternity services to outpatients. • Complies with all applicable federal, state, and local laws and regulations. Birth Center services include: <ul style="list-style-type: none"> — Admission — Labor – ante partum care — Delivery — Postpartum care — Total obstetrical care
Maternity Clinic Services (MCS)	<p>A maternity service clinic is:</p> <ul style="list-style-type: none"> • A facility that is not an administrative, organizational, or financial part of a hospital. • Organized and operated to provide maternity services to outpatients. • Complies with all applicable federal, state, and local laws and regulations. • Maternity clinic services are those medical services provided by registered nurses and determined with or by a licensed physician to be reasonable and medically necessary for the care of a pregnant adolescent or woman during her prenatal period and subsequent 60-day postpartum period. MCS benefits do not include deliveries. Covered clinic services include, but are not necessarily limited to, risk assessment, medical services, specific laboratory/screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling, and patient education regarding maternal and child health.
Family Planning Services	<p>Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Covered services must include, but are not limited to:</p> <ul style="list-style-type: none"> • Family planning annual visit • Comprehensive health history and physical examination • Follow-up office visit • Member education and counseling to include preconception counseling • Laboratory tests, prescriptions and contraceptive devices

	<ul style="list-style-type: none"> • Pregnancy testing • Sterilization services (federal sterilization consent form required) <p>Federal law requires under §1915(b) waivers that members be allowed to retain the right to choose any Medicaid participating family planning provider.</p>
Genetic Services	Genetic services are services to evaluate members regarding the possibility of a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders. These services must be prescribed and performed by or under the supervision of a clinical geneticist (M.D. or D.O.). Covered services include genetic history and physical examination; genetic laboratory services and echography; genetic radiological services; genetic diagnostic procedures; and genetic counseling.
Transplant Services	<p>Transplant services include liver, heart, lung, heart/lung, bone marrow, cornea, peripheral stem cell, and kidney transplants. Coverage of organ transplants is limited to those services that are determined reasonable, medically necessary, and standard medical procedures. Coverage does not include donor expenses or services. Coverage of each type of solid organ transplant is limited to a lifetime benefit of one initial transplant and one subsequent re-transplant due to rejection.</p> <p>Coverage for solid organ transplant includes procurement of the organ and services associated with the procurement. Benefits are not available for any experimental or investigational services, supplies, or procedures.</p>
Respiratory Care	Covered respiratory services include oxygen, nebulizers, breathing treatments, medication for breathing treatments, and inhalers.
Texas Health Steps Medical Checkups	Texas Health Steps is federally mandated and provides basic primary care medical screening services for all Medicaid members under 21 years of age. Medical checkups are covered for persons under 21 when delivered in accordance with the periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the member's life and identifies the time period, based on the member's age, when screening services are covered.
Texas Health Steps - Comprehensive Care Program (CCP)	A federally mandated program that provides for any health care service that is medically necessary and appropriate for all members under 21 years of age, regardless of the limitations of Texas Medicaid.
Renal Dialysis	<p>Renal dialysis services are available for members with one of the following diagnosis:</p> <ul style="list-style-type: none"> • Acute renal disease – a renal disease with a relatively short

	<p>course, the cause of which is usually correctable.</p> <ul style="list-style-type: none"> • Chronic renal disease (end-stage renal disease) – a stage of renal disease that requires continuing dialysis or kidney transplantation to maintain life or health. Medicaid coverage begins with the original onset date and continues until Medicare coverage begins.
Total Parenteral Nutrition (TPN)/Hyperalimentation	<p>TPN is a covered benefit for eligible members who require long-term support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot support nutrition. Covered services include but are not necessarily limited to:</p> <ul style="list-style-type: none"> • Parenteral hyper alimentation solutions and additives as ordered by member’s physician. • Supplies and equipment including refrigeration, if necessary, that are required for the administration of prescribed solutions and additives. • Education of the member and/or appropriate family members or support persons regarding the administration of TPN before administration initially begins. (Education must include the use and maintenance of required supplies and equipment.) • Visits by a Registered Nurse appropriately trained in the administration of TPN. • Customary and routine laboratory work required to monitor the member’s status. • Enteral supplies and equipment, if medically necessary in conjunction with TPN.
Physical Therapy	<p>Covered benefits include services to members suffering from an acute musculoskeletal and/or neuromusculoskeletal condition. Services provided as a result of an exacerbation of a chronic condition necessitating therapy to restore function may also be covered. The Physical Therapist must have the following on file for each member treated:</p> <ul style="list-style-type: none"> • A treatment plan established by the member’s physician and/or Physical Therapist that identifies diagnosis, modalities, frequency of treatment, expected duration of treatment, and anticipated outcomes. • A written prescription by the member’s physician for the therapy services.
Occupational Therapy	<p>Occupational therapy services are a covered benefit if performed in an inpatient or outpatient hospital setting and if it meets the following criteria:</p> <ul style="list-style-type: none"> • It is prescribed by the member’s physician and performed by a qualified occupational therapist. • The therapy is prescribed for an acute condition with a diagnosis involving the muscular, skeletal, and neurological body systems.

	<ul style="list-style-type: none"> • It is designed to improve or restore an individual’s ability to perform those tasks required for independent functioning. • The physician expects the therapy to result in a significant practical improvement in the individual’s level of functioning within 30 days. • For members less than 21 years of age, additional services must be provided under the Texas Health Steps – CCP Program if they are federally allowable, medically necessary, and appropriate.
Speech and Language Therapy	<p>Speech and language evaluations are used to assess the therapeutic needs of patients having speech and/or language difficulties as a result of disease or trauma. Speech- language pathology therapy is allowed only for acute or sub-acute pathological or traumatic conditions of the head or neck that would affect speech production. To be covered, benefits must be:</p> <ul style="list-style-type: none"> • Prescribed by a physician and provided as an inpatient or outpatient hospital service. • Prescribed by a physician and performed by or under his personal supervision. • The therapy may be performed by either a speech-language pathologist or audiologist if they are either on staff at the hospital or under the personal supervision of the physician. <p>For members less than 21 years of age, additional services must be provided under the Texas Health Steps – CCP Program if they are federally allowable, medically necessary, and appropriate.</p>
Pharmacy	<p>All Aetna Better Health members are entitled to a pharmacy benefit as described later in this manual.</p>
Durable Medical Equipment and Supplies (DME)	<p>All providers must obtain prior authorization for the member’s use of medical equipment and supplies over \$1000. The member’s Primary Care Provider/Specialist must complete the Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form) prescribing the DME and/or supplies must be signed before requesting prior authorization for DME equipment and supplies. All signatures must be current, unaltered, original and handwritten. Computerized or stamped signatures will not be accepted. The Title XIX form must include the procedure code and quantities for services requested. The Title XIX must be maintained by the DME provider and the prescribing physicians in the client’s medical record. The completed Title XIX form with the original signature must be maintained by the prescribing physician.</p>
Emergency Services	<p>Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished within the United States by a provider qualified to furnish emergency services. Emergency services includes health care provided in an in-network or out-of-network hospital emergency department or other comparable facility by in-network or out-of-network physicians, providers, or</p>

	facility staff to evaluate and stabilize medical conditions. Emergency services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency exists.
Screening, Brief Intervention and Referral to Treatment Benefit	Aetna Better Health provides for SBIRT, a comprehensive approach to the delivery of early intervention and treatment services for Members with substance use disorders and those at risk of developing such disorders. Substance use screenings performed in hospital emergency departments can be covered and reimbursed and encouraged as a means of early identification and resolution of substance use problems. To learn more about the screening, brief intervention and referral to treatment benefit (SBIRT) and how it can be provided and billed, please refer to the following TMHP links Screening Brief intervention and Referral to Treatment Benefit for Texas Medicaid www.tmhp.com/Texas_Medicaid_Bulletin/228_M.pdf
Long-term Support Services for Qualified Members, including MDCP	Long-term support services for qualified members include: <ul style="list-style-type: none"> • Personal Care services (PCS) (non-MDCP and CFC members) • Private Duty Nursing (PDN) services • Prescribed pediatric extended care center (PPECC) services • Day Activity and Health Services (DAHS)
Community First Choice Services for Qualified Members	Community First Choice (CFC) services for qualified members include: <ul style="list-style-type: none"> • Personal Attendant Services (PAS) / Habilitation • Emergency Response services (ERS) • Support Management
Long-term Support Services for MDCP Members Only	Members qualified for the Medically Dependent Children’s Program are eligible for the following additional long-term support services: <ul style="list-style-type: none"> • Respite care • Supported employment • Employment assistance • Adaptive aids • Minor home modifications • Flexible family support services • Transition assistance service • Financial management services

Please refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) for listing of limitations and exclusions.

Day Activity and Health Services (DAHS) (only for Members 18 of age and older)

Day Activity and Health Services (DAHS), also called adult day care, is a Medicaid state plan service available to STAR Kids members ages 18 and older who require the service because of a chronic medical condition and can benefit therapeutically from the service. DAHS provide attendant care in a

facility setting, under the supervision of a nurse. Services include nursing, physical rehabilitation, nutrition, social activities, and transportation when another means of transportation is unavailable.

Personal Assistance Services (PAS)

PAS provides assistance to members in performing the activities of daily living based on their service plan. PAS services include assistance with the performance of the activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment. PAS also includes the following services: protective supervision provided solely to ensure the health and safety of a member with cognitive/memory impairment and/or services consist of accompanying, but not transporting, and assisting a member to access services or activities in the community; and extension of therapy services. The attendant may perform certain tasks if delegated and supervised by a registered nurse in accordance with Board of Nursing rules found in 22 Texas Administrative Code, Part 11, Chapter 224. This assistance and support provide reinforcement of instruction and aids in the rehabilitative process. In addition, a registered nurse may instruct an attendant to perform basic interventions with members that would increase and optimize functional abilities for maximum independence in performing activities of daily living such as range of motion exercises. PAS will not be provided to members residing in adult foster care homes, assisted living facilities, or during the same designated hours or time period a member receives respite care.

Home and Community Based Services (HCBS) Waiver Services

Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Employment Assistance

(Aetna Better Health of Texas responsible for STAR Kids MDCP Members only) Employment Assistance (EA) is provided to an individual to help the individual locate competitive employment in the community.

Supported Employment

(Aetna Better Health of Texas responsible for STAR Kids MDCP Members only) Supported Employment (SE) services help an individual sustain competitive employment to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed.

Cognitive Rehabilitation Therapy

CRT is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. CRT is provided when determined to be medically necessary through an assessment conducted by an appropriate professional. CRT is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Qualified providers: psychologists licensed under Texas Occupations Code Chapter 50, speech and language pathologists licensed under

Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401, and occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Adult Foster Care

AFC services are personal care services, homemaker, chore, and companion services, and medication oversight provided in a licensed (where applicable) private home by an adult foster care provider who lives in the home. AFC services are furnished to adults who receive the services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home cannot exceed three without appropriate licensure. Separate payment will not be made for personal assistance services furnished to a member receiving AFC services, since these services are integral to and inherent in the provision of adult foster care services. Payments for AFC services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The State allows a member to select a relative or legal guardian, other than a spouse, to be the provider of AL if the relative or legal guardian meets the provider requirements.

Financial Management Services

(Include Support Consultation for Consumer-Directed Service Option only)

A service that is provided to an individual participating in the consumer directed services (CDS) option. Assistance provided to members who manage funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

Support Consultation

SC is an optional service component that offers practical skills training and assistance to enable a member or his legally authorized representative (LAR) to successfully direct those services the member or the legally authorized representative chooses for consumer-direction. This service is provided by a certified support advisor (SA) and includes skills training related to recruiting, screening, and hiring workers, preparing job descriptions, verifying employment eligibility and qualifications, completion of documents required to employ an individual, managing workers, and development of effective back-up plans for services considered critical to the member's health and welfare in the absence of the regular provider or an emergency situation. Skill training involves such activities as training and coaching the employer regarding how to write an advertisement, how to interview potential job candidates, and role-play in preparation for interviewing potential employees.

In addition, the support advisor assists the member or LAR to determine staff duties, to orient and instruct staff in duties and to schedule staff. The SA also assists the member or LAR with activities related to the supervision of staff, the evaluation of the job performance of staff, and the discharge of staff when necessary. This service provides enough information and assistance to ensure that members and their representatives understand the responsibilities involved with consumer direction. SC does not address budget, tax, or workforce policy issues.

The State defines SC activities as the types of support provided beyond that provided by the financial management services provider. The scope and duration of SC will vary depending on a member's need. SC may be provided by a certified SA associated with a consumer directed services agency selected by the member or by an independent certified SA hired by the member. SC has a specific reimbursement rate and is a component of the member's service budget. In conjunction with the service planning team, the member or LAR determines the level of SC necessary for inclusion in each member's service plan.

Medical Supplies

Adaptive aids and medical supplies are specialized medical equipment and supplies which include devices, controls, or appliances that enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Texas State Plan, such as: vehicle modifications, service animals and supplies, environmental adaptations, aids for daily living, reaches, adapted utensils, and certain types of lifts. The annual cost limit of this service is \$10,000 per waiver plan year. The \$10,000 cost limit may be waived by the HHSC upon request of the managed care organization. The State allows a member to select a relative or legal guardian, other than a legally responsible individual, to be his/her provider for this service if the relative or legal guardian meets the requirements for this type of service.

Dental Services

Dental services which exceed the dental benefit under the State Plan are provided under this waiver when no other financial resource for such services is available or when other available resources have been used. Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:

- Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
- Operative procedures that are required to prevent the imminent loss of teeth;
- Routine dental procedures necessary to maintain good oral health;
- Treatment of injuries to the teeth or supporting structures; and
- Dentures and cost of fitting and preparation for dentures, including extractions, molds, etc.

The State allows a member to select a relative or legal guardian, other than a spouse, to be his/her provider for this service if the relative or legal guardian meets the requirements to provide this service. Payments for dental services are not made for cosmetic dentistry. The annual cost cap of this service is \$5,000 per waiver plan year. The \$5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the \$5,000 cap may be made up to an additional \$5,000 per waiver plan year when the services of an oral surgeon are required.

Targeted Case Management (TCM)

Means services designed to assist Members with gaining access to needed medical, social, educational, and other services and supports. Members are eligible to receive these services based on a standardized assessment (the Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths Assessment (ANSA) and other diagnostic criteria used to establish medical necessity.

Mental Health Rehabilitative Services (MHR)

Are those age-appropriate services determined by HHSC and Federally approved protocol as medically necessary to reduce a Member's disability resulting from severe mental illness for adults, or serious emotional, behavioral, or mental disorders for children, and to restore the Member to his or her best possible functioning level in the community. Services that help in maintaining functioning may be considered rehabilitative when necessary to help a Member achieve a rehabilitation goal as defined in the Member's rehabilitation plan.

Electronic Visit Verification for STAR Kids only

Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.

Community First Choice Services

Community First Choice services are personal assistance services, habilitation, emergency response service, and support management. These services are provided in a community setting for eligible Medicaid Members in STAR Kids who have received a Level of Care (LOC) determination from an HHSC-authorized entity.

Service Coordination Services

Service Coordination is a special kind of case management service that is performed by a licensed, certified, and/or experienced person called a service coordinator.

Role of the Service Coordinator

The purpose of a Service Coordinator is to maximize a member's health, wellbeing, and independence. Service Coordination should consider and address the member's situation, including his or her medical, behavioral, social, and educational needs.

Service Coordination Services

A Service Coordinator will:

- Identify member needs and service through the STAR Kids Screening and Assessment Process
- Work with the member's PCP to coordinate all covered services, non-capitated services, and non-covered services available through other sources.
- Work with member, LAR, family or community supports and other providers to develop an individualized service plan that include actions and goals to meet member's needs
- Help make sure members receive services on time.
- Make sure members have a choice of providers and access to covered services.
- Coordinate covered services with social and community support services.

Aetna Better Health of Texas wants our members to be safe and healthy, to be involved in the service plan, and to live where they choose. We will assign a service coordinator to anyone who asks for one. We also will provide a service coordinator if a review of health and support needs show that a service coordinator might be able to help.

The service coordinator will work as a team with the member, Legally Authorized Representative (LAR), primary care provider and specialists to arrange all the services and supports that are needed. The Service Coordination team is the primary point of contact for providers when there are issues or questions about a Member. As such, providers should contact the Service Coordinator whenever there are changes in a Member's health status. When a Member's Service Coordinator changes as a result of staffing vacancy, Membership changes or as the needs of Members evolve, Aetna Better Health of Texas provides notice to the Member within 5 business days of the change. Providers may obtain the name of any Member's assigned Service Coordinator by contacting the STAR Kids Member Services Department at **1-844-STRKIDS (1-844-787-5437)**. Aetna Better Health of Texas has administrative staff Members who assist the Service Coordinators but however, they are not responsible for Service Coordination functions. Their roles are restricted to non-clinical,

administrative, and workflow tasks, such as telephone calls, correspondence, and record keeping.

Authorization of Services may be obtained once a care plan is established by the Service Coordinator. The SC will work closely with the Member's PCP to authorize medically necessary services, including referrals to Specialty Care Providers. If a Specialty Care Provider will be delivering care on an on-going basis, a standing referral maybe established. At the Member's discretion and with the Specialty Care Provider's approval, the Specialty Care Provider may be designated as the Member's PCP. Authorization for office visits to the PCP or in network Specialists is not required. Prior to rendering additional services beyond routine office care, providers should contact the Service Coordinator to ensure that services are authorized appropriately. Providers and Members can reach the Aetna Better Health of Texas STAR Kids Service Coordination Department by dialing **1-844-STRKIDS (1-844-787-5437)**.

Service Coordination for Level 1, 2, and 3 Members

There are three levels of service coordination. Following the completion of the SAI, the service coordination department will assign members to the appropriate level based on findings from member, member's LAR, relevant service providers and based on the guidelines below.

Level 1 Members include the following member types:

- MDCP STAR Kids Members
- Members with Complex Needs or a history of development or behavioral health issues (multiple outpatient visits, hospitalizations, or institutionalization within the past year)
- Members with SED or SPMI
- Members at risk for institutionalization

All Level 1 Members must receive a minimum of four face-to-face Service Coordination contacts annually, in addition to monthly phone calls, unless otherwise requested by the Member or Member's LAR.

Level 2 Members include the following member types:

- Members who do not meet the requirements for Level 1 classification but receive Personal Care Services (PCS), Community First Choice (CFC), or Nursing Services.
- Members of Aetna Better Health believes would benefit from a higher level of service coordination based on results from the STAR Kids SAI and additional Aetna Better Health findings.
- Members with a history of substance abuse (multiple outpatient visits, hospitalization, or institutionalization within the past year).
- Members without SED or SPMI, but who have another behavioral health condition that significantly impairs function.

All Level 2 Members must receive a minimum of two face-to-face and six telephonic Service Coordination contacts annually unless otherwise requested by the member or member's LAR.

Level 3 Members include those who do not qualify as Level 1 or Level 2. All Level 3 members must receive a minimum of one face-to-face visit annually and make at least three telephonic service coordination outreach contacts yearly.

The service coordinator will include findings from the STAR Kids Screening and Assessment Process to create and regularly update a comprehensive person-centered individual service plan (ISP) for each STAR Kids Member. The ISP will also include input from the member, their family and caretakers; providers; and any other individual with knowledge and understanding of the member's strengths and service needs who is identified by the member, the member's LAR, or Aetna Better Health of Texas.

The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and member preferences. The ISP must be used to communicate and help align expectations between the member, their LAR, the service coordinator and key service providers. The service coordinator will provide a copy of the ISP to the member's providers and other individuals specified by the member or member's LAR.

No less than once per calendar year, the service coordinator will re-administer the STAR Kids SAI and make necessary adjustments to the member's ISP.

Discharge Planning

Aetna Better Health of Texas will provide discharge planning, transition care, and other education programs to network providers regarding all available long-term care settings and options. Aetna Better Health of Texas will assess the needs of members discharged from a hospital or other care or treatment facility, including inpatient psychiatric facilities and establish appropriate service authorizations. Aetna Better Health of Texas will ensure that the member, the member's family, and the member's PCP are well informed of all service options available to meet the member's needs in the community.

Transition Plan

Continuity of Care Transition Plan

Aetna Better Health of Texas will ensure that the healthcare of newly enrolled Members is not disrupted, compromised, or interrupted. Upon notification from a member or provider of the existence of a prior authorization, Aetna Better Health of Texas will continue to authorize services through existing authorizations for acute care services (like physical, occupational, or speech therapy) and these authorizations will be honored by six months, until the authorization expires, or until the health plan conducts a new assessment. (2) Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored by six months or until the health plan conducts a new assessment. (3) Aetna will extend STAR Kids continuity of care for physician services (including services provided by a hospital-affiliated physician) where an established relationship existed as of 10/31/2016 for the period from 11/1/2016 to 10/31/2017; additional services ordered by the out of network physician may require prior authorization.

Aetna Better Health of Texas will allow a STAR Kids Member who is receiving services for complex medical needs to remain under the care of a Texas Medicaid Enrolled Provider from whom the Member is receiving care, even if that provider is out of network with Aetna Better Health of Texas as long as there are established Member/Provider relationships, existing treatment protocols and ongoing care plans in place.

Aetna Better Health of Texas' obligation to reimburse the member's existing Out-of-Network

Provider for services provided to a pregnant member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first 6 weeks of delivery.

Adult transition planning

Aetna Better Health of Texas must help to assure that teens and young adult members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Aetna Better Health of Texas is responsible for conducting ongoing transition planning starting when the member turns 15 years old. Aetna Better Health of Texas must provide transition planning services as a team approach through the named Service Coordinator if applicable and with a Transition Specialist within the Member Services Division. Transition Specialists must be an employee of Aetna Better Health of Texas and wholly dedicated to counseling and educating members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition Specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the member in the transition process. Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service.
2. Prior to the age of 10, the Aetna Better Health of Texas must inform the member and the member's LAR regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply. DADS LTSS programs include CLASS, DBMD, TxHmL and HCS.
3. Beginning at age 15, the Aetna Better Health of Texas must regularly update the ISP with transition goals.
4. Coordination with DARS to help identify future employment and employment training opportunities.
5. If desired by the member or the member's LAR, coordination with the member's school and Individual Education Plan (IEP) to ensure consistency of goals.
6. Health and wellness education to assist the member with self-management.
7. Identification of other resources to assist the member, the member's LAR, and others in the member's support system to anticipate barriers and opportunities that will impact the member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the member's 21st birthday.
9. Assistance identifying adult health care providers.

Coordination with Non-Medicaid Managed Care Covered Services

In addition to Aetna Better Health of Texas coverage, STAR members are eligible for the services described below. Aetna Better Health of Texas and our network providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM).

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination
- Early Childhood Intervention Specialized Skills Training

- Department of State Health Services (DSHS) Targeted Case Management (non-capitated service coordinated by LMHAs until August 31, 2014)
- DSHS Mental health rehabilitation (non-capitated until August 31, 2014)
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)

Non-emergency Ambulance Transport Services

Non-emergency transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled appointment, to or from a licensed facility for treatment, or to the client's home after discharge from a hospital when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e. alternate means of transportation are medically contraindicated).

In this circumstance, contraindicated means that the client cannot be transported by any other means from the origin to the destination without endangering the individual's health.

A Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency. Requests can be faxed to **1-866-835-9589** or submitted via the provider website at Availity <https://apps.availity.com/availity/web/public.elegant.login> or the Aetna Provider Web Portal which is found at <https://medicaid.aetna.com/MWP/landing/home>. All requests require clinical information to support the need for the member to be transported by nonemergent ambulance transportation. The ambulance provider may not submit the request. If requests for nonemergent ambulance transportation occur after business hours, then a retrospective review will be conducted if the request is received the next business day.

Non-Emergency Medical Transportation (NEMT) Services

What are NEMT services?

Access2Care provides transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. Access2Care does NOT include ambulance trips.

What services are part of Access2Care?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is \$25 per day for the member and \$25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the

overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.

- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a Member needing assistance while traveling to and from his or her appointment with you, Access2Care will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.

If you have a Member you think would benefit from receiving NEMT services, please refer him or her to Access2Care at **1-866-411-8920** for more information.

Timeframes

- Call Access2Care at **1-866-411-8920**, two business days before your appointment to schedule a ride. They are open 24 hours a day, 7 days a week.

Exceptions to the 2 business day wait or urgent trips

- Hospital discharges (no prior authorization needed, and discharges have a 3-hour window for member pick-up)
- Urgent facility
- Pharmacy Services
- Urgent dental
- Urgent visit PCP

Long distance trips

Medically necessary appointments with an in-network provider can be scheduled beyond 75 miles from the member's home. This will require prior authorization. Trips should be scheduled at least five business days in advance.

Emergency Transportation

When the Member's condition is life-threatening and trained attendants must use special equipment, life support systems or close monitoring while enroute to the nearest appropriate facility, the ambulance transport is deemed an emergency service.

Non-Emergency Medical Transportation

When a Member has a medical problem requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance service requires prior authorization and coordination by Aetna Better Health of Texas.

Medical Transportation Value-Added Service

Aetna Better Health of Texas will offer STAR Kids members and their caregivers non-emergent transportation assistance through bus tokens or cab fare when needed to attend medical appointments for which Medicaid transportation program services are not available. Our Member Services Department will coordinate based on transportation need.

STAR Kids LTSS Claims

STAR Kids and LTSS/Medicare EOB Requirements:

- For dual-eligible clients, Aetna Better Health of Texas does not require an EOB prior to covering benefits not covered by Medicare.
- For non-dual-eligible clients with primary private insurance, Aetna Better Health of Texas does not require a written EOB (e.g., does not require an EOB at all or may accept a verbal denial) for LTSS or other services not covered under a commercial insurance plan, including: PCS, CFC, DAHS, PPECC, MDCP, and mental health rehabilitation, and mental health targeted case management services.

CHIP Covered Services

Aetna Better Health provides CHIP services as outlined below. Please refer to the following pages for a listing of limitations and exclusions.

There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays apply for CHIP members until a family reaches its specific cost-sharing maximum.

Covered services for CHIP Members must meet the CHIP definition of "Medically Necessary." Medically necessary health services mean:

1. Dental services and non-behavioral health services that are:
 - a) Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
 - b) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's Health conditions.
 - c) Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
 - d) Consistent with the member's diagnoses;
 - e) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
 - f) Not experimental or investigative; and
 - g) Not primarily for the convenience of the member or provider.
2. Behavioral health services that:
 - a) Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
 - b) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
 - c) Are furnished in the most appropriate and least restrictive setting in which services can be

safely provided;

- d) Are the most appropriate level or supply of service that can be safely provided;
- e) Could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered;
- f) Are not experimental or investigative; and
- g) Are not primarily for the convenience of the member or provider.

CHIP covered benefit	Limitations	Copayments*
<p>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</p> <ul style="list-style-type: none"> • Hospital-provided Physician or Provider services • Semi-private room and board(or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care • In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. 	<ul style="list-style-type: none"> • Requires authorization for non-emergency care and care following stabilization of an Emergency Condition. • Requires authorization for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section. 	<p>Inpatient co-payment per admission can vary between \$15-\$125 based on Federal Poverty Level (FPL).</p>

<ul style="list-style-type: none"> • Hospital, physician and related medical services, such as anesthesia, associated with dental care. • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> - Dilation and curettage (D&C) procedures; - Appropriate provider-administered medications; ultrasounds; and histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> - Cleft lip and/or palate; or - Severe traumatic, skeletal and/or congenital craniofacial deviations; or - Severe facial asymmetry secondary to skeletal defects, congenital syndrome conditions and/or tumor growth or its treatment • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> - All stages of reconstruction on the affected breast; - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedures(s) have been performed; - Surgery and reconstruction on the other breast to produce symmetrical appearance; and - Treatment of physical complications from the mastectomy and treatment 		
---	--	--

<p>of lymphedemas. Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.</p>		
<p>Skilled Nursing Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semi-private room and board • Regular nursing services • Rehabilitation services <p>Medical supplies and use of appliances and equipment furnished by the facility</p>	<ul style="list-style-type: none"> • Requires authorization and physician prescription. • 60 days per 12 month period limit. 	None
<p>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, 	May require prior authorization and physician prescription.	<p>\$0 copayment for generic drugs \$3 copayment for brand drugs</p>

<p>associated with dental care, when provided in a licensed ambulatory surgical facility.</p> <ul style="list-style-type: none"> • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> - Dilation and curettage (D&C) procedures; - Appropriate provider administered medications; ultrasounds; and histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> - Cleft lip and/or palate; or - Severe traumatic, skeletal and/or congenital craniofacial deviations; or - Severe facial asymmetry secondary to skeletal defects, congenital syndrome conditions and/or tumor growth or its treatment. • Surgical implants • Other artificial aids including surgical Implants • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: <ul style="list-style-type: none"> - All stages of reconstruction on the affected breast; 		
--	--	--

<p>external breast prosthesis for the breast(s) on which medically necessary mastectomy procedures(s) have been performed;</p> <ul style="list-style-type: none"> - Surgery and reconstruction on the other breast to produce symmetrical appearance; and - Treatment of physical complications from the mastectomy and treatment of lymphedemas. <p>Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit</p>		
<p>Physician/Physician Extender Professional Services</p> <p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) • Physician office visits, in-patient and outpatient services • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation Medications, biologicals and materials administered in physician's office • Allergy testing, serum and injections • Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> -Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care -Administration of anesthesia by Physician (other than surgeon) or CRNA -Second surgical opinions 	<p>May require authorization for specialty referral from a PCP to an in-network specialist.</p> <p>Requires authorization for all out-of-network specialty referrals.</p>	<p>\$3 copayment for office visit</p>

<ul style="list-style-type: none"> -Same-day surgery performed in a hospital without an over-night stay -Invasive diagnostic procedures such as endoscopic examinations • Hospital-based Physician services (including Physician-performed technical and interpretive components) • Physician and professional services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> - All stages of reconstruction on the affected breast; - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedures(s) have been performed; - Surgery and reconstruction on the other breast to produce symmetrical appearance; - And treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non viable pregnancy include, but are not limited to: 		
--	--	--

<ul style="list-style-type: none"> - Dilation and curettage (D&C) procedures; - Appropriate provider-administered medications; - Ultrasounds; and histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> - Cleft lip and/or palate; or - Severe traumatic, skeletal and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndrome conditions and/or tumor growth or its treatment. 		
<p>Birthing Center Services</p>	<p>Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)</p>	<p>None</p>
<p>Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.</p>	<p>Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.</p>	<p>None</p>
<p>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</p> <p>Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to:</p>	<ul style="list-style-type: none"> • May require prior authorization and physician prescription. • \$20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap). 	<p>None</p>

<ul style="list-style-type: none"> • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids <p>Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.</p>		
<p>Home and Community Health Services that are provided in the home and community, including, but not limited to:</p> <ul style="list-style-type: none"> • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. • Speech, physical and occupational therapies. 	<ul style="list-style-type: none"> • Requires prior authorization and physician prescription. • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services 	None
<p>Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state operated facilities, including but not limited to:</p> <ul style="list-style-type: none"> • Neuropsychological and psychological testing 	<ul style="list-style-type: none"> • Requires prior authorization for non-emergency services. • Does not require PCP referral. <p>When inpatient psychiatric services are ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits</p>	\$15 inpatient copayment

	<p>for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.</p>	
<p>Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:</p> <ul style="list-style-type: none"> • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state operated facility • Neuropsychological and psychological testing. • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) 	<ul style="list-style-type: none"> • May require prior authorization. • Does not require PCP referral. <p>When outpatient psychiatric services are ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.</p> <ul style="list-style-type: none"> • A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP- CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a 	<p>\$3 copayment for office visit</p>

	<p>licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.</p>	
<p>Inpatient Substance Abuse Treatment Services Inpatient substance abuse treatment services include, but are not limited to:</p> <ul style="list-style-type: none"> • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. 	<ul style="list-style-type: none"> • Requires prior authorization for non-emergency services. • Does not require PCP referral. 	\$15 inpatient copayment
<p>Outpatient Substance Abuse Treatment Services Outpatient substance abuse treatment services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization 	<ul style="list-style-type: none"> • May require prior authorization. • Does not require PCP referral. 	

<ul style="list-style-type: none"> Intensive outpatient services is defined as an organized nonresidential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. <p>Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.</p>		
<p>Rehabilitation Services Habilitation (the process of supplying a child with the means to reach age- appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following:</p> <ul style="list-style-type: none"> Physical, occupational and speech therapy Developmental assessment 	<p>Requires prior authorization and physician prescription.</p>	<p>None</p>
<p>Hospice Care Services</p> <p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death <p>Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.</p>	<ul style="list-style-type: none"> Requires authorization and physician prescription. Services apply to the hospice diagnosis. Up to a maximum of 120 days with a 6 month life expectancy. Patients electing hospice services may cancel this election at any time. 	<p>None</p>

<p>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</p> <p>Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in network and out-of-network providers • Medical screening examination • Stabilization services Access to DSHS designated Level and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts, and treatment relating to oral abscess of tooth or • gum origin. 	<p>Does not require authorization for post-stabilization services</p>	<p>\$3 copayment for non-emergency ER</p>
<p>Transplants</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses. 	<p>Requires authorization.</p>	<p>None</p>

<p>Vision Benefit Covered services include:</p> <ul style="list-style-type: none"> • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period 	<ul style="list-style-type: none"> • The health plan may reasonably limit the cost of the frames/lenses. • Does not require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. 	<p>\$3 copayment for office visit</p>
<p>Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation</p>	<ul style="list-style-type: none"> • Does not require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit). • Does not require authorization for additional visits. 	<p>\$3 copayment for office visit</p>
<p>Cessation Program Covered up to \$100 for a 12-month period limit for a plan-approved program</p>	<ul style="list-style-type: none"> • Does not require authorization. Health Plan defines plan-approved program. • May be subject to formulary requirements. 	<p>None</p>
<p>Drug Benefits Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Outpatient drugs and biological, including pharmacy-dispensed and provider administered outpatient drugs and biological; and • Drugs and biological provided in an Inpatient setting. 		<p>None</p>

Exclusions from covered services for CHIP Members

Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.

- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning).
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, "External Review by Independent Review Organization").
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Dental devices solely for cosmetic purposes.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.

- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, that do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a physician/PCP.
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP DME/Supplies

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X		For covered DME items.
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy supplies.
Communication Devices			
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children ages 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.

Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times, these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery.
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non- function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease.
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	<p>food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include:</p> <ul style="list-style-type: none"> • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product <p>Does not include formula:</p> <ul style="list-style-type: none"> • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product)

			<ul style="list-style-type: none"> • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. • Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are <i>not</i> medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children ages 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic supplies.
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.

Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal.
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: <ul style="list-style-type: none"> • When used to dilute medications for nebulizer treatments; • As part of covered home care for wound care; • For indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catheterization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy supplies.

CHIP Perinate Newborn Covered Services

Aetna Better Health provides services to CHIP Perinate Newborns as outlined below. Please refer to the following pages for a listing of limitations and exclusions.

There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Copays do not apply to CHIP Perinate Newborns.

Covered services for CHIP Perinate Newborns must meet the CHIP definition of "Medically Necessary."

Medically necessary health services mean:

1. Dental services and non-behavioral health services that are:
 - a) Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
 - b) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
 - c) Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
 - d) Consistent with the member's diagnoses;
 - e) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
 - f) Not experimental or investigative; and
 - g) Not primarily for the convenience of the member or provider.

2. Behavioral Health Services that:
 - a) Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
 - b) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral healthcare;
 - c) Are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
 - d) Are the most appropriate level or supply of service that can be safely provided;
 - e) Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
 - f) Are not experimental or investigative; and
 - g) Are not primarily for the convenience of the member or provider.

CHIP Perinate Newborn covered benefit	Limitations	Copayments
<p>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</p> <p>Services include:</p> <ul style="list-style-type: none"> • Hospital-provided Physician or Provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free of-charge to the patient and their administration 	<ul style="list-style-type: none"> • Requires authorization for non-emergency care and care following stabilization of an emergency condition. • Requires authorization for in-network or out of network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section. 	None

<ul style="list-style-type: none"> • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care • In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care • Surgical implants 		
---	--	--

<ul style="list-style-type: none">• Other artificial aids including surgical implants• Inpatient services for a mastectomy and breast reconstruction include:<ul style="list-style-type: none">- All stages of reconstruction on the affected breast;- Surgery and reconstruction on the other breast to produce symmetrical appearance; and- Treatment of physical complications from the mastectomy and treatment of lymphedemas.• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:		
---	--	--

<ul style="list-style-type: none"> — Cleft lip and/or palate; or — Severe traumatic, skeletal and/or congenital craniofacial deviations; or — Severe facial asymmetry secondary to skeletal defects, congenital syndrome conditions and/or tumor growth or its treatment. 		
<p>Skilled Nursing Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility 	<ul style="list-style-type: none"> • Requires authorization and physician prescription • 60 days per 12-month period limit. 	None
<p>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include but are not limited to the following</p>	May require prior authorization and physician prescription	None

services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:

- X-ray, imaging, and radiological tests (technical component)
- Laboratory and pathology services (technical component)
- Machine diagnostic tests
- Ambulatory surgical facility services
- Drugs, medications and biologicals
- Casts, splints, dressings
- Preventive health services
- Physical, occupational and speech therapy
- Renal dialysis
- Respiratory services
- Radiation and chemotherapy
- Blood or blood products that are not provided free-of-charge to the patient and the administration of these products
- Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility,
- Surgical implants.
- Other artificial aids including surgical implants
- Outpatient services

<p>provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:</p> <ul style="list-style-type: none"> - All stages of reconstruction on the affected breast; - Surgery and reconstruction on the other breast to produce symmetrical appearance; and - Treatment of physical complications from the mastectomy and treatment of lymphedemas. <ul style="list-style-type: none"> • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> - Cleft lip and/or 		
---	--	--

<p>palate; or</p> <ul style="list-style-type: none"> - Severe traumatic, skeletal and/or congenital craniofacial deviations; or - Severe facial asymmetry secondary to skeletal defects, congenital syndrome conditions and/or tumor growth or its treatment. 		
<p>Physician/Physician Extender Professional Services</p> <p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • American Academy of Pediatrics recommended well- child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) • Physician office visits, in-patient and out- patientservices • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biologicals and materials administered in Physician’s office • Allergy testing, 	<p>May require authorization for specialty referral from a PCP to an in-network specialist.</p> <p>Requires authorization for all out-of-network specialty referrals.</p>	<p>None</p>

<p>serum and injections</p> <ul style="list-style-type: none"> • Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> — Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care — Administration of anesthesia by Physician (other than surgeon) or CRNA — Second surgical opinions — Same-day surgery performed in a hospital without an over-night stay — Invasive diagnostic procedures such as endoscopic examinations • Hospital-based Physician services (including Physician-performed technical and interpretive components) • Physician and professional services for a mastectomy and breast reconstruction include: <p>All stages of reconstruction on the affected breast;</p>		
--	--	--

<ul style="list-style-type: none"> — Surgery and reconstruction on the other breast to produce symmetrical appearance; and — Treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and 		
--	--	--

<p>clearly outlined treatment plan to treat:</p> <ul style="list-style-type: none"> — Cleft lip and/or palate; or — Severe traumatic, skeletal and/or congenital craniofacial deviations; or — Severe facial asymmetry secondary to skeletal defects, congenital syndrome conditions and/or tumor growth or its treatment. 		
<p>Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.</p>	<p>Covers services rendered to a newborn immediately following delivery.</p>	<p>None</p>
<p>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</p> <p>Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the</p>	<p>May require prior authorization and physician prescription</p> <ul style="list-style-type: none"> • \$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). 	<p>None</p>

<p>treatment of a medical condition, including but not limited to:</p> <ul style="list-style-type: none"> • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids <p>Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)</p>		
<p>Home and Community Health Services Services that are provided in the home and community, including, but not limited to:</p> <ul style="list-style-type: none"> • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. • Speech, physical and occupational therapies. 	<ul style="list-style-type: none"> • Requires prior authorization and physician prescription • Services are not intended to replace the Child’s caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services. 	None

<p>Inpatient Mental Health Services</p> <p>Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:</p> <ul style="list-style-type: none"> • Neuropsychological and psychological testing 	<ul style="list-style-type: none"> • Requires prior authorization for non-emergency services • Does not require PCP referral. <p>When inpatient psychiatric services are ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.</p>	None
<p>Outpatient Mental Health Services</p> <p>Mental health services, including for serious mental illness, provided on an outpatient basis, include but are not limited to:</p> <ul style="list-style-type: none"> • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services (partial 	<ul style="list-style-type: none"> • May require prior authorization. • Does not require PCP referral. <p>When outpatient psychiatric services are ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.</p>	None

<p>hospitalization or rehabilitative day treatment)</p> <ul style="list-style-type: none"> • Skills training (psycho educational skill development) 	<ul style="list-style-type: none"> • A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412 Subchapter G, Division 1, §412.303(31). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP- CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in- home services), patient and family education, and crisis services. 	
<p>Inpatient Substance Abuse Treatment Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. 	<ul style="list-style-type: none"> • Requires prior authorization for non-emergency services • Does not require PCP referral. 	None

<p>Outpatient Substance Abuse Treatment Services</p> <p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized nonresidential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training. 	<ul style="list-style-type: none"> • May require prior authorization. • Does not require PCP referral. 	<p>None</p>
<p>Rehabilitation Services</p> <p>Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy</p>	<p>Requires prior authorization and physician prescription</p>	<p>None</p>

<p>or treatment) and rehabilitation services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Physical, occupational and speech therapy • Developmental assessment 		
<p>Hospice Care Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services. 	<ul style="list-style-type: none"> • Requires authorization and physician prescription • Services apply to the hospice diagnosis. • Up to a maximum of 120 days with a 6-month life expectancy. • Patients electing hospice services may cancel this election at any time. 	None
<p>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</p> <p>Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery.</p> <p>Covered services include but are not limited to the following:</p> <ul style="list-style-type: none"> • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and 	Does not require authorization for post-stabilization services	None

<p>ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers</p> <ul style="list-style-type: none"> • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts. 		
<p>Transplants Services include but are not limited to the following:</p> <ul style="list-style-type: none"> • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses. 	Requires authorization	None
<p>Vision Benefit Services include:</p> <ul style="list-style-type: none"> • One examination of the 	<p>The health plan may reasonably limit the cost of the frames/lenses.</p> <ul style="list-style-type: none"> • Does not require 	None

<p>eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization</p> <ul style="list-style-type: none"> • One pair of non-prosthetic eyewear per 12-month period 	<p>authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.</p>	
<p>Chiropractic Services</p> <p>Covered services do not require physician prescription and are limited to spinal subluxation</p>	<ul style="list-style-type: none"> • Does not require authorization for twelve visits per 12 month period limit (regardless of number of services or modalities provided in one visit) • Does not require authorization for additional visits. 	None
<p>Tobacco Cessation Program</p> <p>Covered up to \$100 for a 12 month period limit for a plan- approved program</p>	<ul style="list-style-type: none"> • Does not require authorization • Health Plan defines plan-approved program. • May be subject to formulary requirements. 	None
<p>Case Management and Care Coordination Services</p>	<p>These services include outreach, informing, case management, care coordination and community referral.</p>	None

Exclusions from covered services for CHIP Perinate newborn members

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning).
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as

described in D, “External Review by Independent Review Organization”).

- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, that do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.

- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP Perinate Newborn DME/Supplies

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items.
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan

Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times, these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non- function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula	X		Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: <ul style="list-style-type: none"> • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula:

			<ul style="list-style-type: none"> For members who could be sustained on an age-appropriate diet. Traditionally used for infant feeding in pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. <p>Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are <i>not</i> medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.</p>
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children ages 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.

Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) When used to dilute medications for nebulizer treatments; b) As part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.

Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catheterization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

CHIP Perinate (unborn child) covered services

Aetna Better Health provides services to CHIP Perinate members (unborn child) as outlined below. Please refer to the following pages for a listing of limitations and exclusions.

There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinate members (unborn child).

Covered services for CHIP Perinate members (unborn child) must meet the CHIP definition of "Medically Necessary."

Medically necessary health services **mean:**

1. Dental services and non-behavioral health services that are:
 - a) Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member, or endanger life;
 - b) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
 - c) Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
 - d) Consistent with the Member's diagnoses;
 - e) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
 - f) Not experimental or investigative; and not primarily for the convenience of the Member or Provider.
2. Behavioral Health Services that:
 - a) Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
 - b) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
 - c) Are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

- d) Are the most appropriate level or supply of service that can be safely provided;
- e) Could not be omitted without adversely affecting the Member’s mental and/or physical health or the quality of care rendered;
- f) Are not experimental or investigative; and
- g) Are not primarily for the convenience of the Member or Provider.

CHIP Perinate covered benefit	Limitations	Copayments
<p>Inpatient General Acute</p> <p>Services include:</p> <ul style="list-style-type: none"> • Covered medically necessary Hospital-provided services • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> - Dilation and curettage(D&C) procedures, - Appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples. 	<p>For CHIP Perinate Members in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however professional services charges associated with labor with delivery are a covered benefit.</p> <p>For CHIP Perinate Members in families with incomes above 185% up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth.</p>	<p>None</p>

<p>Comprehensive Outpatient Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center</p> <p>Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> — Dilation and curettage (D&C) procedures, <p>Appropriate provider- administered medications, ultrasounds, and histological examination of tissue samples.</p>	<ul style="list-style-type: none"> • May require prior authorization and physician prescription <p>Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth.</p> <p>Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy.</p> <p>Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis.</p> <p>Laboratory tests for the CHIP Perinatal Program are limited to: non-stress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface</p>	<p>None</p>
--	---	-------------

	<p>antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. Surgical services associated with (a) miscarriage or (b) a non viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.</p>	
<p>Physician/Physician Extender Professional Services Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. • Physician office visits, in patient and outpatient services • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation • Medically necessary medications, biologicals and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> — Surgeons and assistant surgeons for surgical 	<p>May require authorization for specialty referral from a PCP to an in-network specialist.</p> <p>Requires authorization for all out- of-network specialty referrals.</p> <p>Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation.</p> <ul style="list-style-type: none"> • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis and 	<p>None</p>

<p>procedures directly related to the labor with delivery of the covered unborn child until birth.</p> <ul style="list-style-type: none"> — Administration of anesthesia by physician (other than surgeon) or CRNA — Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. <p>Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).</p> <ul style="list-style-type: none"> • Hospital-based Physician services (including Physician- performed technical and interpretive components) Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples. 	<p>FIUT.</p>	
--	--------------	--

<p>Birth Center Services</p>	<p>Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)</p> <p>Applies only to CHIP Perinate Members (unborn child) with incomes at 186% FPL to 200% FPL.</p>	<p>None</p>
<p>Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.</p>	<p>Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:</p> <ul style="list-style-type: none"> • One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; • One (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; • One (1) visit per week from 36 weeks to delivery. • More frequent visits are allowed as Medically Necessary. <p>Benefits are limited to: —Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies and can be approved upon appeal with</p>	<p>None</p>

	<p>appropriate documentation.</p> <p>—High-risk prenatal visits more than 20 visits per</p> <p>Pregnancy must be appealed with documentation supporting the medical necessity.</p> <p>Documentation supporting medical necessity must be maintained and is subject to retrospective review.</p> <p>Visits after the initial visit must include:</p> <ul style="list-style-type: none"> • Interim history (problems, marital status, fetal status); • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and • Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client). 	
--	---	--

<p>Prenatal care and pre-pregnancy family services and supplies</p> <p>Covered services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: One visits every four weeks for the first 28 weeks or pregnancy; one visits every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary.</p>	<p>Does not require prior authorization.</p> <p>Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies and can be approved upon appeal with appropriate documentation. High-risk prenatal visits more than 20 visits per pregnancy must be appealed with documentation supporting the medical necessity .</p> <p>Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.</p> <p>Visits after the initial visit must include: interim history (problems, maternal status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).</p>	<p>None</p>
--	--	-------------

<p>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</p> <p>Health Plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery.</p>	<p>Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.</p>	<p>None</p>
<p>Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth.</p> <ul style="list-style-type: none"> • Emergency services based on prudent layperson definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor and delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit. <p>Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)</p>		
<p>Case Management Services</p> <p>Case management services are a covered benefit for the unborn child.</p>	<p>Case Management Services</p> <p>Case management services are a covered benefit for the unborn child.</p>	<p>None</p>

<p>Care Coordination Services Care coordination services are a covered benefit for the unborn child.</p>		None
<p>Drug Benefits Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting. 	Services must be medically necessary for the unborn child.	None

Exclusions from Covered Services for CHIP Perinate Members

- For CHIP Perinate Members in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. “Initial Perinatal Newborn admission” means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor and/or

delivery of the covered unborn child.

- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or post-partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, “External Review by Independent Review Organization”).
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor and delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment of injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse that do not require the skill and training of a nurse.
- Vision training, vision therapy, or vision services.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered.

- Donor non-medical expenses.
- Charges incurred as a donor of an organ.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

Coordination with Medicaid, CHIP and STAR Kids services not covered by Managed Care Organizations (Non-Capitated Services)

The following are programs (non-capitated services) available to Medicaid managed care members that are administered through the HHSC.

Texas agency administered programs and Case Management services

The following are services that are not a part of Aetna Better Health Program services; however, Aetna Better Health members can also qualify for:

- **Early Childhood Intervention Program (ECI).** ECI can offer services in the home or in the community for children, birth to three years old who are developmentally delayed. Some of the services for children include screenings, physical, occupational, speech and language therapy, and activities to help children learn better.
- **DSHS Targeted Case Management Programs.** DSHS can offer various mental health and mental retardation programs, such as psychiatric treatment, child and adolescent counseling, and crisis intervention.
- **Women, Infants, and Children (WIC) Program.** WIC can help infants and children under five years old, and pregnant and breastfeeding women who qualify to get nutritious food, nutrition education, and counseling.

Essential public health services

Aetna Better Health is required through its contractual relationship with HHSC to coordinate with public health entities regarding essential public health services. Providers must assist Aetna Better Health in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases that are preventable by immunizations as defined by State law
- Assisting in notifying or referring to the local public health entity, as defined by state law, any communicable disease outbreaks involving Members
- Referring TB cases to the local Public Health Entity for contact investigation and evaluation and preventive treatment of persons whom the Member has come into contact
- Referring STD/HIV cases to the local Public Health Entity for contact investigation and evaluation and preventive treatment of persons with whom the Member has come into contact
- Referring to Women, Infant and Children (WIC) services and information sharing
- Referring lead screening tests to the DSHS Laboratory and assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- Reporting of immunizations provided to the statewide ImmTrac Registry, including parental consent to share data
- Working with Dental Contractors on coordination of care protocols as well as for reciprocal referral and communication of data and clinical information regarding the Member's Medically Necessary Dental Covered Services
- Cooperating with activities required of public health authorities to conduct the annual population and community-based needs assessment
- Aetna Better Health provides case management services to assist public health providers and

primary care providers in effectively referring Members to appropriate public health providers, specialists, and health related services.

Breast Pump Coverage in Medicaid, CHIP and STAR Kids

Texas Medicaid, CHIP and STAR Kids cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother’s Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant’s Medicaid client number.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother’s Medicaid ID or the newborn’s Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid Fee-For-Service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn’s Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn’s CHIP Perinatal ID.
STAR Kids STAR+PLUS STAR Health	STAR Kids STAR+PLUS STAR Health	Medicaid FFS or STAR** STAR+PLUS STAR Health	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother’s Medicaid ID or the newborn’s Medicaid ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn’s Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn’s Medicaid ID if the mother does not have coverage.

Behavioral Health

Definition of behavioral health

Aetna Better Health of Texas provides a continuum of services to meet the behavioral health needs of our members. We provide screening and early intervention for members at risk for behavioral health disorders and comprehensive treatment services for members with behavioral health diagnoses. Our provider network includes inpatient treatment facilities, community mental health centers, and outpatient behavioral health specialists who understand the needs of our STAR, CHIP, and STAR Kids population

Behavioral health describes a system of services that includes promotion of emotional health and wellness; prevention of mental health and substance use problems; treatment and services for mental health and substance use disorders; recovery and support services.

Behavioral Health services include screening/assessment for mental health and substance use; inpatient and outpatient treatment for mental health, substance use, behavioral disorders; care management and service coordination; mental health rehabilitation services and mental health targeted case management.

Covered behavioral health services

Aetna Better Health Texas provides coverage of medically necessary BH services for the treatment of mental, emotional, or substance use disorders. Aetna Better Health of Texas is responsible for authorized inpatient Hospital services; this includes services provided in Freestanding Psychiatric Facilities.

Covered BH services are not subject to the quantitative treatment limitations that apply under traditional, Fee-For-Service (FFS) Medicaid coverage. The services may be subject to the Aetna Better Health of Texas' non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 behavioral health services, including but not limited to:

Medicaid-STAR and STAR Kids - Covered BH Services

- Inpatient mental health services including in freestanding psychiatric facilities for children
- Outpatient mental health services
- Psychiatry services
- Counseling services for adults (age 21 and older)
- Outpatient substance use disorder treatment services, including:
 - Assessment
 - Detoxification services
 - Counseling treatment
 - Medication-assisted therapy
- Residential substance use disorder treatment services, including detoxification services
- Substance use disorder treatment, including room and board
- Mental health rehabilitative services
- Targeted case management

CHIP- Covered BH Services*

- Inpatient mental health
- Outpatient mental health
- Inpatient substance abuse
- Outpatient substance abuse

*These services are not covered for CHIP Perinates

Aetna Better Health is responsible for authorized inpatient Hospital services, this includes services provided in Freestanding Psychiatric Facilities for children in STAR and STAR Kids, and for adults in STAR+PLUS.

Primary Care Provider requirements for behavioral health

Aetna Better Health Texas promotes early intervention and health screening to identify behavioral health problems and identify areas for patient education. Members seen in the primary care setting may present with a behavioral health condition, which the Primary Care Provider (PCP) must be prepared to recognize.

The PCP is expected to:

- Screen, evaluate, treat behavioral health conditions within the scope of their practice;
- Refer member to behavioral health providers for specialized care when appropriate;
- Educate member regarding how and where to obtain behavioral health services, including the self-referral process.

Mental Health Screening

Effective July 1, 2018, Texas Health Steps allows clients 12 through 18 years of age to receive a mental health screening using one or more of the validated, standardized mental health screening tools recognized by Texas Health Steps, once per calendar year during a Texas Health Steps checkup.

Mental health screening is recommended annually for all clients who are 12 through 18 years of age. Validated, standardized mental health screening tools include:

- Pediatric Symptom Checklist(PSC-17)
- Pediatric Symptom Checklist(PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Patient Health Questionnaire Modified for Adolescents (PHQ-A Depression Screen)
- Patient Health Questionnaire for Adolescents (PHQ-A anxiety, eating problems, mood problems and substance abuse screen)
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)

Additional validated Behavioral Health screening tools for the primary care setting include:

- **Edinburgh Postnatal Depression Scale (EPDS):** The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for perinatal depression.
- **The Generalized Anxiety Disorder (GAD-7):** This questionnaire is a seven-item, self-report anxiety questionnaire. The GAD-7 measures the severity of various signs and symptoms of GAD. The tool is appropriate for outpatient and primary care settings for persons age 12 and older.
- **The Primary Care PTSD Screen (PC-PTSD-5):** This is a screening tool designed to identify persons with probable PTSD. Persons with a positive screen should have

further assessment with a structured interview for PTSD, preferably performed by a mental health professional who has experience in diagnosing PTSD.

- **ASQ:** The Ask Suicide-Screening Questions (ASQ) Toolkit can help nurses or physicians identify youth at risk for suicide. The ASQ can be used in a variety of medical settings: primary care, emergency department, inpatient medical and surgical units. The ASQ is a set of four screening questions that takes 20 seconds to administer. The ASQ is available in 14 languages.
- **Columbia - Suicide Severity Rating Scale (C-SSRS):** The Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk assessment through a series of simple, plain- language questions that anyone can ask. The Columbia Protocol is suitable for all ages and special populations in different settings and is available in more than 100 languages.

Member access to behavioral health services

Self-Referral

Eligible members may self-refer to a participating behavioral specialist or participating behavioral health facility. Referral assistance is available 24 hours per day, 7 days per week by calling the Aetna Better Health of Texas hotline. Members may also use the provider search tool on the Aetna Better Health of Texas website at **AetnaBetterHealth.com/Texas**. Members do not need a referral from their PCP for mental health or substance use disorder services.

Referral Information

Members must obtain care from Aetna Better Health participating provider to obtain behavioral health services. Contact us online at **AetnaBetterHealth.com/Texas** or by phone at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

Providers must use DSM-IV multi-axial classifications and other assessment instruments, or outcome measures required by HHSC when assessing Member for behavioral health services.

Members who may need access to intellectual and Developmental Disability (IDD) services and Home and Community Based Services (HCBS) Waiver services will receive an appropriate evaluation and psychometric testing by a qualified care provider. See more details in the Mental Health Rehabilitation Services and Case Management section.

Attention Deficit Hyperactivity Disorder (ADHD)

Treatment services for children diagnosed with ADHD, including follow-up care for children who are prescribed medications, are covered as outpatient mental health care. Please refer to TMPPM for additional information about covered benefits.

Coordination between behavioral health and physical health services

Coordination of Care: Behavioral Health, Physical Health, Long Term Services & Supports

Aetna Better Health is committed to coordinating care for our members across all domains and levels of care. The Primary Care Provider (PCP), Behavioral Health Provider (BH) and Long-Term Services and Supports (LTSS) providers are expected to share pertinent history

and test results in a timely manner and document review of the information received in the member's clinical record. With the member's consent, our care managers and service coordinators can facilitate communication and collaboration between providers, promoting an integrated plan of care for the member.

Coordination of Care: Behavioral Health (BH) Provider

BH (mental health/substance use disorders) providers are expected to use the most current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and other assessment instruments or outcome measures required by HHSC when assessing the member for behavioral health services. BH providers must document DSM diagnoses and assessments in the member's medical record.

BH facilities and outpatient providers are expected to obtain a general health history upon admission to care, including current medical conditions, medications, and medical providers. BH providers will refer members with suspected or untreated physical health problems to their primary care provider (PCP) for evaluation and treatment. BH providers may provide physical health care services within the scope of their practice.

With the member's consent:

- BH providers are asked to communicate concerns regarding the member's health condition with the PCP and collaborate on a plan of care.
- BH providers must send initial and quarterly reports on the member's behavioral health status and progress to their PCP. Clinical information should include the member's diagnosis and DSM code and/or ICD 10 code.
- BH facilities are expected to notify the member's PCP and outpatient BH providers upon admission to care and discharge.

Medical records standards

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals agree to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards.

Consent for disclosure of information

Members are encouraged to share information about their other health care providers during their initial visit. This will promote communication and collaboration between their health care providers, such as primary care, behavioral health (mental health/substance use disorder), and long-term services and supports. The member's consent is required to release verbal and/ or written information from their health record. Providers may use the "Authorization to Release Protected Health Information Form," which is available on the Aetna Better Health Texas website.

Court-Ordered Commitments

Aetna Better Health of Texas covers inpatient and outpatient psychiatric services to STAR, STAR Kids and CHIP members, birth through age 20 and ages 65 and older, who have

been ordered to receive the services by a court of competent jurisdiction, including services ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.

Aetna Better Health of Texas:

- Will not deny, reduce or controvert the medical necessity of any court-ordered inpatient or outpatient psychiatric service for members age 20 and younger or ages 65 and older; any modification or termination of services will be presented to the court with jurisdiction over the matter for determination.
- Will not allow members ordered to receive treatment under the provisions of the Texas Health and Safety Code to appeal the commitment through our complaint or appeals processes.
- Will comply with the utilization review of chemical dependency treatment; chemical dependency treatment must conform to the standards set forth in the Texas administrative code.

Coordination with the Local Mental Health Authority

Aetna Better Health Texas will coordinate with the Local Mental Health Authority (LMHA) and support member access to Mental Health Rehabilitation, Targeted Case Management, SUD treatment, peer support services. Coordination of care will also include specialty populations, such as mental health – substance use disorder and mental health-intellectual/developmental disability. Aetna Better Health Texas will coordinate with state psychiatric facilities regarding projected length of stay, discharge planning, and transition to community care.

Assessment instruments for behavioral health

In addition to the Screening tools provided in the Texas Medicaid Provider Procedures Manual at www.tmhp.com, additional tools are included as Appendix B to this manual.

Focus studies and utilization reporting requirements

- Behavioral Health is a component of the Aetna Better Health Quality Assessment and Performance Improvement Program (QAPI), which ensures a systematic and ongoing process to monitor, evaluate and improve the quality of behavioral health services provided to members.
- The health plan quality management and BH department establish goals and monitors yearly outcomes on BH Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- The health plan completes the annual assessment conducted by the Institute for Child Health Policy (IChP), which is required for the external quality review of Texas Medicaid Managed Care and the Children’s Health Insurance Program.
- Behavioral Health participates in Quality Management HHSC Performance Improvement Projects related to mental health/substance use.

- The health plan routinely monitors claims, encounters, referrals and other data for patterns of potential over/under utilization and identify opportunities to promote efficient and effective use of services.

Procedures for follow-up on missed appointments

Aetna Better Health providers will follow-up with Medicaid members within 24 hours and attempt to reschedule missed appointments. Providers should coordinate with Aetna Better Health Medical Management to ensure that the appointment times are known and attended by the member.

Member Discharged from Inpatient Psychiatric Facilities

All members receiving inpatient psychiatric services must be scheduled for outpatient follow-up care and/or continuing treatment prior to discharge. The outpatient treatment must occur within 7 days from date of discharge. Aetna Better Health Texas providers will follow up with members within 24 hours to reschedule due to a missed appointment.

Value-added services

A \$25 gift card is available for STAR and CHIP members when they complete a 7-day outpatient follow-up appointment after psychiatric hospitalization.

Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM)

Mental Health Rehabilitative (MHR) and Mental Health Targeted Case Management (TCM) services are available for STAR and STAR Kids members with SPMI or SED. The request for these services must be based on the following standardized assessments and level of care guidelines:

1. The Adult Needs and Strengths Assessment (ANSA)
2. The Child and Adolescent Needs and Strengths Assessment (CANS)
3. Texas Resilience and Recovery Utilization Management Guidelines (TRRUMG)

Providers of MHR and TCM must provide all the services contained in all the levels of care. Employees must be trained and certified to administer the ANSA for adults age 18 and older and the CANS for children/youth age 17 and under.

MHR Services include training and services that help the member maintain independence in the home and community, such as the following:

- Medication training and support – curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- Psychosocial rehabilitative services – social, educational, vocational, behavioral, or cognitive interventions to improve the member’s potential for social relationships, occupational or educational achievement, and living skills development
- Skills training and development – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills

necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers

- Crisis intervention – intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
- Day program for acute needs – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting
- Counseling services (Individual, Group and Family)

TCM Services include:

- Case management for members who have SED (age 3 through 17), which includes routine and intensive case management services
- Case Management for members who have SPMI (adult, 18 and older)

A detailed description of MHR and TCM services, along with limitations, can be reviewed in the most current Texas Medicaid Provider Procedures Manual (TMPPM) - Behavioral Health and Case Management Services Handbook. Aetna Better Health of Texas will authorize MHR and TCM services per TRRUMG. Aetna Better Health is not responsible for providing any service that is not a covered benefit or covering Criminal Justice Agency funded procedure codes with modifier HZ because these services are excluded from the capitation.

Texas Resilience and Recovery Utilization Management Guidelines (TRRUMG) for Adult Mental Health and Child and Adolescent Services can be found at:

[www.dshs.texas.gov/TRR/Utilization Management-\(UM\)-Guidelines-and-Manual.aspx](http://www.dshs.texas.gov/TRR/Utilization-Management-(UM)-Guidelines-and-Manual.aspx).

Texas Health Steps Medical Case Management (Medicaid Only)

Case management services are provided to assist Medicaid-eligible recipients under 21 years of age determined to have special health care needs or are medically complex. Case Managers assist Members in gaining access to necessary medical, social, educational and other services to reduce morbidity and mortality among children, to encourage the use of cost-effective health and health-related care, to make referrals to appropriate providers, and to discourage over utilization or duplication of services. For more information on the THSteps case management services or finding a case manager, please call toll-free **1-877-847-8377 (1-877-THSTEPS)**.

Definition of severe and persistent mental illness (SPMI)

SPMI includes a diagnosis of bipolar disorder, major depression, schizophrenia, or other behavioral health disorder for persons 18 and older, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, accompanied by:

1. Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or
2. Impaired emotional or behavioral functioning that interferes substantially with the Member's

capacity to remain in the community without supportive treatment or services.

Definition of severe emotional disturbance (SED)

SED describes psychiatric disorders in children and adolescents, up to age 18, which cause severe disturbances in behavior, thinking and feeling. This includes a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Substance Use Disorder (SUD)

SUD occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. A diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Member access to and benefits of MHR Services and TCM

For members with severe and persistent mental illness (SPMI) or severe emotional disturbance (SED), Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM) must be available to eligible STAR and STAR+PLUS Members.

Provider Requirements

- Providers must provide a behavioral health diagnosis based on the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Providers of Mental Health Rehabilitation Services and Mental Health Targeted Case Management must attest to Aetna Better Health of Texas that they have the ability to provide either directly or through contract, the full array of services to members.
- Providers must comply with all Health and Human Service Commission (HHSC) procedures related to qualification of mental health personnel and supervisory protocols.
- Providers must have documentation that employees administering the assessment instruments (CANS, ANSA) are currently certified.
- Providers must follow the current Texas Resilience and Recovery Utilization Management Guidelines (TRRUMG) for all behavioral health services requiring prior authorization and concurrent review.

CHIP Member Prescriptions

CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

Quality Management

What is quality?

Quality health care means doing the right thing, at the right time, in the right way, for the right person – and having the best possible results. Although we would like to think that every health plan, doctor, hospital, and other provider gives high quality care, this is not always so. Quality varies for many reasons.

The Quality Improvement Program is tailored to the unique needs of the membership, in terms of age groups, disease categories and special risk status. Aetna Better Health complies with all State and federal requirements regarding Quality Improvement (QI). The QAPI Program is overseen by the governing board and committees whose membership broadly represents the network of participating providers and Members.

Our goals for improvement: (Excerpt: Crossing the Quality Chasm, A New Health System for the 21st Century, Institute of Medicine, 2001, National Academy of Sciences).

- **Safe** – avoiding injuries to patients from the care that is intended to help them.
- **Effective** – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding overuse and underuse)
- **Patient Centered** – providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.
- **Timely** – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

Aetna Better Health achieves these goals by developing evidence about which interventions are most effective, developing quality measures, working with frontline clinicians, health care organizations, health leaders, and through close collaborations with the HHSC Quality Division and the Institute of Child Health Policy.

Fortunately, there are scientific ways to measure health care quality. These tools have mostly been used by health professionals and nationally recognized organizations such as NCQA and AHRQ. They use measures to review and improve the quality of care provided. Quality measurement is a relatively new science and requires a large amount of resources to develop and collect information. Fully developed and tested measures are available for reporting on some of the most common conditions or processes of care.

The Chief Medical Director is directly responsible for the Quality Improvement Program. The QAPI Program is directed by a multidisciplinary committee whose Members bring a diversity of knowledge and skills to the design, oversight, and evaluation of the program.

The QI Committee and other QI sub-committees include input from Members, clinical practitioners

and others who are involved in the provision of care and service to Aetna Better Health Medicaid, CHIP and STAR Kids Members.

All aspects of Member care and satisfaction are important to us. The monitoring and evaluation of clinical care encompass all components of the delivery system and the full range of services. The delivery system includes both individual practitioners and institutional providers. The monitoring and evaluation of services includes availability, accessibility, and acceptability services delivered in the appropriate manner.

Satisfaction with the healthcare experience: Member surveys are conducted annually to further evaluate their experiences with the delivery of care and services. A third party NCQA Certified vendor reports member satisfaction via the CAHPS. Focused groups and Member Advisory Committee is another source of obtaining direct feedback on the experience of care and service. A variety of techniques are used to gather suggestions from Members in order to identify and meet their needs. These may include, but are not limited to:

- Satisfaction surveys;
- Focus groups;
- Member advisory councils;
- Member representation on QI Committees and selected QI Work Teams.

Annually, demographics and health risks of enrolled populations are accessed, and meaningful clinical issues are chosen that reflect the health needs of significant groups within that population. High risk, high volume, problem prone diagnoses, preventive health and acute and chronic conditions are monitored and evaluated.

Continuity and coordination of care is evaluated across health care settings and practitioners. Methods may include medical record review for presence of advance directives, discharge plans and signing of abnormal test results; evaluation of the referral process, case management interventions and systems for tracking and notifying practitioners of abnormal lab/radiology results.

Mechanisms are also in place to identify patterns of under- and over-utilization. Methods may include physician profiles, review of practitioner performance against practice guidelines, trending of complaint data, sentinel events and adverse outcomes and number of Member encounters per Primary Care Provider. Access and availability of care are monitored through appointment availability for preventive care, routine primary and urgent care, 24-hour access, number and geographic distribution of primary care providers and high-volume specialists, and telephone service standards. For more detailed access requirements, please see the Primary Care Provider Responsibilities section of this manual.

Medicaid, CHIP and STAR Kids provider participation in Aetna Better Health and HHSC sponsored training programs, as well as the issues are carefully scrutinized. We work in conjunction with its physician and facility partners to maintain a program of the highest quality. All Aetna Better Health Medicaid, CHIP and STAR Kids network providers are required to comply with our QAPI program requirements.

Aetna Better Health strives to partner with our network providers, informing them of new initiatives and results, continuing to re-evaluate in accordance with the Plan, Do, Study, and Act improvement cycle.

Physicians interested in participating with the Provider/Medical Advisory Committee should contact their Provider Relations Representative and/or the Chief Medical Officer.

Practice Guidelines

Clinical Practice Guidelines summarize evidence-based management and treatment options for specific diseases or conditions. They are based on scientific clinical and expert consensus information from nationally recognized sources and organizations, national disease associations, and peer-reviewed, published literature.

Practice guidelines are developed nationally and adopted locally through Medical Advisory Committees that include practicing physicians who participate in the Plan. This group also suggests topics for guideline development, based on relevance to enrolled membership, with selection of high volume, high risk, problem prone conditions as the priority.

The Aetna Better Health Medicaid, CHIP and STAR Kids programs have adopted the following guidelines:

Alcohol Use:

National Institute on Alcohol Abuse and Alcoholism (NIAAA), Helping Patients Who Drink Too Much, A Clinician's Guide, 2005 Edition. This guideline can be found online at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.html

Addiction:

American Society of Addiction Medicine Behavioral Health Checklist for ASAM Adult Patient Placement Criteria-Second Edition Revised. This guideline can be found online at: <http://www.asam.org/>

Asthma:

National Heart Lung and Blood Institute (NHLBI) Full text and a summary report of the guidelines, along with supporting material and tools can be found at www.nhlbi.nih.gov/guidelines/asthma/

Attention-Deficit/Hyperactivity Disorder:

American Academy of Pediatrics (AAP): Diagnosis, Evaluation and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in Children and Adolescents, October 2011. This guideline can be found online at: <https://pediatrics.aappublications.org/content/128/5/1007.full>
www.cdc.gov/ncbddd/adhd/guidelines.html

Chronic Pain:

2016 CDC Guideline for Prescribing Opioids for Chronic Pain:

www.cdc.gov/drugoverdose/prescribing/guideline.html

Errata: www.cdc.gov/mmwr/volumes/65/wr/mm6511a6.htm?s_cid=mm6511a6_w

Coronary Artery Disease:

- 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease: www.onlinejacc.org/content/60/24/e44
- 2014 Focused Update: 2014 ACC/AHA/AATS/PCNA/SCAI/STS Focused Update of the Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease: www.onlinejacc.org/content/64/18/1929

Diabetes:

- American Diabetes Association (ADA): Standards of Medical Care in Diabetes – 2018: http://care.diabetesjournals.org/content/41/Supplement_1
- Summary of 2018 revisions: http://care.diabetesjournals.org/content/41/Supplement_1/S4
- Treatment of Patients with Major Depressive Disorders: American Psychiatric Association (APA) Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition. You can find the full text of this guideline at <http://psychiatryonline.org/guidelines.aspx>. The intent of the guidelines is to promote a consistent application of evidence-based treatment methodologies to reduce unnecessary practice variation. Guidelines are always included in the development of new interventions and study projects. The guidelines are provided for informational purposes and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of physicians or health care professionals, and these guidelines do not dictate or control the clinical judgment of the health care professionals caring for a Member.

Antibiotic Stewardship:

The Centers for Disease Control (CDC) and the Texas Department of State Health Services (DSHS) provide guidance on antibiotic stewardship located at:

CDC www.cdc.gov/antibiotic-use/community/index.html

DSHS www.dshs.texas.gov/IDCU/health/Antibiotic-Stewardship/AS-Home.doc

Preventive Services Guidelines

It is widely known that providing primary prevention services, such as adult and childhood immunizations, can result in the reduction of the incidence of illness, disease and accidents. Secondary prevention services, such as early detection of potentially serious illnesses, may reduce the impact of the illness on the patient, thereby decreasing the cost of care. Aetna has adopted the

U.S. Preventive Services Task Force Preventive Service Guidelines which can be found at: www.uspreventiveservicestaskforce.org/recommendations.htm.

- Centers for Disease Control and Prevention Immunization Schedules which can be found at: www.cdc.gov/vaccines/schedules/index.html

- National Cancer Institute which can be found at:
www.cancer.gov/cancertopics/factsheet/detection/mammograms

Focus study and utilization management reporting requirements

Aetna Better Health conducts focused studies to look at the quality of care and service to our members. The QAPI Program:

1. Evaluates performance using objective quality indicators, such as HEDIS encounter data
2. Fosters data-driven decision-making
3. Recognizes that opportunities for improvement are unlimited
4. Solicits Member and Provider input on performance and Performance Improvement Projects (PIPs)
5. Evaluates clinical and non-clinical effectiveness through HEDIS rates and Member satisfaction
6. Supports programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements
7. Supports remeasurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate

Along with the QAPI Program, Aetna Better Health develops annually a QM Work Plan to track and trend progress throughout the year.

Aetna Better Health works collaboratively with HHSC's External Quality Review Organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. Mid-year evaluations allow both the EQRO and the Health Plan to gauge progress with the Performance Improvement Projects (PIP) and hear recommendations for improvement. The purpose of the health care PIPs is to assess and improve processes, and thereby outcomes of care. For such projects to achieve real improvement in care, and for interested parties to have confidence in the reported improvements, PIPs are designed, conducted, and reported in a methodologically and systematically sound manner.

PIPs are reported in a format that demonstrates the relevance of the activity, validity of the study design, quantitative and qualitative analysis of results, barrier analysis, determination of opportunity for improvement, and strength of interventions.

Aetna Better Health Provider contracts require cooperation with the QAPI efforts. We routinely update providers on the QAPI program and PIP results/interventions as well as make information available to providers upon requests and when the Medical Directors and QM Staff visit providers' offices.

STAR Kids Quality

Providers must submit:

- Quarterly, submit the number of critical incident and abuse report for members receiving LTSS
- Quarterly, submit the number of Aetna Better Health service coordinators receiving CDS training

Provider Responsibilities

Primary Care Provider (Medical Home) responsibilities

A medical home is an approach to providing comprehensive primary care and is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally sensitive. In a medical home, the Primary Care Provider works in partnership with the Member and the Member's family to assure that all the medical and non-medical needs of the Member are met. Through this partnership, the Primary Care Provider can help access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the Member.

Practitioners from any of the following practice areas may act as primary care providers for Aetna Better Health Medicaid, CHIP and STAR Kids Members: general practice, family practice; internal medicine; pediatrics; obstetrics/gynecology (Ob/Gyn); certified nurse midwives (CNM), pediatric and family advanced practice nurses and physician assistants (PA) practicing under the supervision of a physician, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) or similar community clinics; and, with approval by the Aetna Better Health Medical Director, specialists who are willing to provide the primary care services for selected Members who are chronically ill, medically complex or have other special health care needs.

The primary care provider has the following responsibilities:

- Provide for access to medical care 24 hours a day, 7 days a week
- Provide all age appropriate primary care covered services within the scope of the physician's practice, including appropriate health education and instructions to the Member, or if the Member is a child or other dependent, to family members or primary caregivers.
 - For Members under the age of 21, the Primary Care Provider will provide well child health checkups in accordance with the American Academy of Pediatric recommendations for CHIP members and Texas Health Steps checkups in accordance with the STAR members.
 - For Members under the age of 21, the Primary Care Provider must either be enrolled as a Texas Health Steps provider or refer Members due for a Texas Health Steps checkup to a Texas Health Steps provider
 - For adult Members over the age of 21, the Primary Care Provider provides adult health care oversight and appropriate care according to the U.S. Preventive Services Task Force.
- Provide or arrange for the provision of services to Members assigned to their panel. Covered services are detailed in the current year Texas Medicaid Provider Procedures Manual at www.tmhp.com and summarized under the "Covered Services" in this manual.
- Refer to Aetna Better Health participating specialists and other providers when services are indicated.
- Seek prior authorization from Aetna Better Health when referring to nonparticipating providers.
- Initiate the request for authorization for services that require prior approval.
- Facilitate ongoing communication between the primary care provider and specialty care providers while the member is undergoing specialty care. Assure appropriate

transfer of medical information between the primary care providers, specialty care providers, and ancillary care providers.

- Recognize the role that the family members have as primary caregivers for children and other dependents and ensure their participation in decision making.
- Assure integration of member's medical home needs with home and community support services.
- Provide information concerning appropriate support services (for example, WIC, ECI, etc.) within the community. In the case of children with Texas Health Steps benefits, include coordination with existing State agency approved providers and/or case managers within ECI, DARS, TCB, and the DSHS targeted case management program for high risk pregnant women and infants, where appropriate.
- Coordinate care for hospitalized members
 - Assure that pre-admission planning occurs for the member in all non-emergency hospital admissions.
 - Assure that discharge planning is conducted for each admitted member.
 - Assure that the home and community arrangements are available prior to the hospital discharge of the member
 - Assist in the development of alternatives to hospitalization when medically appropriate.
- Provide timely follow-up after emergency care or hospitalization.
- Comply with requirements as outlined as the Primary Care Provider, you must provide telephone access to members 24 hours a day, 7 days a week.

Availability and accessibility

Primary Care Providers provide covered services in their offices during normal business hours and are available and accessible to Members, including telephone access, 24 hours a day, 7 days a week, to advise Members requiring urgent or emergency services. If the Primary Care Provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating physicians must be arranged. If a member is referred to another Primary Care Provider who is not on record as a covering provider, a referral must be submitted to the Aetna Better Health Prior Authorization unit to prevent a delay in payment.

24-Hour Accessibility

You must provide telephone access to members 24 hours a day, 7 days a week .

After-hours access

The following are acceptable and unacceptable phone arrangements for contacting primary care physicians after normal business hours.

Acceptable:

1. 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 Primary Care Provider or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes.
2. Office phone is answered after normal business hours by a recording in English, Spanish and other languages of the major population groups served, directing the

Medical to call another number to reach the Primary Care Provider or another designated provider. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.

3. Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the Primary Care Provider or another designated medical practitioner.

Unacceptable:

1. Office phone is only answered during office hours.
2. Office phone is answered after hours by a recording, which tells the patients to leave a message.
3. Office phone is answered after hours by a recording which directs patients to go to an emergency room for any services needed.
4. Returning after-hour calls outside of 30 minutes.

Appointment Availability

Providers are expected to adhere to the following appointment availability standards

Level of Care	Waiting Times for Appointments
Emergency Services	Upon Member presentation at the service delivery site
Urgent Care (Medical and Behavioral	Within 24 hours of request
Routine Medical Care	Within 14 days of request
Routine Behavioral Health Care	Within 14 days of request
Members under the age of 21, including Texas Health Steps services	Steps Periodicity Schedule and the American Academy of Pediatrics guidelines, but in no case later than 60 days from date of request. For newly enrolled members, appointments must be offered within <ul style="list-style-type: none"> • 14 days of enrollment for newborns; • 90 days for all others
Adult Preventive Health	Within 90 days of request
Preventive Health Physicals/Well-child checkups for Members over the age of 21	Within 14 days of request. For high-risk pregnancies or new Members in the third trimester, appointments should be offered
Pediatric Preventive Health Physicals/Well-child checkups for Members under the age of 21	As soon as possible for members that are due overdue for services in accordance the Texas Health.

For high-risk pregnancies or new Members in the third trimester, appointments should be offered immediately, but no later than 5 days of request.

Updates to contact information

Network providers must inform Aetna Better Health and HHSC's administrative services contractor of any changes to your address, telephone number, group affiliation and/or any other relevant contact information for the purposes of:

- The production of an accurate provider directory

- The support of an accurate online provider lookup function
- The ability to contact you or your office with requests for additional information for prior authorization or other medical purposes, or on behalf of a member's PCP
- The guarantee of accurate claim payment delivery information

Availity Provider Portal

- <https://apps.availity.com/availity/web/public.elegant.login> or call **1-800-282-4548**

Provider Services Call Center

- Medicaid STAR **1-800-248-7767** (Bexar)
- Medicaid STAR **1-800-306-8612** (Tarrant)
- Medicaid STAR Kids **1-844-STRKIDS (1-844-787-5437) (Tarrant)**
- **Medicaid STAR Kids**
- CHIP or CHIP Perinate **1-866-818-0959** (Bexar), **1-800-245-5380** (Tarrant)
- **TXProviderEnrollment@AETNA.com**

Plan termination

Physicians and other providers must inform Aetna Better Health in writing of their intent to terminate their participation with us at least 90 days prior to termination from the plan. This information can be sent to:

Aetna Better Health of Texas
 Provider Relations
 P. O. Box 818042
 Cleveland, OH 44181-8042

Fax: **1-866-510-3710**

Within 15 calendar days after receipt or issuance of a termination notification, we will notify 1) all members in a PCP's panel and 2) all members who have had two or more visits with the Network Provider for home-based or office-based care in the past 12 months and assist them in selecting new providers or coordinate the transition of care.

Member's right to designate an OB/GYN as their Primary Care Provider

Aetna Better Health allows the member to pick any OB/Gyn, whether that doctor is in the same network as the member's Primary Care Provider or not.

Attention Female Members

Members have the right to pick an OB/Gyn without a referral from their Primary Care Provider. An OB/Gyn can give the member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

Right to designate a Specialist as their Primary Care Provider

Members with disabilities, special health care needs, and or Chronic or Complex conditions, have the right to designate a specialist as their Primary Care Provider if the specialist agrees.

Right to select and have access to a Network ophthalmologist or therapeutic optometrist

Aetna Better Health allows member's the right to select and have access to, without a Primary Care Provider referral, a network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery.

What if I choose to go to another doctor who is not my/my child's primary care provider? You can see any doctor or clinic in our network to get services for routine medical care that we cover or approve. This includes Texas Health Steps and well-child exams. You do not need a referral from your primary care provider. The doctor or clinic needs to be listed in our provider directory.

Member's right to obtain medication from any Network pharmacy

All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

Member information on Advance Directives

The Patient Self-Determination Act is a federal law designed to raise public awareness of Advance Directives. An Advance Directive is a written statement, completed in advance of a serious illness, about how one would want medical decisions made if he/she is incapable of making them. The two most common forms of Advance Directives are the Living Will and the Durable Power of Attorney for Health Care.

The Social Security Act Section 1902(a)(57) and Section 1903 (m)(1)(A) requires HMOs and providers to maintain written policies for informing and providing written information to all adult Members about their rights under State and Federal law, in advance of their receiving care. These policies must contain procedures for providing written information regarding the Member's right to refuse, withhold or withdraw medical treatment in advance.

In addition to State laws and rules, Aetna Better Health Medicaid, CHIP and STAR Kids policies and procedures must comply with provisions contained in 42 CFR Section 434.28 and 42 CFR Section 489, Sub Part I, relating to Advance Directives for all hospitals, critical access hospitals, skilled nursing facilities, home health agencies, providers of home health care, providers of personal care services and hospices.

We will assist the provider in understanding the requirements for Advance Directives and how to follow the laws and rules written for such a purpose. Aetna Better Health Advance Directive policies address:

- The Member's right to self-determination in making health care decisions;
- The Member's right under the Natural Death Act (Texas Health and Safety Code Chapter 672) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life sustaining procedures in the event of a terminal condition;
- The Member's right under Texas Health and Safety Code, Chapter 674, relating to

written and non-written Out-of-Hospital Do-Not-Resuscitate Orders;

- The member's right to execute a Durable Power of Attorney for Health Care regarding their right to appoint an agent to make medical treatment decisions on their behalf if the member becomes incapacitated (Civil Practice and Remedies Code, Chapter 135) and procedures for implementing a member's Advance Directives, including a clear and concise statement of limitations if the HMO or a participating provider cannot or will not be able to carry out a member's Advance Directive.

Aetna Better Health encourages you to discuss Advance Directives with your patients. The Advance Directive Notification should be completed by the patient and returned to the primary care physician so that it may be placed in their medical record. During the credentialing and recredentialing processes, we check for Advance Directives when reviewing medical records of members over the age of 18 years old.

Referral to specialists and health-related services

We are committed to promoting the "medical home" and expect participating primary care providers to direct their patient's care, including referring members to specialists as needed. A referral is a primary care provider's request that a member's covered services be provided by another participating provider. Because the Primary Care Provider is responsible for coordinating his/her patient's health care, the Primary Care Provider must authorize a referral prior to the visit to a specialist.

The exceptions to the Primary Care Provider referral authorizations are:

- Services the member may access directly without a referral, such as obstetrical care of behavioral health services. Services that require prior authorization by the health plan (refer to Medical Management section and current Prior Authorization list)

The Primary Care Provider may authorize a referral to an in-network specialist by completing the Texas Referral/Authorization Form or any other mutually agreed upon format. The referral must include all

pertinent clinical information necessary to provide continuity of care and reduce unnecessary duplication of services, such as test results and consultation reports. The referral does not need to specify the services to be performed by the specialist. Services performed in a specialist's office that are integral to the evaluation of the problem that led to the referral to the specialist are included in the scope of the referral and will be reimbursed according to the standard claim processing guidelines. It is the provider's responsibility to verify the member's eligibility and benefits prior to rendering services. It is not necessary for providers to verify authorization for services that are not included on the Aetna Better Health Prior Authorization List. To encourage communication from the specialist to the Primary Care Provider, it is recommended that the initial consultative referral be authorized for one visit. Following an initial consultation, the specialist should communicate with the referring Primary Care Provider in a timely fashion to develop an appropriate course of treatment (for example, referrals for additional services and/or follow-up care, if needed). It is recommended that referrals for additional visits be for no more than three (3) visits and/or 90 days to ensure the Primary Care Provider and specialist communicate frequently regarding the health services provided to each member.

Additional referrals may be required if the specialist:

- Wishes to provide additional services other than the outpatient laboratory or diagnostic imaging

- Refers the member to another specialist for services and procedures that are not included in the referral requires additional visits or an extension of the timeframe authorized by the Primary Care Provider.
- Coordination of care is vital to assuring Member's receive appropriate and timely care. Relevant communication between specialist and the Primary Care Provider should be maintained in both provider's files for the member. Aetna Better Health monitors coordination of care as part of its ongoing quality and utilization management reviews.

Prior authorization is required for certain specialty types (primarily those for which there are limited benefits) and selected procedures. When prior authorization is required, the Primary Care Provider must submit the Texas Referral/Authorization form and all pertinent clinical information that supports the medical necessity of the requested services to the Aetna Better Health Prior Authorization unit for approval. The list of services requiring prior authorization by Aetna Better Health is regularly updated and posted on [AetnaBetterHealth.com/Texas](https://www.aetnabetterhealth.com/Texas).

Please refer to the Medical Management Section of this manual for information about the prior authorization.

How to Help a Member Find Dental Care

The Dental Plan Member ID card lists the name and phone number of a member's Main Dental Home provider. The member can contact the dental plan to select a different Main Dental Home provider at any time. If the member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within 5 business days.

If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can contact the Medicaid/CHIP Enrollment Broker's toll-free telephone number at **1-800-964-2777**.

PCP and behavioral health

Members seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. PCPs are encouraged to treat behavioral health issues that are within their scope of practice and refer members to behavioral health providers when appropriate.

Referral to network facilities and contractors

Quest Labs and Lab Corp are both In Network. Quest and Lab Corp have various draw sites and the member can go the nearest draw site for services.

Access to second opinion

Aetna Better Health allows members access to a second opinion at no additional cost to the member.

Specialty care provider responsibilities

Care by specialists will be provided after a referral has been made by the member's Primary Care Provider. It is the responsibility of the specialist's office to ensure that the member has a valid referral prior to rendering services. Aetna Better Health Medicaid, CHIP and STAR Kids network specialists must:

- Be licensed to practice in the State of Texas.
- Have admitting privileges at an Aetna Better Health participating hospital.
- Obtain a referral from the member's Primary Care Provider. Or, for services on the prior authorization list, approval from the Aetna Better Health Medical Management Department before rendering services.
- Assure that the consultation report and recommendations are sent to the Primary Care Provider and communicate with the Primary Care Provider regarding the Member's status and course of treatment.
- Inform the member and/or family of the diagnostic, treatment and follow-up recommendations in consultation with the Primary Care Provider (if appropriate).
- Provide members/families with appropriate health education in the management of the Member's special needs.

Specialists as primary care provider

A specialty physician may assume the responsibilities of a primary care provider as a primary care provider under specific circumstances, such as in the case of a member with a disability or chronic/complex condition. By allowing a specialist to act as a primary care provider, Members can draw upon the most appropriate care to meet their needs. In this capacity, the specialist is required to fulfill all the responsibilities of a primary care provider.

Specialists who would like to be the Primary Care Provider for an Aetna Better Health Medicaid or CHIP member should contact the Medical Management Department for further information and to complete the request form. A determination will be made within 30 calendar days from the date the request is received. Member and provider requests for a specialist to be a primary care provider will be reviewed by Medical Director and approved if the specialist agrees to coordinate all the member's care and meets other criteria for participation as a primary care provider. The effective date of the designation of the specialist as the primary care provider may not be applied retroactively.

If this request is denied, an enrollee may appeal the decision through the HMO's established complaint and appeal process. Please refer to the complaint and appeal section for more information. If the request for special consideration of a non-primary care physician specialist to act as a primary care physician is approved, the HMO may not reduce the amount of compensation owed to the original primary care physician for services provided before the date of new designation.

If medically necessary covered services are not available through network physicians or providers, the HMO on request of a network physician or provider and within a reasonable time shall allow referral to a non-network physician or provider and fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate. "Within a reasonable time" means with the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation. An HMO must provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral.

Accessibility and availability standards

Providers are expected to adhere to the following appointment and availability standards:

Level of care	Waiting times for appointments
Emergency Services	Upon member presentation at the service delivery site
Urgent Care Appointments	Within 24 hours of request
Routine Specialty Care - Medical	Within 14 days of request
Routine Specialty Care – Behavioral Health	Within 14 days of request
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.

Verify Member eligibility or authorizations for service

All members have an Aetna Better Health Medicaid or CHIP ID card. Eligibility should be verified prior to rendering services via:

- Utilizing our website at **[AetnaBetterHealth.com/Texas](https://www.aetna.com/betterhealth/texas)**
- Contacting Aetna Better Health at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

All Members must be referred by their Primary Care Provider for specialist services other than for behavioral health, Ob/Gyn, vision services, or plan specific benefits (for example, ECI, family planning, etc.).

When an Aetna Better Health Medicaid or CHIP Member presents for services:

- Confirm Member eligibility with Aetna Better Health at **[AetnaBetterHealth.com/Texas](https://www.aetna.com/betterhealth/texas)**.
- Contacting Aetna Better Health at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).
- Upon arrival for their appointment, verify the Aetna Better Health Medicaid and their Your Texas Benefits Medicaid Card.
- If a CHIP Member, ask him/her to present his/her Aetna Better Health CHIP ID card.

Continuity of Care

Pregnant Women

Aetna Better Health allows pregnant members past the 24th week of pregnancy to remain under the care of their current Ob/Gyn through the member’s postpartum checkup, even if the provider is out of-network. She may select an Ob/Gyn within the network if she chooses to do so and if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

Member moves out-of-service area

Members who move out of the service area are responsible for obtaining a copy of their medical records from their current primary care provider to provide to their new primary care provider. Participating providers must furnish members with copies of their medical records.

Pre-existing condition

Aetna Better Health does not have a pre-existing condition limitation. We are responsible for providing all covered services to each eligible member beginning on the member's date of enrollment into the Aetna Better Health Medicaid or CHIP programs, regardless of any pre-existing conditions, prior diagnosis and/or receipt of any prior health services.

Coverage will be authorized for care being provided by nonparticipating providers to members who are in an "active course of treatment" at the time of enrollment until the member's records, clinical information and care can be transferred to a network provider or until such time the member is no longer enrolled in the plan. Coverage will be provided until the active course of treatment has been completed or 90 days, whichever is shorter.

Out-of-network care will be coordinated for members who have been diagnosed and are receiving treatment for a terminal illness at the time of enrollment for up to nine months or until they are no longer enrolled in the plan.

"Active Course of Treatment" is defined as:

- A planned program of services rendered by a physician, behavioral health provider or DME provider
- Starts on the date a provider first renders a service to correct or treat the diagnosed condition, and
- Covers a defined number of services or period of treatment
- Allowing a pregnant woman to remain under the member's current OB/Gyn care through the Member's post- partum checkup even if the OB/Gyn provider is, or becomes, out-of-network

In order to provide transitional coverage for the nonparticipating provider, the following conditions must be met. The member must:

- Be enrolling as a new member, and receiving ongoing treatment for a chronic or acute medical condition from a nonparticipating provider
- Have initiated an "active course of treatment" prior to the initial enrollment date.

If services are received prior to the approval of transition of benefits, the services must be approved by the Medical Director for coverage to be extended at the new Plan level. The Aetna Better Health Medical Management department will coordinate all necessary referrals, or any other authorizations so that the continuity of care is not disrupted.

In order for a nonparticipating provider to continue treating Plan Members during a transition period, the provider must agree to:

- Continue to provide the Members' treatment and follow-up
- Accept Plan rates and/or fee schedules
- Share information regarding the treatment plan with the Plan
- Use the Plan network for any necessary referrals, lab work or hospitalizations.

Any exceptions will be reviewed on a case-by-case basis by the Medical Management staff in consultation with the Medical Director. All requests that do not meet the conditions for continuity of care will be forwarded to the Medical Director who will review the request on a priority basis.

Medical record standards

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals agree to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services.

Medical Record Criteria has been established to provide guidelines for fundamental elements of organization, documentation of diagnostic procedures, treatment, communication and storage of medical records.

Performance goals related to the quality of medical record keeping practices are established and distributed on an annual basis. A copy of the established standards for medical record criteria is included in Appendix D.

Aetna Better Health shall have access to medical records, including confidential Aetna Better Health patient information, for the purpose of claims payment, assessing quality of care, including medical evaluations and audits, and performing utilization management functions. HIPAA Privacy Regulations allow for sharing of personal health information with Aetna Better Health for the purposes of making decisions around treatment, payment or health plan operations. Personal health information must be treated as confidential in accordance with the Aetna Better Health provider agreement. Personal Health Information identifies a member; specifies the relationship of the member with Aetna Better Health, addresses physical or behavioral health status or condition; and specifies payment for the provision of health care to the member. These requirements survive the termination of the provider's contract, regardless of the cause for termination.

As part of the agreement to participate in Texas Medicaid, CHIP and STAR Kids, the Aetna Better Health Medicaid and/or CHIP network provider agrees to provide HHSC:

1. All information required under the Aetna Better Health provider agreement, including but not limited to the reporting requirements and other information related to the Network provider's performance of its obligations under the contract.
2. Any information in its possession enough to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.

All information must be provided in accordance with the timelines, definitions, formats and instructions specified by HHSC. The Aetna Better Health Medicaid or CHIP network provider shall not transfer an identifiable member record, including a patient record, to another entity or person without written consent from the member or someone authorized to act on his or her behalf; however, the Provider understands and agrees that HHSC may ask to transfer a member record to another agency if HHSC determines that the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the member.

Reporting Abuse, Neglect, or Exploitation (ANE)

Medicaid Managed Care Report suspected Abuse, Neglect, and Exploitation:

Aetna Better Health of Texas and providers must report any allegation or suspicion of ANE that occurs

within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include Aetna Better Health of Texas and provider responsibilities related to identification and reporting of ANE. Additional state laws related to Aetna Better Health of Texas and provider requirements continue to apply.

Report to Health and Human Services (HHS) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and HHS;
- Adult day care centers; or
- Licensed adult foster care providers

Contact HHS at **1-800-458-9858**.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS;
 - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
 - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
 - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
 - a managed care organization;
 - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above;
- An adult with a disability receiving services through the Consumer Directed Services option
- Contact DFPS at **1-800-252-5400** or, in non-emergency situations, online at www.txabusehotline.org.

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code,

Section 261.109).

- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Provide Aetna Better Health with a copy of the abuse, neglect, and exploitation report

The Provider must provide the Aetna Better Health with a copy of the abuse, neglect, and exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Justification regarding Out-of-Network referrals

If a required service is not available within the Aetna Better Health Medicaid or CHIP network, the Member's primary care provider may request an out-of-network referral. However, the primary care provider must obtain authorization from the Aetna Better Health Medical Management Department.

The steps for an out-of-network referral are as follows:

1. The member's Primary Care Provider must complete a referral request and specify the services required of the out-of-network provider including the rationale for requesting out-of-network services.
2. The Primary Care Provider can call Medical Management or fax the referral form and all pertinent clinical information to the Aetna Better Health Medical Management Department by calling **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) or faxing **1-866-835-9589** to obtain authorization.
3. The Primary Care Provider will provide authorization information to the specialist.
4. The out-of-network referral is valid for 90 days for a maximum of three visits unless otherwise authorized by the Medical Management Department. A new authorization must be obtained if the original authorization is over 60 days old or if more than two visits are required, unless additional visits have been authorized.
5. Medical Management Department.

Community First Choice:

Program Provider Responsibilities

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must have current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
- The HCS or TxHmL program provider must ensure that the rights of the members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).

- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the member that are required to ensure the member's health, safety, and welfare. The program provider must maintain documentation of this training in the member's record.

The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline. **(1-800-647-7418)**.

- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the member/LAR of CFC PAS or habilitation (HAB) service provider is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the Aetna Better Health of Texas financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

Long-Term Services and Supports Provider Responsibilities

Responsibility to contact Health Plan to verify Member eligibility or authorizations for service

All Members are issued an Aetna Better Health STAR Kids ID card (samples in Appendix A) at the time of enrollment with us. Eligibility should be verified prior to rendering services through the following resources:

- Utilize the Aetna Better Health of Texas website at **AetnaBetterHealth.com/Texas**
- Enter Medicaid ID number at the new, secure Medicaid eligibility verification website, **www.YourTexasBenefitsCard.com**.
- Visit TexMedConnect on the Texas Medicaid & Healthcare Partnership (TMHP) website.
- Call the TMHP Contact Center at **1-800-925-9126**
- Call Automated Inquiry System (AIS) at **1-800-925-9126**
- Through the monthly enrollment panel provided by Aetna Better Health
- Contact Aetna Better Health of Texas at **1-844-787-5437**

Once the Aetna Better Health STAR Kids Member presents for Services:

- Confirm the patient is an Aetna Better Health STAR Kids Member.
- Upon arrival for their appointment, ask the Member to show their Aetna Better Health Medicaid ID card.
- Verify Member eligibility with Aetna Better Health through the monthly enrollment panel provided by Aetna Better Health, use of the Aetna Better Health website (**AetnaBetterHealth.com/Texas**) to verify eligibility.

To ensure minimal impact to established member/provider relationships, existing treatment protocols, and ongoing care plans Aetna Better Health will work with providers to ensure a seamless as possible for Members and their Providers.

Continuity of Care

Care provided to a Member by the same Primary Care physician or specialty provider to ensure that the delivery of care to the Member remains stable, and services are consistent and unduplicated.

Coordination of Benefits with Primary Health Insurance Coverage

Certain members with complex medical needs must remain under care of a Medicaid specialty provider, even if out-of-network.

Aetna Better Health allows a member age 20 or younger, who at the time of the member's enrollment into the Health plan has complex medical needs and, has and maintains healthcare coverage under a primary private insurance plan, to remain under the care of a Medicaid enrolled specialty provider with which the member is receiving care through the primary private insurance plan, even if the specialty provider is an out-of-network provider.

Medicare/Medicaid Coordination

Some Medicaid clients are also covered by Medicare and Medicare Advantage Plans (MAP). Medicaid claims for these clients may be reimbursed after the Medicare or MAP portion is paid.

Notification to Aetna Better Health of Texas of change in Member's physical condition or eligibility

The State or its designee will make eligibility determinations for each of the HHSC Aetna Better Health of Texas programs. The HHSC Administrative Services Contractor will electronically transmit to the Aetna Better Health of Texas new member information and change information applicable to active members.

Community First Choice:

Provider Responsibilities

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must maintain current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
- The HCS or TxHmL program provider must ensure that the rights of the members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the member that are required to ensure the member's health, safety, and welfare. The program provider must maintain documentation of this training in the member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline. **(1-800-647-7418)**.
- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider
- Must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training

- requested by the member/LAR of CFC PAS or habilitation (HAB) service provider is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
 - The program provider must adhere to the Aetna Better Health of Texas financial accountability standards.
 - The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
 - The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

Employment Assistance Responsibilities

Only available through the Consumer Directive Services option - Department of Aging and Disability services (DADs). Providers must develop and update quarterly a plan for delivering employment assistance services.

Supported Employment Responsibilities

Forms issued by Department of Aging and Disability Services (DADs) staff, as well as Home Community-based Services (HCS) and Texas Home Living (TxHmL) waiver program providers to document a service claim for the Supported Employment service component. Providers must develop and update quarterly a plan for delivering supported employment services.

Copy of the abuse, neglect, and exploitation report

The Provider must provide Aetna Better Health with a copy of the abuse, neglect, and exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Pharmacy Provider Responsibilities

Adhere to the Formulary

The Texas Drug Code Formulary is at www.txvendordrug.com which covers more than 32,000 line items of drugs including single source and multi-source (generic) products. You can check to see if a medication is on the state's formulary list. Remember before prescribing these medications to your patient that it may require prior authorization. If you want to request a drug to be added to the formulary, please contact an Aetna Provider Relations Representative for assistance. You may check for drug coverage at www.txvendordrug.com addresses line 294-295.

Adhere to the Preferred Drug List (PDL)

The prescribing provider should adhere to the Preferred Drug List (PDL) Texas Medicaid maintains a Preferred Drug List comprised of various therapeutic classes. You can find out if a medication is on the preferred drug list. All preferred drugs are available without prior authorization (PA). Check the list of covered drugs at www.txvendordrug.com. Prescribers are expected to adhere to the Texas Medicaid Preferred Drug List. Not doing so can cause a delay in your patient receiving their medication.

Coordinate with the prescribing physician

The pharmacy will coordinate members prescriptions with you should the pharmacy encounter any rejects for prescribing non-preferred drugs.

Ensure members receive all medications for which they are eligible

The pharmacy will also ensure the member receives all eligible prescriptions. The pharmacy will also be able to coordinate those members having other benefits such as Medicare Part D or other insurance plans.

Coordination with Texas Department of Family and Protective Service (DFPS) Prescribing provider must coordinate with DFPS and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS and must respond to requests from DFPS, including:

- Providing medical records
- Recognition of abuse and neglect, and appropriate referral to DFPS

Routine, Urgent, and Emergency Services

Definition of Routine Care

“Routine Services” are defined as covered preventive and medically necessary health care services, which are non-emergent or non-urgent. The Member’s Primary Care Provider should perform all routine services that are within the scope of practice for his or her specialty.

Definition of Urgent Care

An “urgent” condition is defined as a health condition which is not an emergency but is severe or painful enough to cause a prudent layperson possessing the average knowledge of medicine to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours to prevent serious deterioration to his or her condition or health.

The Member may need urgent medical care while away from home. If so, the Member should call the Primary Care Provider before seeking medical care. It is the Primary Care Provider’s responsibility to decide if the Member needs any medical care services before returning home. If the Primary Care Provider agrees that the Member needs urgent care, the Primary Care Provider will approve the care. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility.

Certain conditions, such as severe vomiting, earaches, sore throats or fever are considered “urgent” outside the Aetna Better Health of Texas service areas and are covered in any of the above settings. Preventive care services and other routine treatment for conditions such as minor colds and flu are not covered outside the Aetna Better Health service areas.

Emergency Care

Emergency care is covered 24 hours a day, 7 days a week, anywhere in the United States. The Member’s Primary Care Provider or the admitting hospital must call the Aetna Better Health Medical Management Department to provide notification of any emergency hospital admission for an Aetna Better Health of Texas STAR Kids member. Aetna Better Health of Texas must be notified within 24 hours of admission or by the next working day.

Once the attending physician determines the member is stable, post-stabilization care should be coordinated by the Primary Care Provider. The Primary Care Provider should record all pertinent information regarding the emergency room and post stabilization services in the patient's chart.

Definition of Emergency Care - Medicaid

"Emergency Medical" conditions are medical conditions manifesting themselves by acute symptoms of recent onset and enough 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 could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus or unborn child.
- Emergency Behavioral Health services

Requirements for Scheduling Appointments

Follow-up care with nonparticipating physicians or health care professionals is covered only with prior authorization from Aetna Better Health of Texas. Whether treated inside or outside the Aetna Better Health of Texas service areas, the member must obtain a referral before any out of network follow-up care can be covered. Examples of follow-up care include cast removal, x-rays and clinic or emergency room revisits.

Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information: Pharmacy transmits claim as they would any other prescription and will receive a message that a prior authorization is required. The pharmacy will also receive a message to dispense a 72-hour emergency prescription supply if provider is not available for a prior authorization.

Call **1-844-787-5437** for more information about the 72-hour emergency prescription supply policy.

Emergency Transportation

When the Member's condition is life-threatening and trained attendants must use special equipment, life support systems or close monitoring while enroute to the nearest appropriate facility, the

ambulance transport is deemed an emergency service.

Non-Emergency Medical Transportation

When a Member has a medical problem requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance service requires prior authorization and coordination by Aetna Better Health of Texas.

Non-Medical Transportation Program

Non-emergency transport service for an Aetna Better Health of Texas STAR Kids member with severe disabilities must be to or from a scheduled medical appointment. The Non-emergency ambulance transport services provides transportation services to Medicaid eligible clients who have no other means of transportation by the most cost-effective means. To arrange for services contact Access2Care at **1-866-411-8920**.

Emergency Dental Services

Medicaid Emergency Dental Services:

Aetna Better Health is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- Treatment of oral abscess of tooth or gum origin.

CHIP Emergency Dental Services:

Aetna Better Health is responsible for emergency dental services provided to CHIP members and CHIP Perinate Newborn members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- Treatment of oral abscess of tooth or gum origin.

Non-emergency Dental Services

Medicaid Non-emergency Dental Services:

Aetna Better Health is **not responsible** for paying for routine dental services provided to Medicaid Members. These services are paid through Dental Managed Care Organizations.

Aetna Better Health is **responsible** for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members aged 6 through 35 months.

Billing guidelines:

- In conjunction with a Texas Health Steps medical checkup, utilize CPT code 99429 with U5 modifier.
- Must be billed with one of the following medical checkup codes:
 - 99381
 - 99382
 - 99391
 - 99392
- Reimbursed at \$34.16 in addition to the Texas Health Steps checkup reimbursement.

Federally qualified health centers and Rural Health Centers do not receive additional encounter reimbursement. OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.

Documentation Criteria

- Must document all components of OEFV on the documentation form provided during the training.
- Keep record of the referral to a dental home.
- OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.
- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist Members with establishing a Main Dental Home and document Member's Main Dental Home choice in the Members' file.
- Texas Health Steps providers must assist Members with establishing a Main Dental Home (see Attachment D) and document Member's Main Dental Home choice in the Members' file.

CHIP Non-emergency Dental Services:

Aetna Better Health **is not responsible** for paying for routine dental services provided to CHIP and CHIP Perinate Members. These services are paid through Dental Managed Care Organizations.

Aetna Better Health **is responsible** for paying for treatment and devices for craniofacial anomalies.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Aetna Better Health reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children (birth through age 20), Aetna Better Health of Texas also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products. To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must Aetna Better Health of Texas 's enrollment process and claims submission process.

Call **1-844-787-5437** for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

MDCP/DBMD Escalation Help Line

What is the MDCP/DBMD escalation help line?

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about State Fair Hearings and continuing services during the appeal process.

When should Members call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call **844-999-9543** and they will work to connect you with the right people.

Is the escalation help line the same as the HHS Office of the Ombudsman?

No. The MDCP/DBMD Escalation Help Line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at **866-566-8989**, or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized representatives, or your legal representative can call.

Can members call any time?

The escalation help line is available Monday through Friday from 8 a.m.–8 p. After these hours, please leave a message and one of our trained on-call staff will call you back.

Electronic Visit Verification

What is EVV?

- Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.
- EVV is a method by which a person, including but not limited to a personal care attendant, who enters a STAR+PLUS, STAR Kids, Medicare-Medicaid Plan (MMP), or Community First Choice Member's home to provide a service will document their arrival time, services and departure time using a telephonic application system. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to the Aetna Better Health for targeted EVV services.

Do providers have a choice of EVV vendors?

- Provider selection of EVV vendor
 - During the contracting and credentialing process with an Aetna Better Health of Texas, a copy of the Provider Electronic Visit Verification Vendor System Selection form should be provided in the application packet. A provider is

required to use a HHSC-approved EVV vendor as listed on the selection form and select “Initial Selection”. Forms are located at

[AetnaBetterHealth.com/Texas](https://www.aetna.com/betterhealth/texas).

- Provider EVV default process for non-selection
 - Mandated providers that do not make an EVV vendor selection or who do not implement use of their selected vendor, are subject to contract actions and/or will be defaulted to a selected vendor by HHSC. The provider will receive a default letter detailing out the vendor that they have been defaulted to and when they are required to be implemented with the vendor.
- When can a provider change EVV vendors?
 - A provider may change EVV vendors 120 days after the submission date of the change request.
 - A provider may change EVV vendors only twice in the life of their contract with Aetna Better Health of Texas. There are only two vendors.
 - A provider will submit an updated copy of the Provider Electronic Visit Verification Vendor System Selection form and select “Vendor Change” when requesting a change to another EVV Vendor.

Can a provider elect not to use EVV?

All Medicaid-enrolled service providers (provider agencies) who provide STAR+PLUS, STAR Kids, Medicaid and Medicare Program (MMP) and CFC services that are subject to EVV are required to use a HHSC approved EVV system to record on-site visitation with the individual/member. Those services include:

- Personal assistance services (PAS)
- In-Home Respite
- Community First Choice – PAS/Habilitation
- Flexible family support services (for STAR Kids only)

Is EVV required for CDS employers?

No. CDS Employers have the option to choose from the following 3 options:

- a) **Phone and Computer (Full Participation):** The telephone portion of EVV will be used by your Consumer Directed Services (CDS) Employee(s) and you will use the computer portion of the system to perform visit maintenance.
- b) **Phone Only (Partial Participation):** This option is available to CDS Employers who can participate in EVV but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS Employee will call-in when they start work and call-out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.
- c) **No EVV Participation:** If you do not have access to a computer, assistive devices, or other supports, or you do not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.

How do providers with assistive technology (ADA) needs use EVV?

If you use assistive technology and need to discuss accommodations related to the EVV system or materials, please contact the HHSC-approved EVV vendors (List Vendor contact numbers).

Texas Medicaid & Healthcare Partnership (TMHP) has selected two Electronic Visit Verification (EVV) vendors on behalf of the Health and Human Services Commission (HHSC): DataLogic Software Inc. and First Data Government Solutions.

Beginning January 6, 2020, program providers and financial management services agencies (FMSAs) can select one of the two EVV vendors and begin the onboarding process by completing and submitting the EVV Provider Onboarding form, located on each EVV vendor’s website.

EVV Vendor Information:

EVV Vendor	EVV Vendor System Website	Telephone Number	Email Address
DataLogic Software Inc.	https://vestaevv.com/	1-844-880-2400	info@vestaevv.com
First Data Government Solutions	http://solutions.fiserv.com/authenticare-tx	1-877-829-2002	AuthentiCareTXSupport@firstdata.com

Program providers and FMSAs are encouraged to research both vendors before making a selection. For example, program providers and FMSAs are encouraged to learn about the vendor clock in and clock out methods, visit maintenance process, and training options.

Program providers currently using DataLogic’s Vesta EVV system are not required to take any action if they choose to continue using the Vesta EVV system. Action is only required if program providers currently using DataLogic’s Vesta EVV system wish to transfer to First Data Government Solutions’ AuthentiCare EVV system.

Program providers and FMSAs will also have the option to purchase or develop an EVV proprietary system instead of selecting an EVV vendor. Additional information is available on the HHSC EVV Proprietary Systems webpage. <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/evv-proprietary-systems>

For more information about EVV vendor selection, visit the TMHP EVV Vendors page, http://www.tmhp.com/Pages/EVV/EVV_Vendors.aspx where a Selecting an EVV Vendor infographic is available. The HHSC EVV **Vendor Selection Policy** <https://hhs.texas.gov/sites/default/files/documents/govdelivery/evv-vendor-selection-policy-revised>

[jan-20.pdf](#) and the HHSC EVV Vendor Transfer Policy [https://hhs.texas.gov/sites/default/files/documents/govdelivery/evv-vendor-transfer-policy-revised jan-20.pdf](https://hhs.texas.gov/sites/default/files/documents/govdelivery/evv-vendor-transfer-policy-revised-jan-20.pdf) (effective January1, 2020) are available on the HHSC website.

More information about the onboarding process will be available on the TMHP EVV website, http://www.tmhp.com/Pages/EVV/EVV_Home.aspx **HHSC EVV website**, <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification> and MCO websites.

Email TMHP at **EVV@tmhp.com** if you have questions about EVV vendor selection.

What is the HHSC Compliance Plan?

The HHSC Compliance Plan is a set of requirements that establish a standard for EVV usage that must be adhered to by Provider Agencies under the HHSC EVV initiative.

Provider Agencies must achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90 percent per Review Period. Reason Codes must be used each time a change is made to an EVV visit record in the EVV System

EVV Compliance

All providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- The Provider must enter Member information, Provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual process. The provider agency must ensure that all required data elements, as determined by HHSC, are uploaded or entered into the EVV system completely and accurately upon entry, or they will be locked out from the visit maintenance function of the EVV system.
- The Provider must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- The Provider Agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
- The Provider Agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- Providers should notify the appropriate Aetna Better Health of Texas, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.
- Provider Agencies must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. Provider Agencies must submit claims in accordance with their contracted entity claim submission policy. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted on a case-by-case basis.
- Provider agencies must use the reason code that most accurately explains why a change was made to a visit record in the EVV System. Aetna Better Health of Texas will review reason code use by their contracted provider agencies to ensure that preferred reason codes are not misused.
- If it is determined that a provider agency has misused preferred reason codes, the provider agency HHSC EVV Initiative Provider Compliance Plan Score may be negatively impacted, and the provider agency may be subject to the assessment of liquidated damages, imposition of contract actions, implementation of the corrective action plan process, and/or referral for a fraud, waste, and abuse investigation.
- Provider agencies must ensure that claims for services are supported by service delivery records that have been verified by the provider agency and fully documented in an EVV System
- Claims are subject to recoupment if they are submitted before all of the required visit

- maintenance has been completed in the EVV System.
- Claims that are not supported by the EVV system will be subject to denial or recoupment.
 - With the exception of HHSC-identified Displaced CM2000 providers, all provider agencies must use the EVV system as the system of record by September 1, 2015.
 - HHSC-identified Displaced CM 2000 providers must use the EVV system as the system of record by February 1, 2015.
 - Adherence to the Provider Compliance Plan
 - Aetna Better Health of Texas Compliance Plan found on [AetnaBetterHealth.com/Texas](https://www.aetna.com/betterhealth/texas). The HHSC Compliance Plan is located at: <https://hhs.texas.gov/laws-regulations/handbooks/evvpph/section-6000-compliance-plan>. Any Corrective action plan required by Aetna Better Health of Texas is required to be submitted by the Network Provider to Aetna Better Health of Texas within 10 calendar days of receipt of request.
 - Aetna Better Health of Texas Provider Agencies may be subject to liquidated damages and termination from the Aetna Better Health of Texas network for failure to submit a requested corrective action plan in a timely manner.

EVV Complaint Process

Company's complaint and appeal processes applicable to Provider under the terms of the Agreement are set forth in Company's Provider Manual.

Will there be a cost to the provider for the access and use of the selected EVV vendor system?

There is no cost to the provider associated with the use of EVV.

Providers of Home Health Services Responsibilities

To enroll in Texas Medicaid as a provider of home health services, Home Health Services and Home and Community Support Services Agency (HCSSA) providers must complete the Texas Medicaid Provider Enrollment Application. Medicare certification is required for providers that are licensed as a Licensed and Certified Home Health Agency. Providers that are licensed as a Licensed Home Health Agency are not required to enroll in Medicare as a prerequisite to enrollment with Texas Medicaid.

Licensed and Certified Home Health agencies that are enrolled as Medicaid providers can provide personal care services (PCS) using their existing provider identifier. PCS for clients who are 20 years of age and younger will be provided by the Texas Health and Human Services Commission (HHSC) under the PCS benefit.

Refer to: Subsection 2.11, “*Personal Care Services (PCS) (CCP)” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)*.

To provide CCP services, HCSSA providers must follow the enrollment procedures in subsection 5.2, “Enrollment” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)*.

Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting TMHP directly at **1-800-925-9126**. Providers may also obtain the application by writing to the following address:

Texas Medicaid & Healthcare
Partnership Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 512-514-4214

Providers may request prior authorization for home health services by contacting:
Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 512-514-4209

Provider Compliance Plan

Non-CDS EVV providers must adhere to the Provider Compliance plan found at [AetnaBetterHealth.com/Texas](https://www.aetna.com/betterhealth/texas) or by contacting Aetna Better Health at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant).

Use of reason codes

Please find a list of reason codes on the following link: [AetnaBetterHealth.com/Texas](https://www.aetna.com/betterhealth/texas).

The Aetna process for recoupment if needed

EVV claims undergo a prepayment review to match the claims data to the EVV transaction. Recoupment of EVV claims can be related to but not limited to the following:

- Fee schedule changes
- Provider submits a corrected claim
- Additional Claim edits on adjustment claims

Complaint process if the provider has questions

Providers should contact their provider relations representative and follow the provider manual for submission of provider complaints or appeals.

Will training be offered to providers?

Provider training is primarily conducted via online webinars. Currently, the Vesta EVV Training department emails a weekly schedule with available dates and times for Webinars to inquiries sent to the training email address, training@vestaevv.com. On-site, webinar training sessions will be offered on an as needed basis. Aetna staff is also available for in-person trainings with a five-day lead time.

Will claim payment be affected by the use of EVV?

Providers must adhere to EVV guidelines in Provider compliance plan when submitting a claim. Claims must be submitted within 95 calendar days of the EVV Visit.

What if I need assistance?

Providers can call Provider Services at **1-844-787-5437** if they have questions or concerns surrounding the EVV process. The Provider Services team will work in with the EVV vendors to resolve inquiries that cannot be addressed by Aetna Better Health of Texas.

Medicaid Managed Care Provider Dispute, Complaint and Appeal Process

Provider Dispute process to Aetna Better Health of Texas

Providers may file a dispute verbally or in writing directly to Aetna Better Health of Texas to resolve disputes about any aspect of our administrative functions, policies, 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: lost or incomplete claim forms or electronic submissions, resubmitted claims, requests for additional explanation as to services or treatment rendered by a health provider. The dispute will be reviewed and processed according to 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 appeals and are subject to member policies and timeframes.

To initiate an inquiry, complaint, or appeal you can simply log on to the Availity Provider Portal <https://apps.availity.com/availity/web/public.elegant.login> or call **1-800-282-4548**.

Providers can also file a verbal dispute with Aetna Better Health of Texas by calling the Provider Experience department at **1-800-844-STRKIDS (844-787-5437)**; **1-800-245-5380** (Tarrant CHIP); **1-866-818-0959** (Bexar CHIP); **1-800-306-8612** (Tarrant Medicaid); **1-800-248-7767** (Bexar Medicaid).

To file a dispute in writing, providers
Aetna Better Health of Texas
Provider Experience Department
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

The provider may also be asked to complete and submit the Dispute and Resubmission Form with any appropriate supporting documentation. The Form is accessible on Aetna Better Health of Texas's website, via fax or by mail.

If the dispute is regarding claim resubmission, the dispute may be referred to the Claims Inquiry Claims Research (CICR) department. For all disputes, Aetna Better Health of Texas notifies the provider of the dispute resolution by phone, email, and fax or in writing.

Provider Complaints process to Aetna Better Health of Texas

Both network and out-of-network providers may file a complaint verbally or in writing directly with

Aetna Better Health in regard to our policies, procedures, or any aspect of our administrative functions including dissatisfaction with the resolution of a claim dispute. Providers can also file a verbal complaint with Aetna Better Health of Texas by calling **1-844-787-5473**. To file a complaint in writing, providers should write to:

Aetna Better Health of Texas
Appeal and Complaint Department
PO Box 81040
5801 Postal Road
Cleveland, OH 44181
Fax: **1-877-233-4580**

Provider complaints will be acknowledged either orally or in writing within five (5) business days of receipt. Aetna Better Health responds to standard provider complaints within thirty (30) 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's written policies and procedures, collecting pertinent facts from all parties. The complaint with all research will be reviewed for resolution and may be presented to the Complaint Committee for resolution. None of the reviewers or members of the Complaint Committee will have been involved in any prior decision making related to the complaint. When the complaint includes a clinical issue a provider with same or similar specialty will participate and render the final resolution.

Providers can file a complaint with Aetna Better Health verbally or in writing:

Providers can submit their grievances by accessing the Grievance application found in the Availity provider portal <https://apps.availity.com/availity/web/public.elegant.login> or by calling **1-800-282-4548** between the hours of 8 AM and 8PM ET, Monday through Friday

Or by using the Aetna Provider Web Portal which is found at <https://medicaid.aetna.com/MWP/landing/home>

How to submit complaints verbally:

Contact the Provider Experience Department at:

1-800-844-STRKIDS (844-787-5437)
1-800-245-5380 (Tarrant CHIP)
1-866-818-0959 (Bexar CHIP)
1-800-306-8612 (Tarrant Medicaid)
1-800-248-7767 (Bexar Medicaid)

How to submit complaints via Fax or Paper

Providers can file a complaint with Aetna Better Health either in writing or verbally by contacting:

Aetna Better Health of Texas
Provider Experience Department
PO Box 81040
5801 Postal Rd
Cleveland, OH 44181

OR Fax **1-877-223-4580**

Documentation

Retention of fax cover pages, emails to and from Aetna Better Health of Texas log of telephone communication

Aetna Better Health of Texas stores all the documentation related to Providers Complaints in a digital database.

Provider Appeal of MCO Claims Determinations Process to Aetna Better Health of Texas

The provider may file an appeal related to claim denial or claim payment within 120 days from the date of the claim processing date. If the appeal is received verbally, we will send a verbal claim appeal form documenting the verbal claim appeal. Once the provider has reviewed and agrees with this documentation, the provider will return the verbal claim appeal form to Aetna Better Health of Texas for processing.

Aetna Better Health of Texas will send a written acknowledgement letter within 5 business days of receipt of the written request for a claim appeal of the claim denial or claim payment. . This acknowledgement letter will indicate that Aetna Better Health of Texas has 30 calendar days to process and respond to the claim appeal. Aetna Better Health of Texas will send a resolution letter indicating the final determination and criteria used to reach the final decision and notice of the provider's right to file a complaint with HHSC.

Providers can file a complaint with Aetna Better Health verbally or in writing:

How to submit complaints online:

Providers can submit their complaints by accessing the Grievance application found in the Availity provider portal <https://apps.availity.com/availity/web/public.elegant.login> or by calling **1-800-282-4548** between the hours of 8 AM and 8PM ET, Monday through Friday.

Or by using the Aetna Provider Web Portal which is found at

<https://medicaid.aetna.com/MWP/landing/home>

How to submit complaints verbally:

Contact the Provider Experience Department at:

1-800-844-STRKIDS (844-787-5437)

1-800-306-8612 (Tarrant Medicaid)

1-800-248-7767 (Bexar Medicaid)

How to submit Appeals via fax or paper

Providers can file appeals with Aetna Better Health either in writing or verbally by contacting:

Aetna Better Health of Texas

ATTN: Complaints and Appeals Department

P.O. Box 81040
5801 Postal Rd
Cleveland, OH 44181
OR Fax 1-877-223-4580

Provider Complaint Process to Health and Human Services Commission (HHSC)

A provider who believes that they did not receive full due process from Aetna Better Health may file a complaint with HHSC. HHSC is only responsible for management of the complaints. Appeals, hearing or dispute resolutions are the responsibility of Aetna Better Health of Texas. Providers must exhaust the complaint/appeal process with Aetna Better Health of Texas before filing a complaint with HHSC. Providers should refer to the Texas Medical Provider Procedure's Manual for specific information on complaint requirements. Complaints should be mailed to the following address:

Texas Health and Human Services
Commission Health Plan Operations, H-320
Resolution Services
PO Box 85200
Austin, TX 78708-5200
Email: HPM_Complaints@hhsc.state.tx.us

The network provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiries and to conduct investigations into provider and Member complaints.

Provider Appeal Process to HHSC (related to claim recoupment)

Upon notification of a claim payment recoupment, the first step is for the provider to recheck Member eligibility to determine if a Member eligibility change was made to Fee-for-Service or to a different managed care organization.

1. Member eligibility changed to Fee-for-Service on the date of service

Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the

provider will need to submit a corrected claim that contains the valid authorization number.

Note: Label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed prior to eighteen (18) months from the date of service.

Mail Fee-for-Service appeal requests to:

Texas Health and Human Services
Commission HHSC Claims
Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

Prepare a new paper claim for each claim that was recouped and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

Submission of the new claims is not required before sending the administrative appeal letter. However, if a provider appeals prior to submitting the new claims, the provider must subsequently include the new claims with the administrative appeal.

HHSC Claims Administrator Contract Management only reviews appeal that are received within eighteen (18) months from the date-of-service. In accordance with 1 TAC § 354.1003, providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management and all claims must be finalized within 24 months from the date of service.

2. Member eligibility changed from one Managed Care Organization (MCO) to another on the Date-of-Service

Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the Member eligibility was changed on the date of service:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- **The explanation of benefits (EOB) showing the original payment. The EOB showing the recoupment and/or the MCO's "demand" letter for recoupment** must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- **Documentation must identify** the client name, identification number, DOS, and recoupment amount, and other claims information.
- **Note:** Label the request "**Expedited Review Request**" at the top of the letter to

ensure the appeal request is reviewed prior to 18 months from the date of service.

Submit appeals online at:

Appeals can be submitted using the Appeal Submission Application within the Availity provider portal found at

<https://apps.availity.com/availity/web/public.elegant.login> or by calling **1-800-282-4548** between the hours of 8 AM and 8PM ET, Monday through Friday..

Or by using the Aetna Provider Web Portal which is found at

<https://medicaid.aetna.com/MWP/landing/home>

How to submit complaints verbally:

Mail Fee-for-Service related appeals to:

Texas Health and Human Services

Commission HHSC Claims

Administrator Contract

Management Mail Code-91X

P.O. Box 204077

Austin, Texas 78720-4077

Medicaid Managed Care Member Complaint/Appeal Process

Member Complaint Process

Definition of a “Complaint” – Any dissatisfaction expressed by a complainant orally or in writing to Aetna Better Health of Texas about any matter related to Aetna Better Health of Texas other than an Adverse Benefit Determination. Complaints may include, but are not limited to, dissatisfaction with plan administration; the quality of care of services provided; and aspects of interpersonal relationships such as rudeness of a provider or Aetna Better Health of Texas employee, or failure to respect the Member’s rights. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.

The Member’s right to file complaints to Aetna Better Health of Texas and HHSC

A Member or a Member’s Legally Authorized Representative can file a complaint with Aetna Better Health of Texas either in writing or verbally by contacting the Member Advocate at:

Aetna Better Health of Texas

Attn: Member Advocate

PO Box 81139

5801 Postal Road

Cleveland, OH 44181

The toll-free numbers that the member can use to file a Complaint to Aetna Better Health of Texas is:

1-800-844-STRKIDS (844-787-5437)

1-800-306-8612 (Tarrant Medicaid)

1-800-248-7767 (Bexar Medicaid)

The requirements and timeframes for filing a complaint with Aetna Better Health of Texas

A member or a member's designee can submit their complaint at any time either orally or in writing. Within 5 business days of receipt of a complaint by a member or member's LAR, the Member Advocate will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30-calendar daytime frame for resolution of the complaint.

The availability of assistance in the filing process

The Aetna Better Health of Texas' Member Advocate is available to assist the member or member's LAR with understanding and using the complaint process. If the complaint is received verbally, the Member Advocate will send a verbal complaint form documenting the verbal complaint. Once the member or member's LAR has reviewed and agrees with this documentation of the verbal complaint, the member or member's LAR must return the verbal complaint form to the Member Advocate.

The Member's right to file complaint to HHSC

A member or a member's LAR can file a complaint with HHSC in the event they are not satisfied with Aetna Better Health of Texas' complaint decision. Complaints should be mailed to the following address:

Texas Health and Human Services Commission Health
Plan Operations, H-320 Resolution Services 141
PO Box 85200
Austin, TX 78708-5200
Email: HPM_Complaints@hhsc.state.tx.us

Member Appeal Process for Aetna Better Health of Texas

What can I do if Aetna Better Health denies or limits my member's request for a covered service?

A member or member's LAR, including the member's physician or health care provider with written consent from the member, may appeal the Adverse Benefit Determination orally or in writing.

How will I find out if services are denied?

Our Medical Management Department will notify the member or members LAR and the member's provider of a determination made in a utilization review. A notice of adverse benefit determination will be provided in writing in case of a denial or limited authorization of a requested service, including the denial in whole or part of payment for a service; the denial of a type or level of service; and/or the reduction, suspension, or termination of a previously authorized service.

Timeframes for the Appeals process

Aetna Better Health of Texas must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for Appeal, including the option to extend up to 14 Days if Member requests an extension; or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If Aetna Better Health of Texas needs to extend, Member must receive written notice of the reason for the delay.

When does Member have the right to request an Appeal?

All appeals must be received within 60 calendar days from the date of the notice of an adverse benefit determination for denial or payment of services in whole or in part.

Appeals are accepted orally or in writing. Within 5 working days from receipt of the written or verbal appeal, the Member Advocate will send an acknowledgement letter.

The services being received by the member, including the benefit that is the subject of the appeal, will be continued if all the following criteria are met:

- The member or member's LAR, including the member's physician or health care provider with written
- consent from the member files the appeal timely as defined in the contract.
- The appeal involves the termination, suspension, or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member or LAR timely requests an extension of the benefits. If, at the member's request, Aetna Better Health of Texas continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
 - The member withdraws the appeal.
 - 10 days pass after Aetna Better Health of Texas mails the notice, providing resolution of the appeal against the member, unless the member, within the 10-day timeframe, has requested a State Fair Hearing.
 - A State Fair Hearing Officer issues a hearing decision adverse to the member.

The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

Can someone from Aetna Better Health of Texas help the member file an Appeal?

Aetna Better Health of Texas will have Member Advocates available to assist members or member's LAR in filing an Appeal.

Member's option to request an External Medical Review (EMR) after the Aetna Better Health of Texas' Appeals process

Member's option to request an External Medical Review no later than 120 Days after Aetna Better Health of Texas mails the appeal decision notice.

Member's option to request only a State Fair Hearing after the Aetna Better Health of Texas' Appeals process

Member's option to request only a State Fair Hearing no later than 120 Days after Aetna Better Health of Texas mails the appeal decision notice.

Member Expedited Aetna Better Health of Texas Appeal

The member or member's LAR or Member's Service Provider may ask for an emergency appeal if he/she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the member.

How to request an Emergency Appeal

Requests for an emergency appeal can be made verbally or in writing as indicated in the Member Appeal Process to Aetna Better Health of Texas listed above.

Timeframes

Emergency appeals for ongoing emergencies or denial of continued hospitalizations must occur in accordance with the medical or dental immediacy of the case and not later than 1 business day after the member or member's LAR or Member's Service Provider request for the appeal is received. Aetna Better Health of Texas will follow up in writing within 3 business days on a decision for an emergency appeal.

What happens if Aetna Better Health of Texas denies the request for an Emergency Appeal?

If the member or member's LAR or Member's Service Provider requests an emergency appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided they will be notified that the appeal review cannot be expedited. We will continue to work on the appeal within the standard timeframe and respond to you within 30 days from the time the appeal was received.

Who can help me file an Emergency Appeal?

The Aetna Better Health of Texas Member Advocate will be available to assist the member or member's LAR with understanding and using the appeals process including expedited appeals.

Member Request for State Fair Hearing Only

State Fair Hearing Information-

Can a member ask for a State Fair Hearing?

If a member, as a member of the health plan, disagrees with the health plan's decision, the member has the right to ask for a State fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling Aetna Better Health the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the State fair hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the State fair hearing within 120 days, the member may lose his or her right to a State fair hearing. To ask for a State fair hearing, the member or the member's representative should either send a letter to the health plan at:

Aetna Better Health of Texas
PO Box 81139
5801 Postal Rd
Cleveland, OH 44811
or call toll free **1-844-787-5437(1-844-STRKIDS)**

If the member asks for a State fair hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the member does not request a State fair hearing within 10 days from the time the member gets the hearing notice, the service the health plan denied will be stopped.

If the member asks for a State fair hearing, the member will get a packet of information letting the member know the date, time, and location of the hearing. Most State fair hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

Member request for an External Medical Review and State Fair Hearing

EXTERNAL MEDICAL REVIEW INFORMATION

Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should:

- Fill out the 'State Fair Hearing and External Medical Review Request Form provided as an attachment to the Member Notice of Aetna Better Health of Texas Internal Appeal Decision letter and mail or fax it to Aetna Better Health of Texas by using the address or fax number at the top of the form or call **1-844-787-5437**.
- Call us at **1-844-STRKIDS (1-844-787-5437)**
- Email us at TXMemberAdvocate@aetna.com

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if

an Independent Review Organization has already completed the review and made a decision. The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

The Member can make both of these requests by contacting Aetna Better Health of Texas at **1-844-787-5437** or the HHSC Intake Team at:
EMR_Intake_Team@hhsc.state.tx.us.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Aetna Better Health of Texas at **1-844-787-5437**. To qualify for an emergency External Medical Review and emergency State Fair Hearing, the Member must first complete Aetna Better Health's internal appeals process.

CHIP Provider Complaint and Appeal Processes

Provider Complaint process to Aetna Better Health

Definition of a "Complaint" – Any dissatisfaction, expressed by a Complainant, orally or in writing to Aetna Better Health, with any aspect of Aetna Better Health's operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to Medical Necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

Providers can file a complaint with Aetna Better Health either in writing or verbally by contacting:

Aetna Better Health of Texas
ATTN: Complaints and Appeals Department
PO Box 81040
5801 Postal Rd

Cleveland, OH 44181

1-800-306-8612 (Tarrant) or **1-800-248-7767** (Bexar)

Submitting on-line using our provider portal which is found at <https://medicaid.aetna.com/MWP/landing/home>. Providers can register for the provider portal at www.availity.com/provider-portal-registration.

To initiate an inquiry, complaint, or appeal you can simply log on to the Availity Provider Portal <https://apps.availity.com/availity/web/public.elegant.login> or call **1-800-282-4548**.

We will offer dedicated Availity support for all providers who register for training. Providers will contact our Availity customer service line for assistance. Availity offers free on-demand and live training in the **Availity Learning Center** (ALC). Log in and select Help & Training > Get Trained to search the ALC catalog.

In the **Availity Portal**, click Help & Training|Get Trained to open the Availity Learning Center (ALC) in a new browser tab. Filter the ALC catalog by category to explore your options.

For assistance with training questions/issues call **1-800-282-4548** between the hours of 8 AM and 8 PM ET, Monday through Friday.

Addition of training information

Aetna Better Health will make resources available to assist providers in filing a complaint. If the complaint is received verbally, Aetna Better Health will send a verbal complaint form documenting the verbal complaint. Once the provider has reviewed and agrees with this documentation of the verbal complaint, the provider will return the verbal complaint form to Aetna Better Health. If the complaint form is not returned to Aetna Better Health within 15 calendar days from date on letter, a determination will be made based on the available information. Within 5 business days of receipt of a complaint by a provider, Aetna Better Health will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 60-calendar daytime frame for resolution of the complaint.

Once the complaint has been resolved, Aetna Better Health will send a response letter to the provider with the resolution of the complaint, including the process to appeal the complaint when the provider is not satisfied with Aetna Better Health decision. Aetna Better Health will appoint members to a Complaint Appeal Review Panel to advise Aetna Better Health on the resolution of a disputed decision on a complaint. Members of the Complaint Appeal Review Panel may not have been previously involved in the disputed decision. Aetna Better Health will notify the provider of the time and date of the Complaint Appeal Review Panel meeting, at least 5 days prior to the Complaint Review Panel meeting, Aetna Better Health will provide the Provider documentation to be presented to the Panel by Aetna Better Health staff.

Provider Complaint process to Texas Department of Insurance (TDI)

Aetna Better Health will send a resolution letter indicating the final determination and criteria used to reach the final decision and notice of the Provider's right to file a complaint with the Texas Department of Insurance (TDI).

Provider Appeal of Claims Determinations Process to Aetna Better Health

The provider may request an appeal to the address noted above within 60 days from the date of an adverse determination. If the appeal is received verbally, we will send a verbal appeal form documenting the verbal appeal. Once the provider has reviewed and agrees with this documentation, the provider will return the verbal appeal form to Aetna Better Health of Texas for processing. Aetna Better Health of Texas will send a written acknowledgement letter within 5 business days of receipt of the written request for an appeal of the complaint decision. This acknowledgement letter will indicate that Aetna Better Health has 60 calendar days to process and respond to the appeal. Aetna Better Health of Texas will send a resolution letter indicating the final determination and criteria used to reach the final decision and notice of the provider's right to file a complaint with TDI.

Provider Appeal process to TDI

A provider who believes that they did not receive full due process from Aetna Better Health, may file a complaint with TDI by calling toll free **1-800-252-3439** or in writing at:

Texas Department of Insurance
PO Box 149104
Austin, Texas 78714-9104

The network provider understands and agrees that TDI reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into provider and member complaints.

CHIP Member Complaint Process

What should I do if I have a complaint?

Definition of a "Complaint" – Any dissatisfaction expressed by a complainant orally or in writing to Aetna Better Health with any aspect of the Aetna Better Health's operations, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions expressed by a complainant. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.

Who do I call?

CHIP Members, or a CHIP Member's designee, can file a complaint with Aetna Better Health either in writing or verbally by contacting the Member Advocate at:

Aetna Better Health of Texas
Attention: Member Advocate
P.O. Box 81040
5801 Postal Rd
Cleveland, OH 44181
1-800-306-8612 (Tarrant), **1-800-248-7767** (Bexar)

Can someone from Aetna Better Health help me file a Complaint?

The Aetna Better Health of Texas Member Advocate will be available to assist the member or

member's designee with understanding and using the complaint process. If the complaint is received verbally, the Member Advocate will send a verbal complaint form documenting the verbal complaint. Once the member or member's designee has reviewed and agrees with this documentation of the verbal complaint, the member or member's designee will return the verbal complaint form to the Member Advocate. If the complaint form is not returned to the Member Advocate within 15 calendar days from date on letter, a determination will be made based on information available.

How long will it take to investigate and resolve my Complaint?

Within 5 business days of receipt of a complaint by a member or member's designee, the Member Advocate will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar daytime frame for resolution of the complaint. Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case but may not exceed 1 business day from receipt of the complaint. Once the complaint has been resolved, the Member Advocate will send a response letter to the member or member's designee with the resolution of the complaint, including the process to appeal the decision when the member or member's designee is not satisfied with Aetna Better Health's decision.

If I am not satisfied with the outcome, who else can I call?

If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll free to **1-800-252-3439**. If you would like to make your request in writing send it to:

Texas Department of Insurance
Consumer Protection
PO Box 149091
Austin, TX 78714-9091

If you can get on the internet, you can send your complaint in an email to

www.tdi.texas.gov/consumer/complfrm.html.

CHIP Member Appeal Process

What can I do if the Aetna Better Health denies or limits my patient's request for a Covered Service?

A member, a person acting on behalf of the member, or the member's physician or health care provider with written consent from the member, may appeal an adverse determination orally or in writing. Any complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of the adverse determination.

How will I find out if the Appeal is denied?

Our Utilization Review Department will notify the Member or a person acting on behalf of the member and the member's provider of a determination made in a utilization review. A notice of action or adverse determination will be provided in writing in case of a denial or limited authorization of a requested service, including the denial in whole or part of payment for a service; the denial of a type or level of service; and/or the reduction, suspension or termination of a previously authorized service. Notification of an adverse determination will include:

- The action taken or proposed
- Principal reasons for the action or adverse determination
- The clinical basis for the action or adverse determination A description or the source of the screening criteria that were utilized as guidelines in making the determination
- A description of the procedure for the appeal process, including:
 - Notification of the right for the Member to appeal an action or adverse determination orally or in writing and the procedures to request an appeal
 - A statement explaining that HMO must make its decision within 30 days from the date the appeal is received by HMO, or 3 business days in the case of an expedited appeal and
 - Notification of the right to request an independent review within 120 days from date of notice of action or adverse determination.
- An explanation that members may represent themselves, or be represented by a provider, a friend, a relative, legal counsel or another spokesperson;
- A statement that if the member wants an independent review on the action or adverse determination, member must make, in writing, the request for an independent review within 120 days of the date on the notice or the right to request a hearing is waived;
- A description of the circumstances under which expedited resolution is available and how to request it;
- Notification of right to an expedited independent review after exhausting the health plan's expedited appeal process;
- Notification of the right for the member to request continuation of benefits pending resolution of the appeal and the circumstances under which the enrollee may be required to pay the costs of services;
- The date that the action or adverse determination will be taken.

Timeframes for the Appeal process

All appeals must be received within 60 calendar days from the date of the notice of an adverse determination. When an oral appeal of adverse determination is received, a one-page verbal appeal form, documenting the verbal appeal, will be sent to member for review and signature. The time frame in which the appeal is resolved will be based on the medical immediacy of the condition, procedure, or treatment under review, but will not exceed 30 calendar days unless an extension is requested by the member or the member designee is notified of the reason an extension would be in the member's best interest. Within 5 working days from receipt of the written or verbal appeal, the Member Advocate will send an acknowledgement letter. The acknowledgement letter will include:

- The date of receipt of the appeal
- A description of the appeal procedure and time frames,
- The right of the member or authorized representative to examine the member's case file, including medical records and any other information, at any time before or during the appeal process
- The right of the member to present evidence, and allegations of fact or law, in person, as well as in writing
- A list of the documents that will need to be submitted for review during the appeal process.

The services being received by the member, including the benefit that is the subject of the appeal, will be continued if all the following criteria are met:

- The member or his or her representative files the appeal timely as defined in the contract
- The appeal involves the termination, suspension, or reduction of a previously authorized service
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The member or his or her representative timely requests an extension of the benefits.

If, at the member's request, Aetna Better Health continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal
10 days pass after Aetna Better Health mails the notice, providing the resolution of the appeal against the member, unless the member, within the 10-day time frame, has requested an External Review.
- The External Review Organization issues a hearing decision adverse to the Member

The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

When does a member have the right to request an Appeal?

In the event that the complaint is not resolved to the satisfaction of the member, the member or member's designee may request an appeal through the Member Advocate at the address noted above.

Can someone from Aetna Better Health help me file an Appeal?

If the appeal is received verbally, the Member Advocate will send a verbal appeal form documenting the verbal appeal. Once the member or member's designee has reviewed and agrees with this documentation of the verbal appeal, the member or member's designee will return the verbal appeal form to the Member Advocate for processing. All oral appeals received must be confirmed by a written, signed appeal by the member or member's designee, unless an expedited appeal is requested.

Member Expedited Aetna Better Health Appeal

How to request an Expedited Appeal

The member or member's designee may ask for an expedited appeal if he/she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the member. Requests for an Expedited Appeal can be made verbally or in writing as indicated in the Member Complaint to HMO Process listed above. Expedited appeals for emergency care denials and denials of continued hospital stays will be reviewed by a Medical Director that was not involved in the original denial and is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review.

Timeframes

The time frame in which the appeal is completed will be based on the medical immediacy of the condition, procedure, or treatment, but will not exceed 1 working day from the date all information

necessary to complete the appeal is received.

What happens if the Aetna Better Health denies the request for an Expedited Appeal?

If the member or member's designee requests an expedited appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided they will be notified that the appeal review cannot be expedited and include the reason for the denial with instructions on how the member can file a complaint. If the member or member's designee does not agree with this decision, they may submit a request for an External Review as described below.

Members may also file a complaint to the TDI by calling **1-800-252-3439** or writing to:
Texas Department of Insurance Consumer Protection
PO Box 149091
Austin, TX 78714-9091

Who can help me file an Expedited Appeal?

The Aetna Better Health of Texas Member Advocate will be available to assist the member or member's designee with understanding and using the complaint and appeals process including expedited appeals.

Member Independent Review Organization Process

What is an Independent Review Organization (IRO)?

An Independent Review Organization (IRO) is an organization that has no connection to Aetna Better Health or with health care providers that were previously in your treatment or decisions made by Aetna Better Health about services that have not been provided.

How do I request a review by an IRO through the External review Process?

The Member or someone acting on the member's behalf and the provider of record (with members written consent) have the right to request a Standard External Review through MAXIMUS within 4 months after the date of this notification. To request the standard External Review, complete the HHS Federal External Review Request Form enclosed. Mail or fax the form along with this letter directly to MAXIMUS at:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax number: **1-888-866-6190**

Or the member can submit your request online at externalappeal.com under the "Request a Review Online" heading.

Expedited IRO

In urgent care situations, the member the member's representative can file an external review before exhausting Aetna Better Health of Texas's internal appeal process. In urgent care situations the IRO must issue an urgent care decision to the health plan and the member or the member's representative as expeditiously as the member's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

To ask for an expedited external review:

- The member can e-mail the request to FERP@maximus.com
- Call the Federal External review Process at **1-888-866-6205 x3326** or
- Selecting “expedited” when submitting the review request online

In urgent care situations, MAXIMUS Federal Services will accept a request for external review from a medical professional who knows about the claimant’s condition. The medical professional will not be required to submit proof of authorization.

Timeframes

For standard External Review request:

The MAXIMUS Federal Services examiner will contact Aetna Better Health of Texas when they receive the request for External Review. Within five (5) business days, Aetna Better Health of Texas will give the examiner all documents and information used to make the internal appeal decision.

The member or someone acting on the member’s behalf, will receive written notice of the final External Review decision as soon as possible, but no later than 45 days after the examiner receives the request for an External Review.

For expedited or fast External Review request:

The MAXIMUS examiner will give Aetna Better Health of Texas and the member or the person filing on the members behalf the External Review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request.

The member or someone acting on the members behalf, will receive the decision over the phone, but MAXIMUS will also send a written version of the decision within 48 hours of the phone call notification.

Medicaid Managed Care Member Eligibility and Added Benefits

Eligibility Determination by HHSC

HHSC identifies persons with Medicaid who are eligible for participation in the Aetna Better Health of Texas plan. Eligible individuals must reside in Tarrant County Service Areas. Eligibility is determined using the following criteria:

Eligibility Category	Criteria
TANF (formerly AFDC)	Individuals age 21 and over who are eligible for the TANF Program.
TANF Children	Individuals under age 21 who are eligible for the TANF Program.
Pregnant Women – MAO	Medical Assistance Only (MAO) pregnant women whose families’ income is below 185% of the Federal Poverty Limits.
Newborn (MAO)	Children under age 1 (one) year born to Medicaid-eligible mothers.
Expansion Children (MAO)	Children under age 18, ineligible for TANF because of the applied income of their stepparents or grandparents. Children under age 1 whose families’ income is below 185% Federal Poverty Limit. Children age 1 – 5 whose families’ income is at or below 133% of Federal

	Poverty Limit. Children under age 19, born before October 1, 1983, whose families' income is below the TANF income limit
Federal Mandate Children (MAO)	Children under age 19, born on or after October 1, 1983, whose families' income is below 100% Federal Poverty Limit.
CHIP	Children under age 19, born on or after October 1, 1983, whose families' income is between the medically needy standards unit and 100% Federal Poverty Limit.

Verifying Member Medicaid Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the date of service prior to services being rendered. There are two ways to do this:

- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call Provider Services at the patient's medical or dental plan.

Important: Members can request a new card by calling **1-800-252-8263**. Members also can go online to order new cards or print temporary cards at www.YourTexasBenefits.com and see their benefit and case information, view Texas Health Steps Alerts, and more.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.

Your Texas Benefits gives providers access to Medicaid health information

Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). All this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the 'Initial Registration Guide for Medicaid Providers'. For more information on how to get registered, download the 'Welcome Packet' on the home page.

YourTexasBenefitsCard.com allows providers to:

- View available health information such as:
 - Vaccinations
 - Prescription drugs
 - Past Medicaid visits
 - Health Events, including diagnosis and treatment, and
 - Lab Results
- Verify a Medicaid patient's eligibility and view patient program information
- Use the Blue Button to request a Medicaid patient's available health information in a consolidated format

Temporary ID card (Form 1027-A)

A Member may have a temporary Medicaid ID (Form 1027-A) which will include the plan indicator. This is issued prior to receipt of the Form 3087.

Aetna Better Health Medicaid ID card

We will issue a Member ID card to the Member within five (5) days of receiving notice of enrollment of the Member into the Aetna Better Health Medicaid program. The ID card will include at a minimum the following: Member's name; Member's Medicaid number; primary care provider's name and telephone number; primary care provider effective date; plan eligibility effective date; the 24-hour, 7 day per week Member Services eligibility telephone number; the toll-free number for behavioral health and vision services; and directions on what to do in an emergency.

Copies of the Aetna Better Health Medicaid ID card are included in Appendix A to this manual.

If the member also received Medicare benefits, Medicare is responsible for most primary and acute services and some behavioral health services; therefore, the Primary Care Provider's name, address, and telephone number are not listed on the Member's ID card. (STAR Kids Dual Members).

Call Aetna Better Health of Texas

Providers may also verify eligibility through the Aetna Better Health website ([AetnaBetterHealth.com/Texas](https://www.AetnaBetterHealth.com/Texas)), or by calling Member Services at **1-844-787-5437**.

AIS line/TXMedConnect

Call Automated Inquiry System (AIS) at **1-800-925-9126**.

Provider Portal

Effective 1/1/2022 Availity is the Provider Portal for Aetna Better Health of Texas. Providers can register for access directly on Availity site www.availity.com/providers-portal-registration.

Providers can register for access directly on Availity site www.availity.com/providers-portal-registration

All current functionality of the Medicaid Web Portal has parallel functionality on Availity

- Payer Spaces
- Change Healthcare Claim Submission Link
- Contact Us & Messaging
- Claim Status Inquiry
- Grievance Submission
- Appeals Submission
- Grievance and Appeals Status
- Provider Deliverable Manager
- Ambient (Business Intelligence Reporting)
- Clear Claim
- ProPAT
- Provider Intake
- Dynamo (Case Management)

- Prior Authorization submission and status lookup
- Eligibility & Benefits
- Enhanced G&A tool
- Panel Roster
- Remit PDF
- Enhanced (electronic) Remit Viewer

If you are already registered in Availity, you will simply **log in** and select Aetna Better Health from your list of payers to begin accessing the portal and all of the above features.

If you are not registered, we recommend that you do so immediately.

- Click here to learn more about Availity Portal Registration - <https://apps.availity.com/availity/Demos/Registration/index.htm>
- Click here to register - www.availity.com/provider-portal-registration
- For registration assistance, please call Availity Client Services at **1-800-282-4548** between the hours of 8 AM and 8 PM ET, Monday-Friday (excluding holidays)

Pharmacy Providers

Pharmacy must submit claims using Electronic eligibility verification, e.g., NCPDP E1 Transaction.

Added Benefits

Spell of Illness Limitation Removed

Members of the Aetna Better Health Medicaid program are not limited by the “spell of illness” limitation, which is specified in the current Texas Medicaid Provider Procedures Manual. The annual limit of \$200,000 on inpatient services does not apply for Medicaid Members.

Unlimited Prescription

All Aetna Better Health adult Medicaid members are entitled to unlimited medically necessary prescriptions and not limited to three (3) prescriptions, which is specified in the current Texas Medicaid Provider Procedures Manual. Benefit is only available for members who are NOT covered by Medicare.

STAR Value-Added Benefits – see complete list in Member Handbook on our website
AetnaBetterHealth.com/Texas

<p>24-Hour Nurse Line</p>	<p>This 24-hours-a-day, 7-days-a-week service enables all members to have telephonic access to clinical support from experienced registered nurses. Members can call the nurse line directly at 1-800-556-1555 for assistance.</p>
<p>Over-the-Counter Benefits / Discount Pharmacy</p>	<p>The OTC Health Solutions program offers members a \$25 monthly allowance (\$300 annually). OTC medications and products can be ordered by phone, online, fax or mail and are then delivered directly to members' homes. Limited to \$25 per month (\$300 annually) per household. Discount drug store services. These products include*:</p> <ul style="list-style-type: none"> • Baby care • Cold remedies • Digestive health • Ear & eye care • Feminine care • First aid supplies • Foot care • Home diagnostics • Incontinence • Oral care • Pain relievers • Personal care • Vitamins/minerals <p>*Excludes prescriptions, alcohol, lottery, postage stamps, gift cards, money orders, prepaid cards and photo finishing and is not valid on any items reimbursed by the federal government.</p> <p>This benefit covers Over-the Counter (OTC) medications and other products items that do not need a prescription and are not otherwise covered benefits.</p>
<p>Extra help for pregnant women</p>	<p>Aetna Better Health offers our pregnant members:</p> <ul style="list-style-type: none"> • \$25 gift card and a special pregnancy handbook for enrolling in case management within 30 days of enrollment • \$25 gift card and a special pregnancy handbook for enrolling in case management within 30 days of pregnancy diagnosis if already a member • \$50 worth of diapers, baby wipes and/or similar items for completion of 3 prenatal visits • \$50 worth of diapers, baby wipes and/or similar items for completion of 3 additional prenatal visits (6 in total) and 1 postpartum care visit

	<ul style="list-style-type: none"> • Members will call the health plan when they have completed all their prenatal and postpartum visits to claim their gift of baby items • Pregnancy handbook for pregnant members in case management
PROMISE Program	<p>Our pregnant members can earn diapers, baby wipes or similar baby items.</p> <ul style="list-style-type: none"> • If you complete 3 prenatal visits you can earn up to \$50 worth of baby items. • If you complete 3 more prenatal visits (6 total) and 1 postpartum visit after the baby is born you can earn another \$50 worth.
Extra help getting a ride	<p>Need help getting a ride? We can provide daily bus pass/token, cab fare or ride share for members and their legally authorized representative (LAR) as well as siblings if the LAR cannot make other arrangements; when needed to visit for WIC offices, plan sponsored community events/classes or attend Member Advisory Groups meetings.</p>
Extra Vision Services	<p>Aetna Better Health of Texas members will receive financial assistance in obtaining vision services and products.</p> <ul style="list-style-type: none"> • 21 years and older – Aetna will cover the cost of eye exams once every other year. • 21 years and older – Aetna will cover up to \$175 once every other year for eye wear not limited to eyeglass frames, lenses and contact lenses that are not covered by Medicaid. • Under 21 years old – Aetna will cover up to \$175 once a year for eye wear not limited to eyeglass frames, lenses and contact lenses that are not covered by Medicaid.
Behavioral Health Inpatient Follow-up Incentive	<p>Receive a \$25 gift card for members who complete a follow-up visit with their behavioral health provider within 7 days of leaving the behavioral health hospitalization.</p>
Help for Members with Asthma	<p>Members with an asthma diagnosis and enrolled in the asthma disease management program will receive the following, up to \$100 per year:</p> <ul style="list-style-type: none"> • One peak flow meter and holding chamber or spacer each year • Pest control • Hypoallergenic bedding • Vent cleaning • Deep carpet cleaning
Sports Physicals	<p>Medically necessary sports physicals to any member 19 years and younger who have completed a well-child visit.</p>

<p>Cell Phone Assistance</p>	<p>Members that qualify for the Federal Lifeline Program are provided with choice of a smartphone, feature phone or use of their personal cell phone to include the following plan options depending on coverage area.</p> <p>(1) Assurance Wireless: Android smartphone with 500 MB of data, 350 talk minutes and unlimited text;</p> <p>(2) EnTouch Wireless: use of personal cell phone, 500 MB of data, and 500 units of voice/text where 1 unit = 1 text or 1 minute;</p> <p>(3) EnTouch Wireless: Feature phone, 10 MB of data, 500 talk minutes, 100 texts;</p> <p>(4) Life Wireless: use of personal cell phone, 10 MB of data, 500 talk minutes and unlimited text.</p> <p>Member calls to and from the Health Plan and health-related texts received from the Health Plan will not apply to minute or text limits.</p>
<p>Well-Child Exams</p>	<p>Members can receive:</p> <ul style="list-style-type: none"> • \$50 gift card at no cost to members for completing Texas Health Steps/well-child checkups/visits at 2 weeks and 2, 4, 6, months of age. Upon completion of these checkups, Members will call Member Services to redeem and request one \$50 gift card. • \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkup/visit at 9 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one \$25 gift card. • \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkup/visit at 12 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one \$25 gift card. • \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkup/visit at 15 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one \$25 gift card. • \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkups/visits at 18 and 30 months of age. Upon completion of each of these checkups, the Members will call Member Services to redeem and request one \$25 gift card. A total of two \$25 gift cards are available for completing both checkups. • \$25 gift card at no cost to you each time an annual Texas Health Steps/well-child checkups/visits is received for members 3-20 years of age. Upon completion of each of these checkups/visits, the Members will call Member

	Services to redeem and request one \$25 gift card. Limit one card per member per year.
Home visits	Virtual home visit for lactation consultant for all new moms.
Dental Services	Members who are 21 years and older and pregnant members are eligible for the following annual dental benefits: <ul style="list-style-type: none"> • Cleaning every 6 months • X-rays once a year • Simple extractions • Limited fillings • Fluoride treatments

**** Restrictions and limitations may apply****

24-Hour Nurse Line

This 24-hours-a-day, 7-days-a-week service enables all Medicaid members to have ready telephonic access to clinical support from experienced Registered Nurses. The nurses will be available through a toll-free telephone number at **1-800-556-1555**. We will provide TTY service for the hearing and speech- impaired and foreign language translation for non-English speaking members.

The Registered Nurses will provide Medicaid members with current, easy to understand information on a variety of health topics including prevention strategies, self-care skills, wellness, chronic conditions, and complex medical situations. Supported by the Healthwise® Knowledgebase (a computerized database of over 1,900 of the most common health problems) and an array of other online and desk references, the Registered Nurses will help Medicaid members understand health issues, provide information on treatment options, review specific questions to ask their PCP and other providers and provide research analyses of treatments and diagnostic procedures. The Registered Nurses will support patient/provider interaction by encouraging members to give a clear medical history and information to providers and to ask clarifying questions. Through our 24-Hour Nurse Line members will also have 24 hour access to an audio health library with information on more than 2,000 topics, available in both English and Spanish.

Sports physicals

Aetna Better Health offers one sports physicals every 12 months to any Aetna Better Health Medicaid, CHIP and STAR Kids member who is under 19 years of age. Sports Physicals may be billed in conjunction with any other office visit (99201-99205, 99211-99215, 99381-99385, 99391-99395). The code for the completion of the form (99080) should be billed with appropriate diagnosis code in addition to other procedure codes used for the visit.

When a Sports Physical is the only reason for the visit, the provider should use CPT code 97169 – 97172 with the correct diagnosis codes (Z02.89, Z02.5 .) Do not use 99080, as this code is inclusive of the completion of the form only.

Enhanced vision services/elective contact lenses

All Aetna Better Health Medicaid members over the age of 12 may elect to receive medically necessary contact lenses in lieu of eyeglasses, up to a \$100 retail allowance (allowance applicable toward the

contact lenses and associated professional services). This benefit includes a fitting exam with additional benefits to be applied toward the purchase of contact lenses to correct vision. There is a 20% discount available for non-disposable lenses.

The benefit will be tracked using the following CPT codes Contact Lens Evaluation – S0592 Contact Lenses (Supplies) – v2500-v2599

Description of Flexible Benefits

Flexible family support disability-related services that include personal care support for basic activities of daily living (ADL) and instrumental ADL, skilled care and delegated skilled care supports designed to assist an individual participate in childcare or post-secondary education or increase the individual's independence. Flexible family support services provide temporary relief for the primary caregiver from caregiving activities during the time when the primary caregiver is working, attending job training or attending school.

Description of Rewards and Incentives

Description of Nominal Gifts

"Inexpensive" or Nominal Value gifts means a retail value of no more than \$15 per item and \$75 per patient annually.

Intensive Outpatient Treatment/Day Treatment (IOP)

Available for Medicaid members over age 21. At least two (2) hours/day and three (3) days/week of planned, structured services used as an alternative to or step down from more restrictive levels of care. Amount, duration and scope are based on medical necessity.

The benefit will be tracked using the following codes:

Revenue code: 905 (MH) or 906 (SA) HCPC code: H0015 (SA) or S9480 (MH)

Residential

Available for Medicaid members over age 21. Medically monitored diagnostic and therapeutic behavioral health services for members with long-term or severe mental or substance-related disorders that require 24-hour intermediate or non-acute levels of care for services that are not available through existing community programs. Amount, duration and scope are based on medical necessity.

The benefit will be tracked using the following codes:

Revenue code: 1001 (MH) or 1002 (SA)

HCPC code: H0017, H0018, H0019 (not MH or SA specific)

Value-added services to Aetna Better Health STAR Kids members

We also offer the following value-added services to Aetna Better Health STAR Kids Members:

<p>Over-the-Counter Services</p>	<p>The OTC Health Solutions program offers members a \$25 monthly allowance (\$300 annually). OTC medications and products can be ordered by phone, online, fax or mail and are then delivered directly to members' homes. Limited to \$25 per month (\$300 annually) per household. Discount drug store services. These products include*:</p> <ul style="list-style-type: none"> • Baby care • Cold remedies • Digestive health • Ear & eye care • Feminine care • First aid supplies • Foot care • Home diagnostics • Incontinence • Oral care • Pain relievers • Personal care • Vitamins/minerals <p>*Excludes prescriptions, alcohol, lottery, postage stamps, gift cards, money orders, prepaid cards and photo finishing and is not valid on any items reimbursed by the federal government.</p> <p>This benefit covers Over-the Counter (OTC) medications and other products items that do not need a prescription and are not otherwise covered benefits.</p>
<p>Extra Help Getting a Ride</p>	<p>Need help getting a ride? We can provide daily bus pass/token, cab fare or ride share for members and their legally authorized representative (LAR) as well as siblings if the LAR cannot make other arrangements; when needed to visit for WIC offices, plan sponsored community events/classes or attend Member Advisory Groups meetings.</p>
<p>Extra Vision Services</p>	<p>Aetna Better Health of Texas members will receive financial assistance in obtaining vision services and products.</p> <ul style="list-style-type: none"> • 21 years and older – Aetna will cover the cost of eye exams once every other year. • 21 years and older – Aetna will cover up to \$175 once every other year for eye wear

	<p>not limited to eyeglass frames, lenses and contact lenses that are not covered by Medicaid.</p> <ul style="list-style-type: none"> • Under 21 years old – Aetna will cover up to \$175 once a year for eye wear not limited to eyeglass frames, lenses and contact lenses that are not covered by Medicaid.
Behavioral Health Inpatient Follow-up Incentive	<p>Receive a \$25 gift card for members who complete a follow-up visit with their behavioral health provider within 7 days of leaving the behavioral health hospitalization.</p>
Help for Members with Asthma	<p>Members with an asthma diagnosis and enrolled in the asthma disease management program will receive the following, up to \$100 per year:</p> <ul style="list-style-type: none"> • One peak flow meter and holding chamber or spacer each year • Pest control • Hypoallergenic bedding • Vent cleaning • Deep carpet cleaning
Sports Physicals	<p>Medically necessary sports physicals to any member 19 years and younger who have completed a well-child visit.</p>
Cell Phone Assistance	<p>Members that qualify for the Federal Lifeline Program are provided with choice of a smartphone, feature phone or use of their personal cell phone to include the following plan options depending on coverage area.</p> <p>(1) Assurance Wireless: Android smartphone with 500 MB of data, 350 talk minutes and unlimited text;</p> <p>(2) EnTouch Wireless: use of personal cell phone, 500 MB of data, and 500 units of voice/text where 1 unit = 1 text or 1 minute;</p> <p>(3) EnTouch Wireless: Feature phone, 10 MB of data, 500 talk minutes, 100 texts;</p> <p>(4) Life Wireless: use of personal cell phone, 10 MB of data, 500 talk minutes and unlimited text.</p> <p>Member calls to and from the Health Plan and health-related texts received from the Health Plan will not apply to minute or text limits.</p>

Well-Child Exams

Members can receive:

- \$50 gift card at no cost to members for completing Texas Health Steps/well-child checkups/visits at 2 weeks and 2, 4, 6, months of age. Upon completion of these checkups, Members will call Member Services to redeem and request one \$50 gift card.
- \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkup/visit at 9 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one \$25 gift card.
- \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkup/visit at 12 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one \$25 gift card.
- \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkup/visit at 15 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one \$25 gift card.
- \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkups/visits at 18 and 30 months of age. Upon completion of each of these checkups, the Members will call Member Services to redeem and request one \$25 gift card. A total of two \$25 gift cards are available for completing both checkups.
- \$25 gift card at no cost to you each time an annual Texas Health Steps/well-child checkups/visits is received for members 3-20 years of age. Upon completion of each of these checkups/visits, the Members will call Member Services to redeem and request one \$25 gift card. Limit one card per member per year.

STAR Kids Screening and Assessment Gift Program

Aetna Better Health of Texas offers a \$25 gift card after completing the Aetna Better Health STAR Kids Initial Screening and Assessment Process within 10 business days of enrollment, re-assessment of SAI and signs up for the STAR Kids Member web portal within 30 calendar days

	after completion of SAI. Limit 1 gift card per member per year.
Respite Services	Up to an additional 10 hours in-home respite services for Aetna Better Health STAR Kids MDCP and coordinated care waiver members per month.

**** Restrictions and limitations may apply****

CHIP Member Eligibility and Added Benefits

Eligibility determination by HHSC

HHSC identifies recipients who are eligible for Aetna Better Health CHIP participation.

12-month eligibility for CHIP Program Members

Recipients deemed eligible for CHIP Services will have 12 months of continuous coverage. A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC’s enrollment broker.

A CHIP Perinate mother in a family with an income at or below Medicaid Eligibility Threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under Medicaid Eligibility Threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC’s enrollment broker.

A CHIP Perinate will continue to receive coverage through the CHIP Program as a “CHIP Perinate Newborn” if born to a family with an income above Medicaid Eligibility Threshold and the birth is reported to HHSC’s enrollment broker.

A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

Verifying eligibility

Every Aetna Better Health CHIP Member should have an Aetna Better Health CHIP ID card. The provider should request the Member’s plan ID card each time the Member presents for services. A copy of the Aetna Better Health CHIP ID card is included in Appendix A in this manual.

Aetna Better Health Medicaid ID card

We will issue a Member ID card to the Member within five (5) days of receiving notice of enrollment of the Member into the Aetna Better Health Medicaid program. The ID card will include at a minimum the following: Member’s name; Member’s Medicaid number; primary care provider’s name and telephone number; primary care provider effective date; plan eligibility effective date; the 24-hour,

7-day per-week Member Services eligibility telephone number; the toll-free number for behavioral health and vision services; and directions on what to do in an emergency.

Copies of the Aetna Better Health Medicaid ID card are included in Appendix A to this manual.

If the Member also received Medicare benefits, Medicare is responsible for most primary and acute services and some behavioral health services; therefore, the Primary Care Provider's name, address, and telephone number are not listed on the Member's ID card. (STAR Kids Dual Members)

Call Aetna Better Health of Texas

Call Aetna Better Health Providers may also verify eligibility through the Aetna Better Health website ([AetnaBetterHealth.com/Texas](https://www.AetnaBetterHealth.com/Texas)), or by calling Member Services at **1-844-787-5437**.

Provider Portal

Effective 1/1/2022 Availity is the Provider Portal for Aetna Better Health of Texas. Providers can register for access directly on Availity site www.availity.com/providers-portal-registration.

Providers can register for access directly on Availity site www.availity.com/providers-portal-registration

All current functionality of the Medicaid Web Portal has parallel functionality on Availity:

- Payer spaces
- Change Healthcare Claim Submission Link
- Contact us & messaging
- Claim Status Inquiry
- Grievance submission
- Appeals submission
- Grievance and Appeals status
- Provider Deliverable Manager
- Ambient (Business Intelligence Reporting)
- Clear claim
- ProPAT
- Provider intake
- Dynamo (Case Management)
- Prior Authorization submission and status lookup
- Eligibility & Benefits
- Enhanced G&A tool
- Panel Roster
- Remit PDF
- Enhanced (electronic) Remit Viewer

If you are already registered in Availity, you will simply **log in** and select Aetna Better Health from your list of payers to begin accessing the portal and all of the above features.

If you are not registered, we recommend that you do so immediately.

- Click here to learn more about Availity Portal Registration - <https://apps.availity.com/availity/Demos/Registration/index.htm>

- Click here to register - www.availity.com/provider-portal-registration
- For registration assistance, please call Availity Client Services at **1-800-282-4548** between the hours of 8 AM and 8 PM ET, Monday-Friday (excluding holidays)

Pharmacy Providers

Pharmacy must submit claims using Electronic eligibility verification, e.g., NCPDP E1 Transaction

Pregnant teens

Providers should contact Aetna Better Health immediately when they have identified a CHIP member who is pregnant by calling Member Services at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

CHIP Managed Care benefits and Aetna Better Health CHIP value-added services “Spell of illness” limitation removed

CHIP recipients have the following additional benefits under the CHIP Managed Care program. Aetna Better Health has developed several value-added services and extra benefits to provide our members with the best healthcare experience possible!

CHIP/CHIP Perinate Newborn Value-Added Benefits - see complete list in Member Handbook on our website AetnaBetterHealth.com/Texas.

Benefit Type	Benefit Description
24-Hour Nurse Line	This 24-hours-a-day, 7-days-a-week service enables all members to have telephonic access to clinical support from experienced registered nurses. Members can call the nurse line directly at 1-800-556-1555 for assistance.
Over-the-Counter Benefits/Discount Pharmacy	<p>The OTC Health Solutions program offers members a \$25 monthly allowance (\$300 annually). OTC medications and products can be ordered by phone, online, fax or mail and are then delivered directly to members' homes. Limited to \$25 per month (\$300 annually) per household. Discount drug store services. These products include*:</p> <ul style="list-style-type: none"> • Baby care • Cold remedies • Digestive health • Ear & eye care • Feminine care • First aid supplies • Foot care • Home diagnostics • Incontinence • Oral care • Pain relievers • Personal care • Vitamins/minerals <p>*Excludes prescriptions, alcohol, lottery, postage stamps, gift cards, money orders, prepaid cards and photo finishing and is not valid on any items reimbursed by the federal government.</p> <p>This benefit covers Over-the Counter (OTC) medications and other products items that do not need a prescription and are not otherwise covered benefits.</p>
Extra help for pregnant women	<p>Aetna Better Health offers our pregnant members:</p> <ul style="list-style-type: none"> • \$25 gift card and a special pregnancy handbook for enrolling in case management within 30 days of enrollment • \$25 gift card and a special pregnancy handbook for enrolling in case management within 30 days of pregnancy diagnosis if already a member • \$50 worth of diapers, baby wipes and/or similar items for completion of 3 prenatal visits • \$50 worth of diapers, baby wipes and/or similar items for completion of 3 additional prenatal visits (6 in total) and 1 postpartum care visit • Members will call the health plan when they have completed all their prenatal and postpartum visits to claim their gift of baby items • Pregnancy handbook for pregnant members in case management
PROMISE Program	<p>Our pregnant members can earn diapers, baby wipes or similar baby items.</p> <ul style="list-style-type: none"> • If you complete 3 prenatal visits you can earn up to \$50 worth of baby items.

	<ul style="list-style-type: none"> If you complete 3 more prenatal visits (6 total) and 1 postpartum visit after the baby is born you can earn another \$50 worth.
Extra help getting a ride	Need help getting a ride? We can provide daily bus pass/token, cab fare or ride share for members and their legally authorized representative (LAR) as well as siblings if the LAR cannot make other arrangements; when needed to visit for WIC offices, plan sponsored community events/classes or attend Member Advisory Groups meetings.
Extra Vision Services	<p>Aetna Better Health of Texas members will receive financial assistance in obtaining vision services and products.</p> <ul style="list-style-type: none"> 21 years and older – Aetna will cover the cost of eye exams once every other year. 21 years and older – Aetna will cover up to \$175 once every other year for eye wear not limited to eyeglass frames, lenses and contact lenses that are not covered by Medicaid. Under 21 years old – Aetna will cover up to \$175 once a year for eye wear not limited to eyeglass frames, lenses and contact lenses that are not covered by Medicaid.
Behavioral Health Inpatient Follow-up Incentive	Receive a \$25 gift card for members who complete a follow-up visit with their behavioral health provider within 7 days of leaving the behavioral health hospitalization.
Help for Members with Asthma	<p>Members with an asthma diagnosis and enrolled in the asthma disease management program will receive the following, up to \$100 per year:</p> <ul style="list-style-type: none"> One peak flow meter and holding chamber or spacer each year Pest control Hypoallergenic bedding Vent cleaning Deep carpet cleaning
Sports Physicals	Medically necessary sports physicals to any member 19 years and younger who have completed a well-child visit.
Cell Phone Assistance	<p>Members that qualify for the Federal Lifeline Program are provided with choice of a smartphone, feature phone or use of their personal cell phone to include the following plan options depending on coverage area.</p> <p>(1) Assurance Wireless: Android smartphone with 500 MB of data, 350 talk minutes and unlimited text;</p> <p>(2) EnTouch Wireless: use of personal cell phone, 500 MB of data, and 500 units of voice/text where 1 unit = 1 text or 1 minute;</p> <p>(3) EnTouch Wireless: Feature phone, 10 MB of data, 500 talk minutes, 100 texts;</p> <p>(4) Life Wireless: use of personal cell phone, 10 MB of data, 500 talk minutes and unlimited text.</p> <p>Member calls to and from the Health Plan and health-related texts received from the Health Plan will not apply to minute or text limits.</p>

Well-Child Exams	<p>Members can receive:</p> <ul style="list-style-type: none"> • \$50 gift card at no cost to members for completing Texas Health Steps/well-child checkups/visits at 2 weeks and 2, 4, 6, months of age. Upon completion of these checkups, Members will call Member Services to redeem and request one \$50 gift card. • \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkup/visit at 9 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one \$25 gift card. • \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkup/visit at 12 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one \$25 gift card. • \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkup/visit at 15 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one \$25 gift card. • \$25 gift card at no cost to you for completing a Texas Health Steps/well-child checkups/visits at 18 and 30 months of age. Upon completion of each of these checkups, the Members will call Member Services to redeem and request one \$25 gift card. A total of two \$25 gift cards are available for completing both checkups. • \$25 gift card at no cost to you each time an annual Texas Health Steps/well-child checkups/visits is received for members 3-20 years of age. Upon completion of each of these checkups/visits, the Members will call Member Services to redeem and request one \$25 gift card. Limit one card per member per year.
Home visits	Virtual home visit for lactation consultant for all new moms.
Dental Services	<p>Members are eligible for the following annual dental benefits:</p> <ul style="list-style-type: none"> • Cleaning every 6 months • X-Rays once a year • Simple extractions • Limited fillings • Fluoride treatments
Smoking Cessation Program	A smoking cessation program including assessment and counseling is offered to members 12 years of age and older. This program will provide members with the tools and support to assist them to stop smoking and lead healthier lives.

**** Restrictions and limitations may apply****

CHIP Perinate Covered Benefits and Limitations

Benefit Type	Benefit Description	Limitation
<p>Inpatient general acute</p>	<p>Services include:</p> <ul style="list-style-type: none"> • Covered medically necessary hospital-provided services. • Operating, recovery and other treatment rooms. • Anesthesia and administration (facility technical component). • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). <p>Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:</p> <ul style="list-style-type: none"> • Dilation and curettage (d&c) procedures, • Appropriate provider - administered medications, • Ultrasounds, and • Histological examination of tissue samples 	<p>For CHIP Perinate in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however professional services charges associated with labor with delivery are a covered benefit.</p> <p>For CHIP Perinate in families with incomes above 185% up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth.</p>

Benefit Type	Benefit Description	Limitation
<p>Comprehensive outpatient hospital, clinic (including health center) and ambulatory health care center</p>	<p>Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Outpatient services associated with miscarriage or non-viable pregnancy includes, but are not limited to: <ul style="list-style-type: none"> – Dilation and Curettage (d&c) procedures, – Appropriate provider-administered medications, ultrasounds, and – Histological examination of tissue samples <p>Note: Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth</p> <p>Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy.</p> <p>Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis.</p> <p>Laboratory tests for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody</p>	<p>May require prior authorization and physician prescription</p>

	<p>screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.</p> <p>Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.</p>	
<p>Comprehensive outpatient hospital, clinic (including health center) and ambulatory health care center (Continued)</p>	<p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. <p>Physician office visits, in-patient and out-patient services</p>	<p>May require authorization for specialty referral from a primary care provider to an in-network specialist.</p>

Benefit Type	Benefit Description	Limitation
Physician / physician extender professional services	<p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. • Physician office visits, in-patient and out-patient services • Laboratory, x-rays, imaging and pathology services, including technical component or professional interpretation Medically necessary medications, biologicals and materials administered in Physician’s office • Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> – Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. – Administration of anesthesia by physician (other than surgeon) or CRNA – Invasive diagnostic procedures directly related to the labor with delivery of the unborn child – Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). 	<p>Requires authorization for all out-of-network specialty referrals.</p> <p>Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation.</p>
Physician / physician extender professional services (continued)	<ul style="list-style-type: none"> • Hospital-based physician services (including Physician-performed technical and interpretive components) • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional services associated with miscarriage or non-viable pregnancy include but are not limited to: dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples. 	<p>Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.</p>

		are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review.
Prenatal care and pre-pregnancy family services and supplies	<p>Covered services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:</p> <ul style="list-style-type: none"> • One visit every four weeks for the first 28 weeks of pregnancy; • One visit every two to three weeks from 28 to 36 weeks of pregnancy; and • One visit per week from 36 weeks to delivery. <p>More frequent visits are allowed as medically necessary.</p>	Does not require prior authorization.

Member Rights and Responsibilities

Medicaid Managed Care Member Rights and Responsibilities Member Rights:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
 - a) Be treated fairly and with respect.
 - b) Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - a) Be told how to choose and change your health plan and your primary care provider.
 - b) Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
 - c) Change your primary care provider.
 - d) Change your health plan without penalty.
 - e) Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
 - a) Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
 - b) Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - a) Work as part of a team with your provider in deciding what health care is best for you.
 - b) Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
 - a) Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
 - b) MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program.
 - c) Get a timely answer to your complaint.
 - d) Use the plan's appeal process and be told how to use it.
 - e) Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
 - f) Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - a) Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
 - b) Get medical care in a timely manner.

- c) Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
- d) Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language,
 - e) help someone with a disability, or help you understand the information.
 - f) Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
- 7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do, or is to punish you.
- 8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- 9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
 - a) Learn and understand your rights under the Medicaid program.
 - b) Ask questions if you do not understand your rights.
 - c) Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
 - a) Learn and follow your health plan's rules and Medicaid rules.
 - b) Choose your health plan and a primary care provider quickly.
 - c) Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
 - d) Keep your scheduled appointments.
 - e) Cancel appointments in advance when you cannot keep them.
 - f) Always contact your primary care provider first for your non-emergency medical needs.
 - g) Be sure you have approval from your primary care provider before going to a specialist.
 - h) Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
 - a) Tell your primary care provider about your health.
 - b) Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
 - c) Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
 - a) Work as a team with your provider in deciding what health care is best for you.
 - b) Understand how the things you do can affect your health.
 - c) Do the best you can to stay healthy.

- d) Treat providers and staff with respect.
- e) Talk to your provider about all your medications.

Additional Member Responsibilities while using our NEMT services with Access2Care.

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

CHIP Member Rights and Responsibilities

Member Rights:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.

10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
19. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
20. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member Responsibilities:

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.

5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child's provider about all your child's medications.

CHIP Perinate Member Rights and Responsibilities

Member Rights:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.

You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
3. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
4. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
5. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
6. You have the right and responsibility to take part in all the choices about your unborn child's health care.
7. You have the right to speak for your unborn child in all treatment choices.
8. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
9. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
10. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
11. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Member Responsibilities:

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. Talk to your provider about all your medications.

Member's Right to Designate an OB/GYN

Members' right to designate an OB/GYN (Excluding STAR Kids Dual Eligible Members)

Aetna Better Health of Texas allows the member to pick any OB/GYN, whether that doctor is in the same network as the Member's Primary Care Provider or not.

Attention Female Members:

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

Fraud Reporting

Fraud Information - Reporting Waste, Abuse or Fraud by a provider of client

Medicaid Managed Care and CHIP

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she must get benefits.

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184**;

- Visit <https://oig.hhsc.state.tx.us/>. Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
- You can report directly to your health plan:
Aetna Better Health of Texas
P. O. Box 818042
Cleveland, OH 44181-8042
1-800-306-8612 (Tarrant) or **1-800-248-7767** (Bexar).

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
 - Name, address, and phone number of providers
 - Name and address of the facility (hospital, nursing home, home health agency, etc.)
 - Medicaid number of the provider and facility, if you have it
 - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
 - Names and phone numbers of other witnesses who can help in the investigation
 - Dates of events
 - Summary of what happened
- When reporting about someone who gets benefits, include:
 - The person’s name
 - The person’s date of birth, Social Security number, or case number if you have it
 - The city where the person lives
 - Specific details about the waste, abuse, or fraud

Medicaid Managed Care/CHIP Encounter Data, Billing and Claims Administration

Where to send claims/Encounter Data

Network providers must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid Program.

For claims submission:

Electronic claims: Change HealthCare – Use Payer ID **38692**

If your electronic billing vendor can convert to 38692, but doesn’t submit directly to Change HealthCare, we recommend that you use “MC” prior to the member number to make sure the claims are processed correctly.

Claims submitted by providers that are newly enrolled in Texas Medicaid must be received within 95 days of the date that the new provider identifier is issued, and within 365 days of the date of service. Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be denied by Aetna Better Health until a provider identifier is issued. Providers can use the Aetna Better Health remittance advice with the denial as proof of meeting the 365-day deadline and submit an appeal. The appeal must include a copy of the letter from TMHP assigning the provider identifier (TPI). It is not necessary to include a new claim. A report, worksheet, or copy of the denied claim remittance advice along with the TMHP letter is adequate. An alternate method for newly enrolling providers is to wait until the TPI number letter is received to bill the claims. The claims must then be billed on a paper claim form with a

copy of the TMHP letter attached to each claim. As in the method above, we must receive the claims with attached letter within 95 days of the TMHP letter date and within 365 days of the date of service. All claims should be sent to us by either Electronic Data Interchange (EDI) or on paper claim forms as listed below. The preferred method of submitting claims is via EDI. Please submit with Payer ID 38692.

If submitting claims on paper claim forms, please mail to:

Aetna Better Health of Texas

P.O. Box 982964

El Paso, TX 79998-2964

These submission methods apply to all claim types including:

- Professional claims for all medical services
- Inpatient and outpatient facility claims
- Claims for services rendered in a nursing facility or ICF for IDD or other related conditions
- Claims for custom DME or augmentative devices when the member changes health plans and the authorizing health plan is not the Aetna Better Health on the date of delivery
- Claims for minor home modifications for a MDCP STAR Kids Waiver Member when the member changes health plans and the authorizing health plan is not Aetna Better Health on the date of completion of the modifications
- Claims for LTSS (Long Term Support Services) for MDCP STAR Kids Waiver Members.
- Nursing Facilities daily rate claims continue to be responsibility of TMHP, claims for Acute Care and Service Coordination services to a Member residing in a Nursing Facility or an ICF/IID which are not part of the daily rate should be submitted to Aetna.

The following Texas programs, services, or benefits have been excluded from Aetna Better Health of Texas Covered Services. Members may be eligible to receive these Non-capitated Services on another basis, such as a Fee-for-Service basis or through a Dental health plan (for most dental services).

- Texas Health Steps dental (including orthodontia) – bill to Member’s Dental Plan;
- Texas Health Steps environmental lead investigation (ELI) – bill to Texas Medicaid & Healthcare Partnership (TMHP)
- Early Childhood Intervention (ECI) case management/service coordination – bill to TMHP;
- Early Childhood Intervention Specialized Skills Training – bill to TMHP;
- Case Management for Children and Pregnant Women – bill to TMHP;
- Texas School Health and Related Services (SHARS) – bill to TMHP;
- Department of Assistive and Rehabilitative Services Blind Children’s Vocational Discovery and Development Program – bill to TMHP;
- Tuberculosis services provided by DSHS-approved Providers (directly observed therapy and contact investigation) – bill to TMHP;
- Health and Human Services Commission’s Medical Transportation Program – bill to TMHP;
- DADS hospice services – bill to TMHP;
- DADS or DSHS HCBS Waiver programs, authorized under Social Security Act § 1915(c), including Youth Empowerment Services (YES)
- Community Living Assistance and Support Services (CLASS)

- Deaf Blind with Multiple Disabilities (DBMD)
- Texas Home Living (TxHmL)
- Home and Community-based Services (HCS) – bill to TMHP
- LTSS services only to TMHP for all waivers except MDCP STAR Kids.
- Court-Ordered Commitments to inpatient mental health facilities as a condition of probation – bill to TMHP; and
- Nursing facility services and intermediate care facility (ICF) which includes daily rate claims – bill to TMHP.

Provider Portal Functionality (both online and batch claims processing)

Providers can verify the status of a claim via the web portal.

Form/Format to use

The claim forms providers use to submit claims to Aetna Better Health have changed to accommodate the National Provider Identifier (NPI). The approved claim forms are the CMS 1500 and the CMS 1450. Allowable billing methods include paper or electronic billing. Forms CMS 1500 and CMS 1450 are explained below.

CMS-1500 Professional Claim Forms

Providers must use the revised CMS-1500 (version 08/05) claim form to file or re-file claims. The table below provides HHSC Managed Care Organization paper claim filing requirements. The fields indicated below are specific to the NPI Implementation.

Field	Definition	Description	Requirement
11c	Insurance Plan or Program Name	Enter the benefit code, if applicable, for the billing or performing provider.	Benefit code, if applicable
17	Referring Provider or Other Source	Name of the professional who referred or ordered the service(s) or supply(s) on the claim.	NPI
17a	Other ID#	The Other ID number of the referring provider, ordering provider, or other source should be reported in 17a.	NPI or Atypical
17b	NPI	Enter the NPI of the referring provider, ordering provider, or other source.	NPI
24j	Rendering Provider ID# (Performing)	The individual rendering the service should be reported in 24j. Enter the TPI in the shaded area of the field. Enter the NPI in unshaded area of the field.	TPI is shaded field and NPI in unshaded area

32	Service Facility Location Information	Enter the name, address, city, state, and ZIP code of the location where the services were rendered.	Enter facility information when applicable
32a	NPI	Enter the NPI of the service facility location.	NPI
32b	Other ID#	Enter the non-NPI ID number of the service facility. This refers to the payer-assigned unique identifier of the facility.	TPI
33	Billing Provider Info and Ph. No.	Enter the provider's or supplier's billing name, address, ZIP code, and telephone number.	The billing provider's information
33a	NPI	Enter the NPI of the billing provider.	NPI
33b	Other ID#	Enter the non-NPI ID number of the service facility. This refers to the payer-assigned unique identifier of the facility.	TPI required

UB-04 Institutional Claim Form

Field	Definition	Description	Requirement
56	NPI	Enter the NPI of the billing provider.	NPI
57a	Other ID#	Enter the non-NPI ID number of the billing provider.	TPI (optional)
73	Benefit Code	Enter the benefit code, if applicable, for the billing provider.	Benefit code, if applicable (optional)
76	Attending Provider	Attending provider name and identifiers (including NPI): Required when claim/encounter contains any services other than nonscheduled transportation services. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/encounter.	NPI required. TPI in field to the right of Qualifier box, if applicable

77	Operating Provider	Operating provider name and identifiers (including NPI): Required when a surgical procedure code is listed on the claim. The name and ID number of the individual with the primary responsibility for performing the surgical procedure(s).	NPI required. TPI in field to the right of Qualifier box, if applicable
78-79	Other (a or b) Provider	<p>Other provider name and identifiers (including NPI): The name and ID number of the individual corresponding to the action of the claim: Referring Provider – The provider who sends the patient to another provider for services.</p> <p>Required on an outpatient claim when the referring provider is different than the attending physician.</p> <p>Other Operating Physician – An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved.</p> <p>Rendering Provider – The health care professional who performs, delivers, or completes a particular medical service or non-surgical procedure.</p>	NPI required. TPI in field to the right of Qualifier box, if applicable

Providers must use the UB-04 CMS-1450 claim form to submit or resubmit claims, including appeals. The table below provides HHSC Managed Care Organizations paper claim filing requirements. The fields indicated in the table below are specific to the NPI Implementation. What services are included in the monthly capitation.

Please call Aetna Better Health to **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) if you have any questions about the member benefits.

Emergency Services Claims

Payment for emergency services is made based on the “Prudent Layperson” standard. Utilization of the emergency department for routine follow-up services such as suture removal, dressing change or well-person checkups is not appropriate. Claims for routine services provided in the emergency room will be denied.

Aetna Better Health does not require prior authorization for emergency services and does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The attending emergency physician or the provider treating the Member is responsible for determining when the Member is stable. Post-stabilization care provided to maintain, improve, or resolve the Member's stabilized condition is subject to prior authorization and notification requirements. We require notice of inpatient admission on the next business days following a non-elective admission.

Services are covered for the period of time it takes for us to make a determination, including times Medical Management cannot be contacted, does not respond to a request for approval within an hour, or a Medical Director is not available for consultation when medical necessity is questioned by the Medical Management staff.

The Aetna Better Health's Medical Management Department has staff available by toll-free telephone at least 40 hours per week during normal business hours, Monday through Friday, except for State approved holidays. The phone system can accept and recording messages for incoming phone calls during non-business hours and the Medical Management staff responds to such calls the next business day in most cases and no later than 2 working days.

In the event a provider requests post stabilization care subsequent to emergency treatment when Medical Management staff is available, notification will occur within a time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from request. In such circumstances, notification shall be provided verbally to the treating physician or health care provider. In any instance where a service authorization request or authorization of service in an amount, duration or scope less than that requested is questioned, the health care provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the patient with the clinical basis for the decision with a physician prior to the issuance of a determination.

At least 1 documented attempt at peer to peer between the Medical Director and the treating physician will be made prior to an adverse determination. Benefits may be continued for the period of time it takes an appeal of the adverse determination to be resolved, both at the health plan appeal level and the external review by a State Fair Hearing officer or an Independent Review Organization (IRO).

Cost sharing schedule for Aetna Better Health CHIP members

The chart below is the complete cost sharing table for all CHIP eligible members depending on their income level. Copayments for medical services or prescription drugs are paid to the health care provider at the time of service. No copayments are paid for well-child and well-baby services, preventive services or pregnancy-related assistance. No copayments are required for CHIP Members who are Native Americans or Alaskan Natives.

The Aetna Better Health CHIP ID card lists the copayments that apply to each family's situation. Aetna Better Health CHIP members should present their ID card when they receive physician or emergency room services or have a prescription filled.

No co-payments for MMC Members, CHIP Perinate Members, CHIP Perinate Newborn Members, and CHIP Members who are Native Americans or Alaskan Natives. Additionally, for CHIP Members there is no cost-sharing on benefits for well-baby and well-child services, preventive services, or pregnancy- related assistance.

CHIP Cost-Sharing	
	Effective January 1, 2014
Enrollment Fees (for 12-month enrollment period):	
<u>At or below 151% of FPL*</u>	\$0
	Charge
<u>At or below 151% of FPL*</u>	\$0
<u>Above 151% up to and including 186% of FPL</u>	\$35
<u>Above 186% up to and including 201% of FPL</u>	\$50
Co-Pays (per visit):	
At or below 151% FPL	Charge
Office Visit (non-preventative)	\$5
Non-Emergency ER	\$5
Generic Drug	\$0
Brand Drug	\$5
Facility Co-pay, Inpatient (per admission)	\$35
Cost-sharing Cap	5% (of family's income)**
Above 151% up to and including 186% FPL	Charge
Office Visit (non-preventative)	\$20
Non-Emergency ER	\$75
Generic Drug	\$10
Brand Drug	\$35
Facility Co-pay, Inpatient (per admission)	\$75
Cost-sharing Cap	5% (of family's income)**
Above 186% up to and including 201% FPL	Charge
Office Visit (non-preventative)	\$25
Non-Emergency ER	\$75
Generic Drug	\$10
Brand Drug	\$35
Facility Co-pay, Inpatient (per admission)	\$125
Cost-sharing Cap	5% (of family's income)**

CHIP cost sharing caps

Members receive a guide from the CHIP Enrollment Broker when they enroll in the CHIP program. Included in the guide is a tear-out form that can be used to track CHIP expenses. To ensure that members do not exceed their cost-sharing limit, guardians must keep track of CHIP-related expenses

on the form. The enrollment packet welcome letter tells the member exactly what their cost-sharing cap is, based on family income.

Members may contact the CHIP Helpline at **1-800-647-6558** to verify their annual limit. When members reach their annual cap, they may send the form to CHIP Enrollment Broker and CHIP Services will notify Aetna Better Health of this information and we will issue a new Member ID card. This new card will show that no copayments are due when the member receives services.

Billing Members

Except as specifically indicated in the Medicaid benefit descriptions, a provider may not bill or require payment from members for Medicaid covered services. Providers may not bill or take recourse against members for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the STAR Program. For more information, please refer to Section 1.4.9 of the Texas Medicaid Provider Procedures Manual found at www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html.

Private Pay Agreement/Member Acknowledgement

If an Aetna Better Health of Texas STAR Kids member decides to go to a provider that is not within the Aetna Better Health of Texas STAR Kids network or chooses to get services that have not been authorized or are not a covered benefit, the member must document his/her choice by signing the Private Pay Agreement (Appendix I) and the Member Acknowledgement form (Appendix J).

If a claim is not received by Aetna Better Health within 95 days, the claim will be denied unless excepted from the claims filing deadline. For more information, refer to the Texas Medicaid Provider Procedures Manual, Section 6.1.3, "Claims Filing Deadlines," which includes exceptions for inpatient facility claims, claims by newly-enrolled Medicaid providers, claims by out-of-state providers, and other exceptions www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html.

Participating providers shall be paid by us, no later than 30 working days after receipt of a completed "clean" claim for covered services. A clean claim is one that is accurate, complete (that is, includes all information necessary to determine Aetna Better Health liability), not a claim on appeal, and not contested (that is, not reasonably believed to be fraudulent and not subject to a necessary release, consent or assignment). Aetna Better Health will indicate to participating providers within 30 days of receipt if claims received by Aetna Better Health, are not clean claims.

Time limit for submission of claims/Encounter Data/claims Appeals

If the claim is not filed with Aetna Better Health within 95 days from the date the covered service was rendered, the right to payment will be waived by the participating provider. Payment will not be waived if the participating provider establishes to the reasonable satisfaction that there was justification for a delay in billing or that delay was caused by circumstances beyond the participating provider's control. In the case of a retroactive enrollment of the member, the filing deadline is the later of 95 days from the date of enrollment or 95 days from the member's add date as shown on the TMHP website.

Claims payment

30-day Clean Claim payment for professional and institutional claim submission

Aetna Better Health of Texas will pay providers interest at an 18 percent annual rate, calculated daily,

for the full period in which the Clean Claim or portion of the Clean Claim remains un-adjudicated beyond the 30-day Claims Processing deadline. The principal amount on which the interest payment will be calculated is the amount due but unpaid at the contracted rate for the service.

18-day Clean Claim payment for electronic pharmacy claim submission

Pharmacy providers are required to submit their electronic claims for payment within 90 days. Participating pharmacy providers must be paid by our Pharmacy Benefits Manager, CVS Caremark, no later than 18 working days after receipt of a completed “clean” claim for covered services. CVS Caremark pays pharmacies in accordance with Texas prompt pay regulations. Aetna Better Health Pharmacy Benefit Manger performance guarantee’s all clean claims are paid within 18 days, while submitted clean paper claims will be paid within 21 days.

Claim submission requirement (within 95 days)

Providers must submit claims within 95 days of the rendering of service, or within 95 days of the primary carrier’s EOB in the Coordination of Benefits (COB) case. The network provider understands and agrees that it may not interfere with or place any liens upon the state’s right or the Aetna Better Health’s right, acting as the State’s agent, to recovery from third party resources.

Payment/accrual of interest by Aetna Better Health

Aetna Better Health reimburses at an 18 percent annual rate, calculated daily, for the full period in which the Clean Claim, or portion of the Clean Claim remains un-adjudicated beyond the 30-Day Claims Processing deadline.

EFT/ERA Registration Services (EERS)

Aetna Better Health of Texas partners with Change Healthcare for Electronic Remittance Advice and Electronic Funds Enrollment.

EERS offers providers a standardized method of electronic payment and remittance while also expediting the payee enrollment and verification process. Provider will be able to use the Change Healthcare tool to manage EFT and ERA enrollments with multiple payer on a single platform.

How and when to enroll?

For new provider enrollment to EERS, please visit <https://payerenrollservices.com/>.

Providers currently enrolled with ABHTX EFT/ERA will not be impacted by this.

For questions or concerns, please visit the Change Healthcare FAQ page.

Contact Change Healthcare

1-800-956-5190

Monday-Thursday 8AM-5PM CT

Allowable billing methods

Allowable billing methods include paper or electronic billing. Forms CMS 1500 and CMS 1450.

Special billing

Special Billing for Newborns

Providers may bill claims for newborns using the mother's ID. The name of the member should be listed as the same last name of the mother and then Baby Girl or Baby Boy. The baby's actual date of birth should be used.

Special Billing for Value Added Services

Value added services should be billed as described above.

Special Billing for SSI

Claims for members on SSI should be billed as described above.

Special Billing for Non-Emergency Transportation (NEMT)

Claims for NEMT services for members should be billed to Access2Care

Toll free line: **1-866- 874-0222**, Option 3.

Email to: **A2CAUDITS@AMR.net**

Claims Submission Address:

6363 S. Fiddlers Green Circle, Suite 1400

Greenwood Village, CO 80111

Medical Management

Aetna Better Health's Medical Management model emphasizes integrated care management, prior authorization, discharge planning and targeted concurrent review. The Medical Management staff is accessible through a toll- free telephone number at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) during normal business hours (8 AM – 5 PM, Monday through Friday). Messages left on weekends, State-approved holidays and after normal business hours will be returned on the next business day.

The Aetna Better Health Medical Management utilization management department makes decisions based on the appropriateness of care and service. Requests for coverage are reviewed to determine if the service requested is a covered benefit and is delivered in accordance with established guidelines. If a request for coverage is denied, the Member (or a physician acting on behalf of the Member) may appeal this decision through the complaint and appeal process.

Medical Management has adopted screening criteria and established review procedures which are periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians and other health care providers. Utilization review decisions are made in accordance with

currently accepted medical or health care practices, considering special circumstances of each case. In addition to the Texas Medicaid Provider Procedures Manual, Aetna Better Health has adopted Milliman Care Guidelines®, which are nationally recognized objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis.

The Medical Management staff also utilizes Aetna Better Health Clinical Policy Bulletins (CPBs) as supplemental guidelines in determining the safety, effectiveness and medical necessity of selected medical technologies. Screening criteria is used to determine only whether to approve the requested service. Flexibility may be utilized when applying screening criteria in determining utilization review

decisions for Members with special health care needs. This may involve Members who have a disability, acute condition or a life-threatening illness. Cases that cannot be approved by a nurse reviewer are referred to a Medical Director to determine medical necessity.

In any instance where an authorization request of service in an amount, duration or scope less than that requested is questioned, the health care provider who ordered the services shall be afforded an opportunity to discuss the plan of treatment for the patient with the clinical basis for the decision with a physician prior to the issuance of a determination. A reasonable opportunity to discuss their services under review (peer to peer) between the Medical Director and the treating physician will be made prior to an adverse determination.

Aetna Better Health does not require prior authorization for emergency services and does not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms. The attending emergency physician or the provider treating the Member is responsible for determining when the Member is stable.

Post-stabilization care provided to maintain, improve or resolve the Member's stabilized condition is subject to prior authorization and notification requirements, but is covered for the period of time it takes for Aetna Better Health to make a determination, including times the Plan cannot be contacted, does not respond to a request for approval within one hour, or a Medical Director is not available for consultation when medical necessity is questioned by the Medical Management staff.

Utilization Management

The Utilization Management Department is responsible for maintaining a system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of health services provided, being provided, or proposed to be provided to members.

Prior authorization

Prior Authorization is the prospective review of the medical necessity and appropriateness of the selected health services. The prior authorization list is reviewed and revised periodically to ensure only those services that are medical management issues are subject to review by the health plan and approved before the services are eligible for reimbursement. Requests for prior authorization must be submitted for medical necessity review and a determination made prior to the start of care.

The process for requesting services that require prior authorization:

- Complete the Texas Universal Authorization Form.
- Fax acute care and private duty nursing request to Aetna Better Health Prior Authorization department at **1-866-835-9589**.
- Fax LTSS requests to Aetna Better Health Service Coordination Department at **1-844-275-5728**.
- Include any pertinent clinical information that supports the medical necessity of the request, such as a Title XIX form, test results, information about failed conservative treatment.
- Allow at least 3 business days for a response if medically appropriate. Urgent requests for medically non-urgent services will be handled within the timeframes for a routine request.
- Respond to requests for additional information timely.

Medical Management staff will review the information submitted for medical necessity, verify eligibility and benefits for the member and issue a determination. Approvals will be communicated to

the requesting provider. Adverse determinations will be communicated to the requesting provider immediately followed by a written notice of the determination and appeal rights. For the most up to date Prior Authorization list of services and codes, please refer to our online provider authorization tool <https://medicaidportal.aetna.com/propat/Default.aspx>.

PA Not Required

If a request for services is submitted to Aetna Better Health of Texas's Utilization Management department which doesn't require prior authorization, the request will be returned stating PA not required or Prior Authorization not required. "PA Not Required" does not mean that service is approved. It means a medical necessity review of the request is not required.

Concurrent review

Concurrent Review is the ongoing review of the medical necessity and appropriateness of previously authorized health services. This includes extensions of outpatient services and review of hospitalized members. Aetna Better Health of Texas must be notified of an inpatient admission within one business day of the admission. A coverage determination will be made within one business day.

The process for requesting services for an inpatient admission:

- Complete the Texas Universal Authorization Form.
- Fax to Aetna Better Health Concurrent Review department at **1-866-706-0529**.

Include any pertinent clinical information that supports the medical necessity of the request, such as a Title XIX form, test results, information about failed conservative treatment.

- Allow at least 1 business days for a determination to be made.

Respond to requests for additional information timely. A determination will be made with information Available in order to make a determination within 1 business day.

Maternity Members

Members who become eligible for Medicaid due to pregnancy, as well as any Medicaid or CHIP member who becomes pregnant while on the Plan, receive educational materials and telephone interventions encouraging them to seek early prenatal care, attend all scheduled prenatal visits and make healthy lifestyle choices to succeed in a healthy birth outcome. Assessment and questionnaires are conducted to identify members who may be at risk for complications related to their pregnancy.

In addition to the traditional Medicaid obstetrical benefits, including genetic services from full-service genetic providers, we provide case management for high-risk pregnancies. Care Management staff initiate contact with these members as soon as they are identified to provide coaching, education and other services to help the member and her providers in developing a care plan. Care Managers follow up with the member to assess compliance with their plan of care and monitor for early signs of complications.

Providers are encouraged to refer their OB patients to the Care Management Department as soon as the pregnancy is confirmed to facilitate care coordination and minimize delays in payment. To refer an OB patient, please call the Aetna Better Health Member Services Department at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

Transplants

Members that require organ/tissue transplants that include bone marrow, peripheral stem cell, heart, lung, liver, kidney and combined heart/lung receive case management services to facilitate continuity and coordination of care among the providers who care for the member. Transplants must be performed in an institution that is certified by Texas Medicaid and participates in the Aetna Better Health Medicaid, CHIP and STAR Kids programs. Prior authorization for transplant services is required and exceptions to any provisions defined in the Texas Medicaid Provider Procedures manual must be approved by the Medical Director. To request case management services for an Aetna Better Health member who is a potential transplant recipient, call the Aetna Better Health Member Services Department.

Integrated Care Management services

Integrated Care Management is a collaborative process of biopsychosocial assessment, planning, facilitation, care coordination, evaluation, and advocacy for service and support options to meet a member's and/or family/ representative's comprehensive care needs to promote quality cost-effective outcomes. Care management includes assistance to members with the management of chronic conditions, providing them education and encouragement to learn self-management skills and coordinating access to the appropriate services and supports. Aetna Better Health attempts to assist in the efficient utilization of medical resources for Members with special health care needs, including highly complex chronic and catastrophic cases to improve access to quality care and avoid unnecessary medical costs.

Aetna Better Health utilizes data from multiple sources to identify members who may benefit from care management. Sources include information obtained from the predictive modeling tools; data collected through the utilization management and care management processes.

The multidisciplinary Medical Management staff includes designated Care Managers for high-cost catastrophic cases, high-risk OB, pediatric, adult, premature infant, behavioral health and Members with Special Health Care Needs.

The Medical Management staff use screening tools and guidelines to identify Members with catastrophic, complicated or complex conditions as soon as possible after becoming Aetna Better Health Medicaid, CHIP and STAR Kids Members. Members are assigned to a Care Manager as soon as they are identified for assessment and development of a care plan. Care plans are based on the Member's medical, behavioral health care or social needs. Templates for condition-specific care plans are customized with Member specific goals in cooperation with the Member, the Member's family, the Primary Care Provider and other practitioners involved in the care of the Member. The plan includes goals and objectives with targeted interventions to meet those goals and objectives.

Reassessment is done regularly to determine progress and the plan is modified when acute needs are identified and then periodically as the Member moves through the continuum of care. Once the stated goals and objectives are met, the Member is discharged from care management. The Care Manager takes a proactive approach to managing the health of the Member and providing Members with health promotion information and assistance based on individual Member conditions. Results have shown that personalized care management planning with regular follow-up is the most effective method of managing cost and improving outcomes.

Treating providers may refer Members for Care Management services by calling the Aetna Better Health Member Services Department at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

Members may also self-refer for case management.

Chronic Condition Management (Disease Management) Interventions

A component of ICM that is offered in each service level is assistance with the management of chronic conditions. Care Management staffs work with members to address issues related to their asthma, diabetes, and depression.

Condition management interventions include telephonic and print education on self-monitoring, health behaviors, referral for appropriate medical testing, assistance with techniques to better adhere to medication regimens and treatment plans addressing member rationale for non-adherence, collaboration (with member's consent) with providers and caregivers, and provision of resources external to the organization, as appropriate. Further, as behavioral health and substance use issues are commonly co-occurring, each member identified as having problems in one of these areas (either by self-report, referral, initial assessment or claims data) is screened for both issues so that the appropriate resources and services can be arranged.

These assessments are based on national clinical guidelines for care and self-management of specific chronic illnesses:

- Asthma (adult and pediatric modules)
- Depression
- Diabetes

Additionally, members are screened for behavioral health and substance use disorders:

- K-6
- UNCOPE
- PSC-17
- CRAFFT

These assessments are used to generate chronic condition management education and to evaluate whether members are receiving recommended care for their chronic conditions. If the screenings indicate a problem the case manager will arrange for member to receive an assessment and any recommended services with the appropriate provider.

Case managers also use care plan intervention options to help address a member's chronic condition goals. Interventions associated with the management of chronic conditions typically include:

- Referral to PCP and/or specialty provider for a full clinical assessment (e.g. allergist, pulmonologist)
- Facilitate access to durable medical equipment (DME) (e.g. Peak Flow Meter, Nebulizer peak flow meter, nebulizer)
- Review of the member's co-morbidities for possible referral to intensive care management
- Referral to community agencies and support programs (e.g.. support groups)
- Condition specific educational mailings targeted toward the member's unique conditions
- Bi-annual condition specific newsletters
- Website for members and providers for access to condition related information and educational materials (i.e. Krames, Medline Plus)

- Provider notification of member enrollment
- Collaboration with providers on care plan goals, appointment follow-up, and both treatment and care plan adherence
- Introductory letter explaining the program benefits, services and how providers are involved
- Periodic health review of claims (medical and pharmacy) activity
- 24-Hour Nurse Line
- Member and provider web portals to access care plans and member information
- Encouraging members to communicate with their care and service providers
- Psychosocial issues and cognitive limitations are incorporated into the individualized care plan as are the cultural practices and beliefs that are most important to the member
- Arranging transportation as indicated
- Access to online health appraisals
- Access to wellness programs to address health behaviors that may affect the member's overall health (e.g.: physical activity, tobacco use, alcohol consumption)

To refer a patient for chronic condition management, please call the Aetna Better Health Member Services Department at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

Members with special health care needs

Members with Special Health Care Needs are those members who have has a serious ongoing illness, a Chronic or Complex Condition, or a Disability that has lasted or is anticipated to last for a significant period of time, and requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel. These conditions require ongoing treatment and or monitoring. Aetna Better Health provides the following services for members with Special Health Care Needs or needs other than the general population.

Provider Portal

Providers can verify the status of a Prior Authorization via the web portal. Claims questions/Appeals (see Section VII - included in the complaint and appeals processes).

How to find a list of covered drugs

Check the list of covered drugs at www.txvendordrug.com.

How to find a list of preferred drugs

You can find out if a medication is on the preferred drug list. All preferred drugs are available without prior authorization (PA). Check the list of covered drugs at www.txvendordrug.com.

How to find a list of PA required services and codes

Check the list of services and code that require PA on our website AetnaBetterHealth.com/Texas.

Continuity of Care and Out of Network Provider Requirements

Pregnant Women

Aetna Better Health allows pregnant members past the 24th week of pregnancy to remain under the care of their current Ob/Gyn through the Member's postpartum checkup, even if the provider is out

of-network. She may select an Ob/Gyn within the network if she chooses to do so and if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

Member moves out-of-service area

Members who move out of the service area are responsible for obtaining a copy of their medical records from their current primary care provider to provide to their new primary care provider. Participating providers must furnish members with copies of their medical records.

Pre-existing condition

Aetna Better Health does not have a pre-existing condition limitation. We are responsible for providing all covered services to each eligible member beginning on the member's date of enrollment into the Aetna Better Health Medicaid or CHIP programs, regardless of any pre-existing conditions, prior diagnosis and/or receipt of any prior health services.

Coverage will be authorized for care being provided by nonparticipating providers to members who are in an "active course of treatment" at the time of enrollment until the member's records, clinical information and care can be transferred to a network provider or until such time the member is no longer enrolled in the plan. Coverage will be provided until the active course of treatment has been completed or 90 days, whichever is shorter.

Out-of-network care will be coordinated for members who have been diagnosed and are receiving treatment for a terminal illness at the time of enrollment for up to nine months or until they are no longer enrolled in the plan.

"Active Course of Treatment" is defined as:

- A planned program of services rendered by a physician, behavioral health provider or DME provider
- Starts on the date a provider first renders a service to correct or treat the diagnosed condition, and
- Covers a defined number of services or period of treatment
- Allowing a pregnant woman to remain under the member's current Ob/Gyn care through the member's postpartum checkup even if the Ob/Gyn provider is, or becomes, out-of-network

In order to provide transitional coverage for the nonparticipating provider, the following conditions must be met. The member must:

- Be enrolling as a new member, and receiving ongoing treatment for a chronic or acute medical condition from a nonparticipating provider
- Have initiated an "active course of treatment" prior to the initial enrollment date.

If services are received prior to the approval of transition of benefits, the services must be approved by the Medical Director in order for coverage to be extended at the new Plan level. The Aetna Better Health Medical Management department will coordinate all necessary referrals, or any other authorizations so that the continuity of care is not disrupted.

In order for a nonparticipating provider to continue treating Plan members during a transition period, the provider must agree to:

- Continue to provide the member's treatment and follow-up

- Accept Plan rates and/or fee schedules
- Share information regarding the treatment plan with the Plan
- Use the Plan network for any necessary referrals, lab work or hospitalizations.

Any exceptions will be reviewed on a case-by-case basis by the Medical Management staff in consultation with the Medical Director. All requests that do not meet the conditions for continuity of care will be forwarded to the Medical Director who will review the request on a priority basis.

Medicaid Managed Care Member Enrollment and Disenrollment from Aetna Better Health Enrollment

HHSC, in coordination with their Enrollment Broker, administers the enrollment process for Medicaid-eligible. The Enrollment Broker initiates the enrollment process by sending the Medicaid-eligible person an enrollment packet. It is at that time the Medicaid-eligible person picks a health plan and a primary care provider. All enrollments into Aetna Better Health Medicaid must occur only through the Enrollment Broker. The enrollment counselors can be reached at **1-800-964-2777**.

Newborn Process

Newborns of current Aetna Better Health Medicaid Members are automatically covered by Aetna Better Health Medicaid for the first 90 days of life. However, it is the responsibility of the Member to notify HHSC to add the newborn in the STAR program to continue benefits. Aetna Better Health Medicaid will assign the newborn an internal “proxy ID” in order to expedite the payment of claims and systematically track the newborn. Once the newborn is enrolled with the STAR program, the “proxy ID” will be updated with the State-assigned Medicaid ID.

Practitioners and facility providers can report information about each child born to a mother eligible for Medicaid. To report this information, Federally Qualified Health Centers (including FQHCs with birthing centers), hospitals, and birthing centers should complete the “Hospital Report” (Newborn Child or Children) HHSC (Form 7484) and submit it to DADS Data Control within five days of the child's birth.

For more detailed information on Newborn Services, please refer to Section 2.3.2.3 in the Physician section of the Texas Medicaid Provider Procedures Manual found at www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html.

Automatic Reenrollment

Members who are disenrolled because they are temporarily ineligible for Medicaid will be automatically reenrolled into their previously selected health plan and primary care provider. Temporary loss of eligibility is defined as a loss of eligibility for a period of six months or less. When Aetna Better Health informs members of their rights and responsibilities, they will also inform them of the automatic reenrollment process including the option to change health plans after reenrollment. This information is given to the member in the Member Handbook.

Disenrollment

Aetna Better Health has a limited right to request a member be disenrolled from the Plan without the member's consent. Request to disenroll a Member from the Plan will require medical documentation from the member's primary care provider or documentation that indicates sufficiently compelling

circumstances that merits disenrollment. HHSC must approve and will make the final decision on any request by Aetna Better Health for disenrollment of a member for cause.

We will take reasonable measures to correct a member's behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

- If all reasonable measures fail to remedy the problem, Aetna Better Health will notify the Member of the decision to recommend disenrollment to HHSC. The notice will include the process available to the member to file an appeal or request a State Fair Hearing.
- We cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are medically necessary for treatment of a member's condition.
- Additionally, a provider cannot take retaliatory action against a member who is disenrolled from Aetna Better Health Medicaid.

CHIP Member enrollment and disenrollment

Enrollment

(12-month eligibility)

Parents and guardians can apply telephonically for CHIP coverage by contacting CHIP at **1-800-647-6558**. Applicants can ask for a blank form or CHIP will print completed applications based on phone information and mail to the requesting party for signature and return. Applicants can download and complete application forms from the internet at www.chipmedicaid.com. Once enrolled, the CHIP eligibility remains continuous for 12 months. Eligibility determination is the responsibility of the HHSC Administrative Services Contractor.

Enrollment process

Eligibility determination notices are sent to families determined eligible based on completed applications. The enrollment packet mailed to families contains:

- Explanation of CHIP benefits
- Comparison table showing value-added services by health plan
- A place to indicate a child with special health care needs
- A place to indicate whether a medical support order is applicable
- How to pick a health plan, primary care provider, and the choice to pick a specialist as Primary Care Provider
- Provider directories
- Cost-sharing information specific to the income level of the family and payment coupon book for families with net income over 150% Federal Poverty Level
- Simple form to track cost-sharing expenses relative to caps

Information concerning the grievances and appeals process. Reminder notices are sent 14 days after enrollment packages are mailed to members. Concurrent notice is sent to the Community Based Organization (CBO) when there is a record of past involvement with the family. A follow-up letter is mailed 14 days after the reminder notices. Families who are unresponsive to the two follow-up attempts are timed out after 60 days.

Post-enrollment letters are sent as temporary evidence of coverage, pending receipt of the health plan ID card. Enrollment letters will contain the following information:

- Member ID numbers
- First date of coverage
- Health plan and Primary Care Provider sections
- Applicable co-payments

Re-enrollment

At the beginning of the tenth month of coverage, the Administrative Services Contractor will send a notice to the family outlining the next steps for renewal for continuation of coverage. The Administrative Services Contractor will also send a notice to the Health Plan regarding its members and to a community-based outreach organization providing follow-up assistance in the members' areas. To promote continuity of care for children eligible for re-enrollment, the HMO can ease re-enrollment through reminders to members and other appropriate means. Failure of the family to respond to the Administrative Services Contractor's renewal notices will result in disenrollment from the plan and from CHIP.

Disenrollment

For those members who are disenrolled because they are no longer eligible for CHIP, the HMO will receive from the Administrative Services Contractor notice informing the HMO that the members' coverage will end on a particular date. Disenrollment due to loss of eligibility includes, but is not limited to; "aging-out" when a child turns 19, failure to re-enroll at the conclusion of the 12 month eligibility period, change in health insurance status, failure to meet monthly cost-sharing obligation, death of the child, child permanently moves out of the state, and data match with the Medicaid system indicates dual enrollment in Medicaid, CHIP and STAR Kids.

Aetna Better Health has a limited right to ask for a member be disenrolled from the Plan without the member's consent. Aetna Better Health's request to disenroll a member from the Plan will require medical documentation from the member's Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merits disenrollment. HHSC must approve and will make the final decision on any request by Aetna Better Health for disenrollment of a member for cause.

Aetna Better Health will make sure that punitive action is not taken in retaliation against a member who requests an appeal or a provider who requests an expedited resolution or supports a member's appeal.

- We will take reasonable measures to correct a member's behavior before asking for disenrollment.
- Reasonable measures can include providing education and counseling regarding the offensive acts or behaviors.
- If all reasonable measures fail to remedy the problem, Aetna Better Health will inform the member of the decision to recommend disenrollment to HHSC.
- We cannot ask for a disenrollment based on adverse change in the member's health status or utilization of services that are medically necessary for treatment of a member's condition.
- Additionally, a provider cannot take retaliatory action against a member who is disenrolled from Aetna Better Health.

Plan Changes

Members are allowed to make health plan changes under the following circumstances:

- For any reason within the 90 days of enrollment in CHIP and once thereafter;
- For cause at any time;
- If the client moves to a different service area; and
- During the annual re-enrollment period.

HHSC must approve and will make the final decision on any request by members to change health plans.

CHIP Perinatal member enrollment and disenrollment

Newborn process

- When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member's health plan if those health plans are different. All members of the household must remain in the same health plan until the later of: 1) the end of the CHIP Perinatal member's enrollment period; or 2) the end of the traditional CHIP member's enrollment period. Copayments, cost-sharing and enrollment fees still apply to children enrolled in the CHIP Program. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be prepopulated to include the CHIP Perinate Newborn's and the CHIP members' information. Once the child's CHIP Perinatal coverage expires, the child will be added to his or her siblings' existing CHIP case.

Disenrollment

HHSC must approve and will make the final decision on any request for disenrollment of a member for cause.

A provider cannot take retaliatory action against a member who is disenrolled from Aetna Better Health CHIP Perinate or Aetna Better Health CHIP Perinate Newborn.

Plan Changes

- A CHIP Perinate (unborn child) who lives in a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.
 - A CHIP Perinate mother in a family with an income at or below 185% of the FPL may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under 185% of the FPL will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC's enrollment broker.
- A CHIP Perinate will continue to receive coverage through the CHIP Program as a "CHIP Perinate Newborn" if born to a family with an income above 185% to 200% FPL and the birth is reported to HHSC's enrollment broker.
- A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the

month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

- CHIP Perinate mothers must select a health plan within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into Aetna Better Health and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another health plan.
- When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member's health plan if the plan is different. All members of the household must remain in the same health plan until the later of: 1) the end of the CHIP Perinatal member's enrollment period; or 2) the end of the traditional CHIP members' enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form, which will be prepopulated to include the CHIP Perinate Newborn's and the CHIP members' information. Once the child's CHIP Perinatal coverage expires, the child will be added to his or her siblings' existing CHIP case.
- CHIP Perinatal Members may request to change health plans under the following circumstances:
 - For any reason within the 90 days of enrollment in CHIP Perinatal;
 - If the member moves to a different service delivery area; and
 - For cause at any time.

Medicaid Managed Care/CHIP Special Access Requirements

General transportation and ambulance/wheelchair van

Medicaid reimburses for emergency and non-emergency transports for those clients that meet the severely disabled criteria. Severely disabled means that "the clients' physical condition limits mobility and requires the client to be bed-confined at all times or unable to sit unassisted at all times or requires continuous life support systems (including oxygen or IV infusion) or monitoring of unusual physical or chemical restraint." All non-emergency transports require prior authorization. Emergency transports do not require prior authorization. For more information regarding ambulance services and/or limitations, please refer to Section 8.2.5 of the Texas Medicaid Provider Procedures Manual found at www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html.

Interpreter/translation services

Aetna Better Health of Texas provides language interpretation services to translate multiple languages. We do this through a language line which may be accessed by calling our Member Services line and our Member Services Staff will then contact the language line as a third-party conversation.

For persons who are deaf or hearing impaired, please call TTY line at **1-800-735-2989** and ask them to call the Member Services Line.

Aetna Better Health of Texas also maintains a current list of interpreters who remain available to provide interpreter services. We will arrange, with 72-hour notice, to have someone that speaks the Member's language meet the patient at the provider's office when they come for their appointment. For Members in need of a sign language interpreter, Aetna Better Health will provide an approved interpreter from the American Sign Language Association. Interpreter services will be paid for by Aetna Better Health. Trained interpreters must be used when technical, medical, or treatment

information is to be discussed. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality or confidentiality is critical unless specifically requested by the member.

Provider coordination

Aetna Better Health of Texas will comply with the HHSC standards regarding care for persons with disabilities or chronic and complex conditions. We will provide information, education and training programs to members, families, primary care providers, specialty physicians, and Community Agencies about the care and treatment available within Aetna Better Health for members with disabilities or chronic or complex conditions. Specialists may function as a primary care provider for treatment of Members with chronic/complex conditions when approved by Aetna Better Health of Texas.

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of ethnicity, sex, age, religion, color, mental or physical disability, national origin, marital status, sexual orientation, or health status (including, but not limited to, chronic communicable diseases such as AIDS or HIV positive status). All participating physicians and health care professionals may also have an obligation under the Federal Americans with Disabilities Act to provide physical access to their offices and reasonable accommodations for patients and employees with disabilities.

For each person with disabilities or chronic or complex conditions, the Primary Care Provider is required to develop a plan of care that meets the special preventive, primary acute care and specialty care needs of the member. The plan must be based on:

- Health needs
- Specialist recommendations
- Periodic reassessment of the member's functional status and service delivery needs.

The Primary Care Provider must maintain an initial plan of care in the medical records of persons with disabilities or chronic or complex conditions and that plan must be updated as often as the member's needs change, but at least annually.

Aetna Better Health of Texas will ensure the members with special health care needs have adequate access to primary care providers and specialists skilled in treating persons with disabilities or chronic or complex conditions. Case Management services are available to assist members with special health care needs, their families and health care providers to facilitate access to care, continuity and coordination of services.

Reading/grade level consideration

Adhering to the policies and procedures set by HHSC, any literature that is published for informational use by Aetna Better Health STAR Kids Members needs to be written at or below a 6th grade reading level and in English and Spanish. This will help to enhance the communication between the population, providers and Aetna Better Health of Texas.

Cultural sensitivity

It is critical that Aetna Better Health and its participating providers be sensitive to the vast cultural differences that span the Texas STAR Kids population. To that end, it is critical that we, as partners, develop a culturally competent system of care – one that acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the

adaptation of services to meet culturally unique needs (Cross et al 1989).

Texas STAR Kids recipients will vary in language and culture (for example, customs, religion, backgrounds, etc.). Our goal is to effectively serve Members of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each. We must operate at a level in which cultural knowledge is high and policies and practices are in place that produces positive results and satisfaction from the viewpoint of the culturally diverse member.

Aetna Better Health of Texas maintains a cultural competency plan which is available upon request to Aetna Better Health of Texas.

Standing Referrals

Aetna Better Health of Texas members with Special Health Care Needs will have direct access to a specialist as appropriate for the member's condition and identified needs, such as a standing referral to a specialty physician.

Aetna Better Health of Texas members with Special Health Care needs have direct access to specialists and do not require a PCP referral to a specialist, however appropriate to the member's condition and identified needs, such as a standing referral for a specialty physician will be in place.

Access to telemedicine, telemonitoring, and telehealth

The provision of telemedicine medical services and telehealth services involves: (1) a patient site presenter responsible for presenting the patient for services; and (2) a distant site provider rendering consultation or evaluation for the purposes of diagnosis or treatment of the patient. The patient site presenters and distant site providers are restricted to certain provider types and locations as specified in the state's rules for Medicaid services.

The patient site must be: an established medical site (telemedicine); an established health site (telehealth); or a state mental facility (telemedicine and telehealth); or a state supported living center (telemedicine and telehealth). A patient's private home is not an established home site.

Telemonitoring is a health service that requires scheduled remote monitoring of data related to a client's health, and transmission of the data from the client's home to a licensed home health agency or a hospital. The data transmission must comply with standards set by HIPAA. Data parameters are established as ordered by a physician's plan of care. Data must be reviewed by a registered nurse (RN), nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA), who is responsible for reporting data to the prescribing physician in the event of a measurement outside the established parameters. Online evaluation and management for home telemonitoring services is a benefit in the office or outpatient hospital setting when services are provided by an NP, CNS, PA or physician provider.

Insurance requirements, laws, rules and regulations

Insurance

An Aetna Better Health Medicaid or CHIP Network Provider shall maintain, during the term of the network provider contract, Professional Liability Insurance of \$100,000 per occurrence and \$300,000 in the aggregate, or the limits required by the hospital at which network provider has admitting privileges.

NOTE: Community-based Long-Term Care providers are exempt from this requirement as long as their licensure does not require the professional liability insurance. This provision will not apply if the network provider is a state or federal unit of government that is required to comply with, and is subject to, the provisions of the Texas and/or Federal Tort Claims Act.

An Aetna Better Health Medicaid or CHIP network provider shall maintain, during the term of the network provider contract:

1. Worker's Compensation coverage in the amounts required by Texas law
2. Comprehensive Liability Insurance including Bodily Injury Coverage of \$100,000 per occurrence and Comprehensive Liability Insurance including Property Damage Coverage of \$25,000 per occurrence.

Laws, rules and regulations

The Aetna Better Health Medicaid or CHIP Network Provider understands and agrees that it is subject to all state and federal laws, rules, regulations and waivers that apply to the network provider Contract, the Medicaid and/or CHIP Program and all persons or entities receiving state and federal funds. The network provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this network provider contract, or any violation of the HHSC/Aetna Better Health contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

The network provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the network provider contract:

1. Environmental protection laws:
 - a) Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products
 - b) National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures
 - c) Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans")
 - d) State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State
 - e) Implementation Plans under §176(c) of the Clean Air Act and
 - f) Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water
2. State and federal anti-discrimination laws:
 - a) Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352)
 - b) Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112)
 - c) Americans with Disabilities Act of 1990 (Public Law 101-336) and d. Title 40, Texas Administrative Code, Chapter 73.
3. The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 et seq.) regarding employment verification and retention of verification forms and
4. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

Liability

In the event the Aetna Better Health becomes insolvent or ceases operations, the network provider understands and agrees that its sole recourse against Aetna Better Health will be through Aetna's bankruptcy, conservatorship or receivership estate. The network provider understands and agrees that the Aetna Better Health's Members may not be held liable for the Aetna's debts in the event of the entity's insolvency. The network provider understands and agrees that HHSC does not assume liability for the actions of, or judgments rendered against, Aetna, its employees, agents or subcontractors.

Further, the network provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to the network provider by Aetna Better Health or any judgment rendered against Aetna. HHSC's liability to the network provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.).

Marketing

The Aetna Better Health Medicaid or CHIP network provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the HHSC/Aetna Better Health Managed Care Contract (which includes HHSC's Uniform Managed Care Manual).

The network provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain network providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

Professional conduct

While performing the services described in the network provider contract, the network provider agrees to:

1. Comply with applicable state laws, rules and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations and
2. Otherwise conduct themselves in a businesslike and professional manner.

Update to Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook

On November 1, 2018, TMHP updated the Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook, Section 8.1, "Enrollment" (for nurse practitioners and clinical nurse specialists), and Section 10.1, "Enrollment" (for physician assistants [PAs]).

The update states that advanced practice registered nurses (APRNs) and PAs may be included as primary care providers in the provider network for Medicaid and the Children's Health Insurance Program (CHIP) (both fee-for-service and managed care), regardless of whether the physician supervising the APRN is enrolled in Medicaid or in the provider network.

For more information, call the TMHP Contact Center at **1-800-925-9126**.

Conclusion

We are pleased to partner with Medicaid and/or CHIP network providers to coordinate covered services for STAR and CHIP Members. Members who take an active part in their health care begin with effective and appropriate communication, in large part given by the provider. We appreciate you taking the time to review the Aetna Better Health Medicaid, CHIP and STAR Kids Program requirements presented in this manual.

Should you have questions, please contact Aetna Better Health Provider Relations at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

Appendixes

Appendix A – Sample ID cards

Your Texas Medicaid ID card, form 3087 and plan ID cards

 Your Texas Benefits Health and Human Services Commission	
Medicaid ID Card	Health plan / Plan de salud
Member name: John Doe	Your plan 1-800-###-####
Member ID (Medicaid ID): 123456789	
Issuer ID: (80840) XXXXXXXXXX	Date card sent: 10/01/2011
RxBIN: 001111	
RxPCN: ADV	
RxGRP: RX1234	

P.O. BOX 149030 952-X
 AUSTIN, TEXAS 78714-9030
 RETURN SERVICE REQUESTED

9 ADEQ 01-0000
 Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
 IDENTIFICACIÓN DE MEDICAID

DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Date Recd:	BIN	BP	TP	Col	Case No.	GOOD THROUGH:
538690CAME	610098		45	02	123456789	VALIDA HASTA: JULY 31, 2007

952-X 123456789 45 02 070731
 JOHN DOE
 743 GOLF IRONS
 COOLSVILLE TX 78703



**ANYONE LISTED BELOW
 CAN GET MEDICAID SERVICES**

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help. **READ BACK OF THIS FORM!**

**CADA PERSONA NOMBRADA ABAJO
 PUEDE RECIBIR SERVICIOS DE MEDICAID**

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años o más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el Programa STAR?

Por favor, llame al 1-800-964-2777 para conseguir ayuda. **¡LEA EL DORSO DE LA FORMA!**

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JOHN DOE	04-30-1990	M	04-30-2003	P	
THSTEPS MEDICAL AND DENTAL CHECK-UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THSTEPS BEST HEALTH PLAN / 1-800-123-4 5 6 7 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION						

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Back of 3087 ID form

FOR THE CLIENT: About your Medicaid ID Form

This is your Medicaid identification form. A new Medicaid identification form will be mailed to you each month. Take your most recent Medicaid identification form with you when you visit your doctor or receive services from any of your health care providers. This form helps health care providers know which services you can receive.

If you receive a letter from HHSC stating that the Medicaid program will not pay for certain health services your provider thinks you need, the letter will tell you about your right to ask for a fair hearing to appeal the denial of services. The letter will tell you who to call and list an address where you can write to request a hearing.

NOTE: If you accept Medicaid benefits (services or supplies), the HHSC has the right to receive payment for those services or supplies from other insurance companies and other liable sources, up to the amount paid by Medicaid.

Get Answers to Your Questions		
Question	Contact	Phone
Who can I call for help finding or contacting a doctor, dentist, case manager or other Medicaid provider for someone 20 years old or younger?	Texas Health Steps	1-877-847-8377
When can I call to find out which services are paid by Medicaid or if I get a bill from a Medicaid provider?	Statewide Medicaid Helpline	1-800-335-8957
Who can help me get to my Medicaid provider?	Medical Transportation	1-877-833-8747
Who can help me if I have questions or problems with my health plan, or my Primary Care Case Management (PCCM) doctor?	STARLink, Medicaid Managed Care Helpline	1-888-566-8888
Who can I call about keeping my Medicaid benefits?	2-1-1 Information and Referral	211 or 1-877-541-7305
If I am receiving help paying my medical bills and I need information about my Medicaidly Needy Program spend down case, who can I call?	Statewide Medicaid Helpline	1-800-335-8957
Who can I call to find out about nursing home care, adult day care or other long-term care services and supports?	Department of Aging and Disability Services Consumer Rights Hotline	1-800-458-9858
Who can tell me about how my other insurance affects my Medicaid benefits?	Texas Medicaid Healthcare Partnership Third Party Resources Hotline	1-800-846-7307
To whom do I report Medicaid fraud, waste or abuse?	Office of Inspector General	1-800-436-8184
Who can I talk to about getting help to pay my private insurance premiums?	Health Insurance Premium Program Hotline	1-800-440-0493
Who can I talk to if I receive Supplemental Security Income (SSI) and I need to change my address?	Social Security Administration	1-800-772-1213
Who can I call if I have questions about my Medicare Rx Prescription Program?	Medicare	1-800-MEDICARE (1-800-633-4227)
Who can I call to use TDD? for hearing impairment?	Texas Relay	1-800-735-2988

Form H3087/Page 2/09-2007

PARA EL CLIENTE: Información sobre la forma de identificación de Medicaid

Esta es su forma de identificación de Medicaid. Se le enviará por correo una nueva forma de identificación de Medicaid cada mes. Lleve con usted la forma más reciente cuando vaya al doctor o reciba servicios de uno de sus proveedores de atención médica. Esta forma ayuda a los proveedores de atención médica a saber cuáles servicios puede recibir usted.

Si recibe una carta de la Comisión de Salud y Servicios Humanos (HHSC) indicando que el programa Medicaid no pagará ciertos servicios de salud que su proveedor cree que usted necesita, la carta le dará sobre su derecho de pedir una audiencia imparcial para apelar la negación de servicios. La carta le indicará a quién debe llamar y tendrá la dirección a dónde puede escribir para solicitar una audiencia.

NOTA: si acepta beneficios de Medicaid (servicios o artículos), la HHSC tiene el derecho de recibir el pago de esos servicios o artículos de otras compañías de seguro y de otras fuentes responsables, hasta la suma que pagó Medicaid.

Recibe respuestas a sus preguntas		
Pregunta	Contacto	Teléfono
¿A quién puedo llamar si necesito ayuda para encontrar o comunicarme con un doctor, dentista, administrador de casa u otro proveedor de Medicaid para alguien que tiene 20 años o menos?	Pasos Salud de Texas	1-877-847-8377
¿A quién puedo llamar para información sobre qué servicios paga Medicaid o si recibo una cuenta de un proveedor de Medicaid?	Línea Estatal de Ayuda de Medicaid	1-800-335-8957
¿Quién me puede llevar a mi proveedor de Medicaid?	Transporte médico	1-877-833-8747
¿Quién me puede ayudar si tengo preguntas o problemas con mi plan de salud o con mi doctor de Primary Care Case Management (PCCM)?	STARLINK	1-888-566-8888
¿A quién puedo llamar sobre cómo seguir recibiendo mis beneficios de Medicaid?	2-1-1 Información y Envío a Servicios	2-11 o 1-877-541-7305
Si estoy recibiendo ayuda para pagar mis cuentas médicas enviadas y necesito información sobre mi caso, ¿a quién llamo?	Línea Directa del Cliente de Texas Medicaid Healthcare Partnership	1-800-335-8957
¿A quién llamo para información sobre atención en una casa para convalecientes, cuidado de adultos durante el día u otros servicios y apoyo de atención a largo plazo?	Línea Directa de Derechos del Cliente del Departamento de Servicios para Adultos Mayores y Personas Discapacitadas	1-800-458-9858
¿Quién me puede decir cómo puede afectar mi otro seguro médico mis beneficios de Medicaid?	Línea Directa de Recursos de Terceros de Texas Medicaid Healthcare Partnership	1-800-846-7307
¿A quién le denuncio el fraude, malgasto o abuso de Medicaid?	Oficina de la Fiscalía General	1-800-436-8184
¿Con quién hablo sobre ayuda para pagar mis primas de seguro privado?	Línea Directa del Programa de Primas de Seguro de Salud	1-800-440-0493
¿Con quién hablo si recibo Seguridad de Ingreso Suplementario y necesito cambiar mi dirección?	Administración de Seguro Social	1-800-772-1213
¿A quién llamo si tengo preguntas sobre mi Programa de Medicare Rx para Medicamentos con Receta?	Medicare	1-800-MEDICARE (1-800-633-4227)
¿A quién llamo para utilizar TDD? para deficié auditivo?	Texas Relay	1-800-735-2988

Aetna Better Health of Texas ID cards

Medicaid ID card

<p>Aetna Better Health® of Texas Medicaid</p>  <p>Member name / Nombre del/la miembro Medicaid ID / Identificación de Medicaid Effective date / Fecha de vigencia</p> <p>PCP PCP phone / Teléfono del PCP PCP effective date / Fecha de vigencia del PCP</p> <hr/> <p>Pharmacy coverage RxBIN: 610591 RxPCN: ADV RxGRP: RX8801 Pharmacist use only 1-877-874-3317</p>  <p style="text-align: right;">TX-21-02-07</p>	<p>Carry this card with you and present it at time of service. Lleve esta tarjeta consigo y preséntela en el momento de recibir servicios.</p> <hr/> <p>Attention doctor/hospital You must call 1-800-306-8612 for precertification or case management</p>												
<div style="background-color: black; color: white; padding: 5px; text-align: center;"> <p>In case of an emergency, please call 911 En caso de una emergencia, por favor llame al 911</p> </div> <p>Directions for what to do in an emergency In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. For additional information regarding emergency services, see your member handbook.</p> <p>Instrucciones para lo que debe hacer en caso de una emergencia En caso de emergencia llame al 911 ó vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame a su PCP dentro de 24 horas ó tan pronto como sea posible. Para información adicional sobre los servicios de emergencia, vea su manual del miembro.</p>	<table border="0"> <tr> <td>Member Services / Servicios para Miembros – 24/7</td> <td style="text-align: right;">1-800-306-8612</td> </tr> <tr> <td>Behavioral Health / Salud Mental – 24/7</td> <td style="text-align: right;">1-800-306-8612</td> </tr> <tr> <td>24-Hour Nurse Line / Línea de enfermería</td> <td style="text-align: right;">1-800-306-8612</td> </tr> <tr> <td>Superior Vision</td> <td style="text-align: right;">1-800-879-6901</td> </tr> <tr> <td>NEMT Non Emergency Medical Transportation / Transporte médico para casos que no sean de emergencia</td> <td style="text-align: right;">1-866-411-8920</td> </tr> <tr> <td>Relay Texas TTY / Relevo TTY de Texas</td> <td style="text-align: right;">1-800-735-2989</td> </tr> </table> <p>Mail claims to this address / Envíe las reclamaciones a este domicilio: Claims Processing Center PO Box 982964 El Paso, TX 79998-2964 Payer ID: 38692</p>	Member Services / Servicios para Miembros – 24/7	1-800-306-8612	Behavioral Health / Salud Mental – 24/7	1-800-306-8612	24-Hour Nurse Line / Línea de enfermería	1-800-306-8612	Superior Vision	1-800-879-6901	NEMT Non Emergency Medical Transportation / Transporte médico para casos que no sean de emergencia	1-866-411-8920	Relay Texas TTY / Relevo TTY de Texas	1-800-735-2989
Member Services / Servicios para Miembros – 24/7	1-800-306-8612												
Behavioral Health / Salud Mental – 24/7	1-800-306-8612												
24-Hour Nurse Line / Línea de enfermería	1-800-306-8612												
Superior Vision	1-800-879-6901												
NEMT Non Emergency Medical Transportation / Transporte médico para casos que no sean de emergencia	1-866-411-8920												
Relay Texas TTY / Relevo TTY de Texas	1-800-735-2989												

CHIP

<p>Aetna Better Health® of Texas Children's Health Insurance Program TDI</p>  <p>Member name / Nombre del/la miembro Member ID / Identificación del/la miembro Effective date / Fecha de vigencia Expiration date / Fecha de expiración</p> <p>PCP PCP phone / Teléfono del PCP PCP effective date / Fecha de vigencia del PCP</p> <hr/> <p>Pharmacy coverage RxBIN: 610591 RxPCN: ADV RxGRP: RX8801 Pharmacist use only 1-877-874-3317</p>  <p style="text-align: right;">TX-21-02-09</p>	<p>No copayments apply for well-child or well-baby immunization visits. No aplican copagos para visitas de vacunas de bienestar infantil o de bebés.</p> <p>Doctor's office visit / Visita al consultorio del doctor: Hospital inpatient / Paciente interno en el hospital: Emergency room / Sala de emergencias: Hospital outpatient / Paciente externo en el hospital: Prescription generic drugs / Medicamentos genéricos de prescripción: Prescription brand drugs / Medicamentos de marca de prescripción:</p> <hr/> <p>Attention provider You must call 1-800-245-5380 for precertification or case management</p>										
<div style="background-color: black; color: white; padding: 5px; text-align: center;"> <p>In case of an emergency, please call 911 En caso de una emergencia, por favor llame al 911</p> </div> <p>Directions for what to do in an emergency In case of emergency call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible. For more information regarding emergency services, please refer to your member handbook.</p> <p>Instrucciones para lo que debe hacer en caso de una emergencia En caso de emergencia llame al 911 ó vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo/a dentro de 24 horas ó tan pronto como sea posible. Para información adicional sobre los servicios de emergencia, por favor vea su manual del miembro.</p>	<table border="0"> <tr> <td>Member Services / Servicios para Miembros – 24/7</td> <td style="text-align: right;">1-800-245-5380</td> </tr> <tr> <td>Behavioral Health / Salud Mental – 24/7</td> <td style="text-align: right;">1-800-245-5380</td> </tr> <tr> <td>24-Hour Nurse Line / Línea directa de enfermería</td> <td style="text-align: right;">1-800-245-5380</td> </tr> <tr> <td>Superior Vision</td> <td style="text-align: right;">1-800-879-6901</td> </tr> <tr> <td>Relay Texas TTY / Relevo TTY de Texas</td> <td style="text-align: right;">1-800-735-2989</td> </tr> </table> <p>Mail claims to this address / Envíe las reclamaciones a este domicilio: Claims Processing Center PO Box 982964 El Paso, TX 79998-2964 Payer ID: 38692</p>	Member Services / Servicios para Miembros – 24/7	1-800-245-5380	Behavioral Health / Salud Mental – 24/7	1-800-245-5380	24-Hour Nurse Line / Línea directa de enfermería	1-800-245-5380	Superior Vision	1-800-879-6901	Relay Texas TTY / Relevo TTY de Texas	1-800-735-2989
Member Services / Servicios para Miembros – 24/7	1-800-245-5380										
Behavioral Health / Salud Mental – 24/7	1-800-245-5380										
24-Hour Nurse Line / Línea directa de enfermería	1-800-245-5380										
Superior Vision	1-800-879-6901										
Relay Texas TTY / Relevo TTY de Texas	1-800-735-2989										

CHIP Perinate Newborn ID card

<p>Aetna Better Health® of Texas Children's Health Insurance Program TDI</p>   <p>Member name / Nombre del/la miembro Member ID / Identificación del/la miembro Effective date / Fecha de vigencia</p> <p>PCP PCP phone / Teléfono del PCP PCP effective date / Fecha de vigencia del PCP</p> <p>.....</p> <p>Pharmacy coverage RxBIN: 610591 RxPCN: ADV RxGRP: RX8801 Pharmacist use only 1-877-874-3317</p>  <p style="text-align: right;">TX-21-02-11</p>	<p>Co-pays do not apply. No aplican copagos.</p> <p>.....</p> <p>Attention provider You must call 1-800-245-5380 for precertification or case management</p>										
<div style="background-color: black; color: white; padding: 5px; text-align: center;"> <p>In case of an emergency, please call 911 En caso de una emergencia, por favor llame al 911</p> </div> <p>Directions for what to do in an emergency In case of emergency call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible. For additional information regarding emergency services, please refer to your member handbook.</p> <p>Instrucciones para lo que debe hacer en caso de una emergencia En caso de emergencia llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo/a dentro de 24 horas o tan pronto como sea posible. Para información adicional sobre los servicios de emergencia, vea su manual del miembro.</p>	<table border="0"> <tr> <td>Member Services / Servicios para Miembros – 24/7</td> <td style="text-align: right;">1-800-245-5380</td> </tr> <tr> <td>Behavioral Health / Salud Mental – 24/7</td> <td style="text-align: right;">1-800-245-5380</td> </tr> <tr> <td>24-Hour Nurse Line / Línea directa de enfermería</td> <td style="text-align: right;">1-800-245-5380</td> </tr> <tr> <td>Superior Vision</td> <td style="text-align: right;">1-800-879-6901</td> </tr> <tr> <td>Relay Texas TTY / Relevo TTY de Texas</td> <td style="text-align: right;">1-800-735-2989</td> </tr> </table> <p>Mail claims to this address / Envíe las reclamaciones a este domicilio: Claims Processing Center PO Box 982964 El Paso, Texas 79998-2964 Payer ID: 38692</p>	Member Services / Servicios para Miembros – 24/7	1-800-245-5380	Behavioral Health / Salud Mental – 24/7	1-800-245-5380	24-Hour Nurse Line / Línea directa de enfermería	1-800-245-5380	Superior Vision	1-800-879-6901	Relay Texas TTY / Relevo TTY de Texas	1-800-735-2989
Member Services / Servicios para Miembros – 24/7	1-800-245-5380										
Behavioral Health / Salud Mental – 24/7	1-800-245-5380										
24-Hour Nurse Line / Línea directa de enfermería	1-800-245-5380										
Superior Vision	1-800-879-6901										
Relay Texas TTY / Relevo TTY de Texas	1-800-735-2989										

STAR Kids ID card

<p>Aetna Better Health® of Texas STAR Kids</p>   <p>Member / miembro Medical ID / Medicaid núm Effective date / fecha de efectividad</p> <p>PCP PCP phone / teléfono del PCP PCP effective date / fecha de efectividad el PCP</p> <p>.....</p> <p>Pharmacy coverage RxBIN: 610591 RxPCN: ADV RxGRP: RX8801 Pharmacist use only 1-877-874-3317</p>  <p style="text-align: right;">TX-21-02-04</p>	<p>Carry this card with you and present it at time of service. Lleve esta tarjeta con usted y preséntela antes de recibir servicios.</p> <p>.....</p> <p>Attention doctor/hospital You must call 1-844-787-5437 for precertification or case management</p>												
<div style="background-color: black; color: white; padding: 5px; text-align: center;"> <p>In case of an emergency, please call 911 En caso de una emergencia, por favor llama al 911</p> </div> <p>Directions for what to do in an emergency In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.</p> <p>Instrucciones en caso de emergencia En caso de emergencia, llama al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.</p>	<table border="0"> <tr> <td>Member Services / Servicios para Miembros – 24/7</td> <td style="text-align: right;">1-844-787-5437</td> </tr> <tr> <td>Behavioral Health / Salud Mental – 24/7</td> <td style="text-align: right;">1-844-787-5437</td> </tr> <tr> <td>24-Hour Nurse Line / Línea directa de enfermería</td> <td style="text-align: right;">1-844-787-5437</td> </tr> <tr> <td>Superior Vision</td> <td style="text-align: right;">1-800-879-6901</td> </tr> <tr> <td>NEMT Non Emergency Medical Transportation / Transporte médico para casos que no sean de emergencia</td> <td style="text-align: right;">1-866-411-8920</td> </tr> <tr> <td>Relay Texas TTY / Relevo TTY de Texas</td> <td style="text-align: right;">1-800-735-2989</td> </tr> </table> <p>Mail claims to this address / Envíe reclamaciones a este dirección: Claims Processing Center PO Box 982964 El Paso, Texas 79998-2964 Payer ID: 38692</p>	Member Services / Servicios para Miembros – 24/7	1-844-787-5437	Behavioral Health / Salud Mental – 24/7	1-844-787-5437	24-Hour Nurse Line / Línea directa de enfermería	1-844-787-5437	Superior Vision	1-800-879-6901	NEMT Non Emergency Medical Transportation / Transporte médico para casos que no sean de emergencia	1-866-411-8920	Relay Texas TTY / Relevo TTY de Texas	1-800-735-2989
Member Services / Servicios para Miembros – 24/7	1-844-787-5437												
Behavioral Health / Salud Mental – 24/7	1-844-787-5437												
24-Hour Nurse Line / Línea directa de enfermería	1-844-787-5437												
Superior Vision	1-800-879-6901												
NEMT Non Emergency Medical Transportation / Transporte médico para casos que no sean de emergencia	1-866-411-8920												
Relay Texas TTY / Relevo TTY de Texas	1-800-735-2989												

Appendix B – Behavioral health screening tools

Additional validated Behavioral Health screening tools for the primary care setting include:

- **Edinburgh Postnatal Depression Scale (EPDS):** The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for perinatal depression.
- **The Generalized Anxiety Disorder (GAD-7):** This questionnaire is a seven-item, self-report anxiety questionnaire. The GAD-7 measures the severity of various signs and symptoms of GAD. The tool is appropriate for outpatient and primary care settings for persons age 12 and older.
- **The Primary Care PTSD Screen (PC-PTSD-5):** This is a screening tool designed to identify persons with probable PTSD. Persons with a positive screen should have further assessment with a structured interview for PTSD, preferably performed by a mental health professional who has experience in diagnosing PTSD.
- **ASQ:** The Ask Suicide-Screening Questions (ASQ) Toolkit can help nurses or physicians identify youth at risk for suicide. The ASQ can be used in a variety of medical settings: primary care, emergency department, inpatient medical and surgical units. The ASQ is a set of four screening questions that takes 20 seconds to administer. The ASQ is available in 14 languages.
- **Columbia - Suicide Severity Rating Scale (C-SSRS):** The Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The Columbia Protocol is suitable for all ages and special populations in different settings and is available in more than 100 languages

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at <http://www.dshs.state.tx.us/thsteps/providers.shtm>.

AGE	History	Nutritional Screening	MENTAL HEALTH		TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	MEASUREMENTS				VISION		HEARING		Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	LABORATORY TESTS				Health Education/Anticipatory Guidance	
			Mental Health: Psychosocial/Behavioral Health Screening	PSC-17, PSC-35, YFSC, PHQ-9, PHQ-A, GRAFT, or Patient Health Questionnaire for Adolescents			Height	Weight	BMI	Blood Pressure	Visual Acuity	Subjective Vision	Audiometric Screening	Subjective Hearing			Dyslipidemia	Type 2 Diabetes	STD/STI Screening	HIV Test		
11	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
12	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
13	Mandatory	Mandatory	Mandatory	Recommended	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
14	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
15	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
16	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
17	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
18	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
19	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
20	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory

LEGEND	
■	Mandatory
■	If not completed at the required age, must be completed at the first opportunity if age appropriate.
■	For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.
■	Recommended
■	Risk-based

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: <http://www.dshs.texas.gov/thsteps/Texas-Health-Steps-Checkup-Components/>. For free online provider education: txhealthsteps.com.

Appendix D – Texas Referral/Authorization Form

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

[Clear Form](#) [Print](#)

SECTION I – SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
--------------	--------	------	-------

SECTION II – GENERAL INFORMATION

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:
Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #:

SECTION III – PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV – PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V – SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version__)	Code

Inpatient Outpatient Provider Office Observation Home Day Surgery Other: _____

Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehab Mental Health/Substance Abuse
Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____

Home Health (MD Signed Order Attached? Yes No) (Nursing Assessment Attached? Yes No)
Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

DME (MD Signed Order Attached? Yes No) (Medicaid Only: Title 19 Certification Attached? Yes No)
Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

SECTION VI – CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____

Appendix E – Request for initial outpatient therapy

Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form

Note: Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.

Comprehensive Care Program (CCP) Fax: 1-512-514-4212		Special Medical Prior Authorization (SMPA) Fax: 1-512-514-4213		Home Health (HH) Services Fax: 1-512-514-4209	
Client Name*					
Medicaid Number*			Date of Birth*		
Condition: <input type="checkbox"/> Acute (up to 60-day authorization) <input type="checkbox"/> Chronic (up to 180-day authorization)					
Treatment Diagnoses: _____ Medical Diagnoses: _____					
Place of Service Requested (please check one of the following):					
<input type="checkbox"/> Office <input type="checkbox"/> Outpatient <input type="checkbox"/> Home <input type="checkbox"/> Other, specify: _____					
Date of Last Therapy Evaluation or Re-Evaluation PT: _____ OT: _____ ST: _____					
Attach a copy of the therapy evaluation/re-evaluation or progress summary (acute) for each therapy discipline requested below. Provide all other required documentation for an authorization as listed in the Texas Medicaid Provider Procedures Manual.					
Discipline and Modifier	Dates of Service		Projected Frequency (per week or per month) **	Total Number of Units or Encounters Requested	
	From*	Through*			
PT (GP)					
OT (GO)					
ST (GN)					
** If projected frequency will be tapered down or variable, indicate frequency plans here. If client is to be discharged, write "discharged" and date of discharge in this space.					
Procedure Codes Requested*:					
	Specialist	Printed Name	Signature	Date	
	Physical Therapist				
	Occupational Therapist				
	Speech Therapist				
	Requesting Provider*				
Requesting Provider NPI and License No.*:					
Date client last seen by requesting provider:					
The provider's signature certifies the client's medical record includes a completed, signed and dated Plan of Care (POC) that contains all elements of the Texas Medicaid POC, including, for clients birth through 20 years of age, a current Texas Health Steps checkup or developmental screening performed within the last 60 calendar days.					
The form may be submitted without the requesting providers' signature and date, however, one of the following must be submitted with the request: a signed and dated prescription, a dated written order, or a dated documented verbal order.					
Rendering Therapy Billing Provider Information					
Name*:		Telephone:		Fax:	
Street address*:			City:	State:	ZIP + 4*:
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*:		

* Essential/Critical field

F00139

Page 2 of 2

Revised Date: 07/09/2021 | Effective Date: 09/01/2021

CCP Prior Authorization Request Form

Note: Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.

Request for:	<input type="checkbox"/> ABA	<input type="checkbox"/> DME	<input type="checkbox"/> Supplies	<input type="checkbox"/> Private Duty Nursing	<input type="checkbox"/> PPEC	<input type="checkbox"/> Inpatient Rehabilitation	<input type="checkbox"/> Other
A: Client Information							
Client Name (Last, First, M.I.): _____							
Medicaid Number*:				Date of Birth*:			
B: Rendering Provider/Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information							
Name*:		Telephone:			Fax:		
Street Address*:							
City:		State:		ZIP + 4*:			
Tax ID*:	NPI*:	Taxonomy*:		Benefit Code*:			
QRP Name:		QRP Tax ID:		QRP NPI:			
QRP Taxonomy:			QRP Benefit Code:				
QRP Street Address:							
City:		State:		ZIP + 4:			
C: Type of Request							
<input type="checkbox"/> ABA Evaluation	Requested Start Date*:		Requested End Date*:				
<input type="checkbox"/> ABA Re-evaluation	Requested Start Date*:		Requested End Date*:				
<input type="checkbox"/> ABA Treatment	Requested Start Date*:		Requested End Date*:				
<input type="checkbox"/> Initial / New Client	Requested Start Date*:		Requested End Date*:				
<input type="checkbox"/> Recertification	Requested Start Date*:		Requested End Date*:				
<input type="checkbox"/> Revision**	Revised Start Date*:		End Date*: (Cannot extend beyond current authorization period.)				
** Reason for Revision:							
D: Diagnosis and Medical Necessity of Requested Services (Initial and Recertification)							

* Essential/Critical field

F00012

Page 2 of 3

Revised: 09/17/2021 | Effective: 02/01/2022

Appendix F – Request for extension of outpatient therapy

Forms

B.51 Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)

Request for Extension of Outpatient Therapy (Form TP-2)				
CCP - Texas Medicaid & Healthcare Partnership PO Box 200735 Austin TX 78720-0735 1-800-846-7470 CCP FAX: 1-512-514-4212		Texas Medicaid & Healthcare Partnership CSHCN PO Box 200855 Austin TX 78720-0855 1-800-568-2413 or 1-512-514-3000 FAX: 1-512-514-4222		
Medicaid Number:		CSHCN Number:		
Client Name:		Date of birth: / /	Telephone:	
Client Address:				
Has the child received therapy in the last year from the public school system? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of Initial Evaluation	PT	OT	SLP	
A copy of the initial evaluation must be attached				
ICD-9 Code/Diagnosis:		Date of onset:		
Category of Therapy Being Requested				
PT/OT for:	<input type="checkbox"/> Developmental anomalies	<input type="checkbox"/> Pre-surgery	<input type="checkbox"/> Post-surgery Date of surgery: / /	
<input type="checkbox"/> Cast Removal	Date Removed: / /	<input type="checkbox"/> Serial Casting	<input type="checkbox"/> Acute Episode of Chronic Condition	
<input type="checkbox"/> New Condition	<input type="checkbox"/> Specialty Clinic	<input type="checkbox"/> Home Program	<input type="checkbox"/> ADL (activities of daily living)	
<input type="checkbox"/> Equipment Assessment		<input type="checkbox"/> Equipment Training		
Speech for:	<input type="checkbox"/> Craniofacial	<input type="checkbox"/> Developmental Anomalies	<input type="checkbox"/> New Condition <input type="checkbox"/> Post Cochlear Implant	
Check the service requested, indicate the date(s) of service and frequency per week or month: Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.				
Service Type	Service Date(s)		Frequency per week	Frequency per month
	From:	To:		
<input type="checkbox"/> PT	/ /	/ /		
<input type="checkbox"/> OT	/ /	/ /		
<input type="checkbox"/> SLP	/ /	/ /		
Procedure code(s) for therapy services:				
Specialist	Name	Signature	Date Signed	
Physician			/ /	
PT Therapist			/ /	
OT Therapist			/ /	
SLP Therapist			/ /	
Provider Information				
Name:		Telephone:	Fax:	
Address:				
Medicaid Identifying Information				
TPI:	NPI:	Taxonomy:	Benefit Code:	
CSHCN Identifying Information				
TPI:	NPI:	Taxonomy:	Benefit Code:	
FOR OFFICE USE ONLY: Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No HMO <input type="checkbox"/> Yes <input type="checkbox"/> No Restrictions:				

B

FORM TP-2 Page 1 of 2
Effective Date: 07/20/2007/Revised Date: 09/12/07

Appendix G – Request for Durable Medical Equipment

Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature.

Note: Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.

Section A: Requested Durable Medical Equipment and Supplies							
This section was completed by (check one): <input type="checkbox"/> Requesting Physician <input type="radio"/> Rendering Provider							
Client Information							
Client Name*:			Medicaid Number*:		Date of Birth*:		
Rendering Provider Information							
Name*:			Telephone:		Fax:		
Street Address*:							
City:			State:		ZIP + 4*:		
Tax ID*:		NPI*:		Taxonomy*:		Benefit Code*:	
QRP Name:				QRP NPI:			
QRP Tax ID:			QRP Taxonomy:		QRP Benefit Code:		
QRP Street Address:							
City:			State:		ZIP + 4:		
<i>I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.</i>							
Rendering Provider's Signature:						Date:	
Rendering Provider Name (typed or printed):							
Requesting Physician Information							
Name*:			Telephone:		Fax:		
Item Number	HCPCS Code*	Description of DME/Medical Supplies	Qty.*	Price	Prior Authorization Required?	Beyond Quantity Limit? ¹	Custom Item? ¹
1					<input type="checkbox"/> Y <input type="radio"/> N	<input type="checkbox"/> Y <input type="radio"/> N	<input type="checkbox"/> Y <input type="radio"/> N
2					<input type="checkbox"/> Y <input type="radio"/> N	<input type="checkbox"/> Y <input type="radio"/> N	<input type="checkbox"/> Y <input type="radio"/> N
3					<input type="checkbox"/> Y <input type="radio"/> N	<input type="checkbox"/> Y <input type="radio"/> N	<input type="checkbox"/> Y <input type="radio"/> N
4					<input type="checkbox"/> Y <input type="radio"/> N	<input type="checkbox"/> Y <input type="radio"/> N	<input type="checkbox"/> Y <input type="radio"/> N
1. If "Yes," additional documentation must be provided to support determination of medical necessity.							

* Essential/Critical field

Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Section B: Diagnosis and Medical Need Information			
<i>This is a prescription for DME/supplies and must be filled out by the prescribing physician.</i>			
Item Number ² (From Section A)	Diagnosis Code	Brief Diagnosis Description	Complete justification for determination of medical necessity for requested item(s) ² <small>(Refer to Section A, footnote 1)</small>
<p>2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification. Enter all Item numbers from the table in Section A that pertain to each diagnosis. A range of item numbers may be entered.</p> <p>If applicable, include height/weight, wound stage/dimensions and functional/mobility status:</p>			
<i>Note: The "Date last seen" and "Duration of need" items must be filled in.</i>			Date last seen by physician:
Duration of need for DME: _____ month (s)		Duration of need for supplies: _____ month (s)	
<p>By signing this form, I hereby attest that the information in Section "A", with the exception of the rendering provider's signature, was complete at the time of my signature and is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.</p>			
Signature and Attestation of Requesting Physician:			Date:
Signature stamps and date stamps are not acceptable			
Requesting Physician NPI*:		License Number:	

* Essential/Critical field

Appendix H – Medical record criteria

Primary Care Physician – Medical record criteria

Providers using electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

Organization

- a. Each page has patient's name or ID*
- b. Personal data: gender, date of birth, address, occupation, home/work phone numbers, marital status is recorded*
- c. All entries in the record contain author's signature or initials or electronic identifier*
- d. All entries are dated*
- e. All entries are legible to someone other than the writer
- f. Medication list is completed including dosages and date of initial or refill prescription
- g. Medication allergy or lack thereof and adverse reactions are prominently noted.*
- h. Problem list is completed including significant illnesses and medical and psychological conditions*
- i. Past medical history is completed (for patients seen 3 or more times) is easily identified and included serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
- j. For patients 14 years and up, there is a note concerning cigarettes, alcohol and substances (for patients seen 3 or more times, query substance abuse history).
- k. History and Physical documents have subjective/objective information for presenting problem.
- l. Note regarding follow-up care, calls, and visits. Specific time of return is noted in weeks, months or as needed.
- m. Unresolved problems from previous visits are addressed in subsequent visits.
- n. An immunization record has been initiated for children or history for adults*
- o. Preventive screening and services offered according to Aetna guidelines
- p. A uniform prenatal record form (Ob/Gyn and FP OB charts only)*
- q. Information about Advance Directives is noted (Members over 18 years old)*
- r. Identification of all providers participating in the Member's care and information on services provided by these providers
- s. Treatment plan is documented
- t. Prescribed medications including dosages and dates of initial prescription or refill
- u. Possible risk factors for patient relevant to particular treatment are noted

Examination

- v. Blood pressure measured/recorded on the first visit (patient's xx years old and older)
- w. Weight measured/recorded on first visit

Studies

- x. Lab and other studies are ordered, as appropriate
- y. Evidence that physician has reviewed lab, X-ray, or biopsy results (signed or initialed reports) and Member has been notified of results before filing report.*

Communication

- z. Copies of letters/notes or documentation of telephone contacts from referred specialists
- aa. Phone instructions/communications with patients are documented*
- bb. A system to document missed appointments
- cc. Hospital Discharge Summary or Emergency Room Report or Summary Sheet

Storage

- dd. Medical records protected from public access*
- ee. Each patient has an individual medical record*
- ff. All documents in medical record are securely placed in the record
- gg. All documents in medical records should be retained and produced for review according to regulatory requirements of Texas Medicaid, CHIP and STAR Kids programs.

Specialist Physician Medical Record Criteria

Providers using electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

Organization

- a. Each page has patient's name or ID*
- b. Personal data: gender, date of birth, address, occupation, home/work phone numbers, marital status is recorded*
- c. All entries in the record contain author's signature or initials or electronic identifier*
- d. All entries are dated*
- e. All entries are legible to someone other than the writer
- f. Medication list is completed including dosages and date of initial or refill prescription
- g. Medication allergy or lack thereof and adverse reactions are prominently noted.*
- h. Problem list is completed including significant illnesses and medical and psychological conditions*
- i. Past medical history is completed.
- j. For patients 14 years and up, there is a note concerning cigarettes, alcohol and substances (for patients seen 3 or more times, query substance abuse history).
- k. History and Physical documents have subjective/objective information for presenting problem.
- l. Note regarding follow-up care, calls, visits. Specific time of return is noted in weeks, months or as needed.
- m. Unresolved problems from previous visits are addressed in subsequent visits.
- n. A uniform prenatal record form (Ob/Gyn and FP OB charts only)*
- o. Information about Advance Directives is noted (Members over 18 years old)*
- p. Identification of all providers participating in the Member's care and information on services provided by these providers
- q. Treatment plan is documented
- r. Prescribed medications including dosages and dates of initial prescription or refill
- s. Possible risk factors for patient relevant to particular treatment are noted

Examination

- a. Blood pressure measured/recorded on the first visit (patient xx years old and older)
- b. Weight measured/recorded on first visit

Studies

- a. Lab and other studies are ordered, as appropriate
- b. Evidence that physician has reviewed lab, X-ray, or biopsy results (signed or initialed reports) and Member has been notified of results before filing report.*

Communication

- a. Copies of letters/notes or documentation of telephone contacts from referring physician
- b. Phone instructions/communications with patients are documented*
- c. A system to document missed appointments
- d. Hospital Discharge Summary or Emergency Room Report or Summary Sheet

Storage

- a. Medical records protected from public access*
- b. Each patient has an individual medical record*
- c. All documents in medical record are securely placed in the record
- d. All documents in medical records should be retained and produced for review according to regulatory requirements of Texas Medicaid, CHIP and STAR Kids programs.

*Indicates items assessed for Medical Record Keeping Practices during Office Assessments

Appendix I – Private Pay Agreement

Private Pay Agreement

Private Pay Agreement Example Form

I understand _____ is accepting me, _____,
(Provider Name) (Member Name)
as private pay patient for the period of _____, and I will
be responsible for paying for any services I receive. The provider will not
file a claim to Medicaid for services provided to me.

Patient Signature

Date

Appendix J – Member Acknowledgement

Member Acknowledgement

Member Acknowledgement Example Form

I, _____,
(Member Name) am agreeing to receive services from
_____,
(Provider Name) that may not have been authorized or
may not be a covered benefit. I will be responsible for paying for any
services I receive. The provider will not file a claim to Medicaid for
services provided to me.

Patient Signature

Date

Appendix K – Consent for Disclosure of Confidential Information

I hereby authorize Aetna Better Health and any of its parents, subsidiaries, or other affiliates and their respective agents and subcontractors, to disclose confidential information about the member/insured listed below.

Please Print All Responses

If you do not fill out all of this form, Aetna Better Health may be unable to process your request. Incomplete authorization requests will be returned to the member.

I UNDERSTAND THIS AUTHORIZATION IS VOLUNTARY and the information to be disclosed may be protected by law.

Member Name _____	ID Number _____	Date of Birth _____
Street Address _____	City/State/Zip Code _____	(____)____-____ Daytime Phone Number

I authorize the individual or company identified below to receive confidential information pertaining to the member/insured named above.

Individual or company authorized to receive confidential information

Street Address

City, State, and Zip Code

Daytime Area Code and Phone Number

Information to be disclosed to this individual or company includes application or enrollment information, eligibility information, claims records, claim status, and patient management records.

Disclosure requested will include otherwise confidential medical information. If our records include claims or other information pertaining to chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information, these records will be included in the information we will make available to the individual or company designated above.

IMPORTANT: *Your signature below means you understand and agree to the following:*

- You understand your eligibility for benefits and payment for services covered by Aetna Better Health under your plan will not be affected if you do not sign this form. *(However, without your signature, your request to release the information described above to a third party will not be honored.)*
- The confidential information provided to the authorized individual or company upon their request, may include diagnosis and treatment information, including information on chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.
- You understand you may receive a copy of this form if you ask for it by writing to the address listed at the bottom of this page.

You understand this authorization will expire one year from the date you sign this authorization. You also understand if you sign this form, you may revoke the authorization at any time by notifying Aetna Better Health in writing, but if you do, it will not have any effect on actions Aetna Better Health took before we received the notification.

- You agree to hold Aetna Better Health and its affiliates harmless from any claim or liability, including, but not limited to, any claim brought under a confidentiality or privacy law, in connection with the release at your request of information and records described above.

Signature of member or legal representative

Date

Print name of member legal representative (if applicable)

Relationship to member/ insured

If this authorization is being requested by member/insured's legal representative, you must furnish a copy of the power of attorney, or other relevant document designating you as the representative.

(Important note: the witness below may not be the person authorized to receive the information to be disclosed.)

Witnessed by:

Printed Name of Witness

Date

Signature of Witness

Consent for Disclosure of Confidential Information - Spanish

Autorización para Divulgar Información Personal y Confidencial a Terceras Personas

Por medio de la presente autorizo a Aetna Better Health así como también a cualesquiera de sus casas matrices, subsidiarias, u otras afiliaciones y sus agentes respectivos y subcontratistas, a divulgar información confidencial acerca del miembro/asegurado indicado mas abajo.

Favor de Escribir las Respuestas con Letra de Molde

Si esta forma no se llena en su totalidad, Aetna Better Health podría no procesar su solicitud. Las solicitudes para autorización incompletas serán regresadas al afiliado/miembro correspondiente.

ENTIENDO QUE ESTA AUTORIZACION ES DE CARACTER VOLUNTARIO y la información a ser divulgada eSTARá protegida por la ley.

Nombre del Miembro	Numero Identificación	Fecha de Nacimiento
_____	_____	(--) _____

Domicilio Particular	Ciudad/Estado/C. Postal	No. de Telefono Diumo
----------------------	-------------------------	-----------------------

Mediante este documento autorizo a la persona o a la compañía que se identifica aquí debajo para recibir información confidencial acerca del miembro/asegurado indicado anteriormente.

Persona o compañía autorizada para recibir información confidencial

Domicilio Particular

Ciudad, Estado, Código Postal

Numero de Telefono Diumo incluyendo Numero de Area

La información a ser divulgada a la persona o compañía indicada, incluye información sobre la solicitud de membresía y registro, información sobre elegibilidad, registro de reclamaciones, estado de reclamaciones y registros sobre el manejo del paciente.

La divulgación solicitada incluirá información médica confidencial. Si nuestros registros incluyen reclamaciones u otra información perteneciente a enfermedades crónicas, condiciones de la salud relacionadas con el comportamiento, incluyendo el abuso del alcohol u otras sustancias, enfermedades contagiosas, incluyendo HIV/SIDA, y/o información de índole genética, dichos registros serán incluidos en el grupo de información que entregaremos a la persona o a la compañía arriba indicada.

IMPORTANTE: Su firma al calce indicará su entendimiento y su acuerdo a lo siguiente:

- Si usted no firma esta forma, usted entiende que su derecho de obtener beneficios y pago por servicios cubiertos por Aetna Better Health bajo su plan de cobertura, no se verá afectado. *(Sin embargo, si usted no firma esta forma, su solicitud para divulgar la información descrita anteriormente a terceras personas, no podrá cumplirse.)*
 - La información confidencial entregada a la persona autorizada o compañía que haya hecho la solicitud, podría contener información sobre diagnósticos y tratamiento, incluyendo información sobre enfermedades crónicas, condiciones de la salud relacionadas con el comportamiento, incluyendo el abuso del alcohol u otras sustancias, enfermedades contagiosas, incluyendo HIV/SIDA, y/o información de índole genética.
 - Usted entiende que podrá obtener una copia de esta forma a solicitud suya, pidiéndola por escrito a la dirección indicada al calce.
 - Usted entiende que esta autorización tendrá vigencia durante un año a partir de la fecha que usted firme la misma. También entiende que si usted firma esta forma, usted tendrá el derecho de revocar su autorización en cualquier momento mediante una notificación por escrito a Aetna Better Health, en el entendimiento de que, si lo hiciera, su revocación no tendrá efecto sobre las acciones adoptadas por Aetna Better Health antes de recibir dicha notificación por escrito.
- Usted acuerda de no hacer responsable a Aetna Better Health y a sus afiliadas por reclamaciones o daños incluyendo, mis no limitada a, cualesquiera reclamaciones presentadas bajo alguna ley de confidencialidad o privacidad relacionada con la divulgación, a solicitud suya, de información y registros descritos anteriormente.

Firma del miembro o representante legal

Fecha

Nombre del representante legal del miembro con
letra de molde (si fuera aplicable)

Relación con el miembro/
asegurado

Si esta autorizaci6n esti siendo solicitada por el representante legal del miembro/asegurado, este deberi presentar copia del poder notarial u otro documento legal que lo autorice como el representante.

(Nota Jmportante : el testigo firmante no podra ser la misma persona autorizada para recibir la informaci6n a ser divulgada.)

Testigo:

Nombre del Testigo con Letra de Molde

Fecha

Firma del Testigo

Appendix L – Texas Health Steps Quick Reference Guide

Texas Health Steps Quick Reference Guide

Remember: Use Provider Identifier • Use Benefit Code EPI

Texas Health Steps Medical Checkup Billing Procedure Codes

Texas Health Steps Medical Checkups					Tuberculin Skin Testing (TST)			
99381	99382	99383	99384	99385*	Use procedure code 86580 for TST. Procedure code 86580 may be reimbursed on the same day as a checkup.			
99391	99392	99393	99394	99395*				
* For clients who are 18 through 20 years of age, use diagnosis code Z0000 or Z0001.					Oral Evaluation and Fluoride Varnish			
Texas Health Steps Follow-up Visit					Use procedure code 99429 with U5 modifier.			
Use procedure code 99211 for a Texas Health Steps follow-up visit.					Developmental and Autism Screening			
ICD-10 Diagnosis Codes					Developmental screening with use of the ASQ, ASQ:SE, PEDS or SWYC is reported using procedure code 96110.			
Z00110	Routine newborn exam, birth through 7 days				Autism screening with use of the M-CHAT or M-CHAT R/F is reported using procedure code 96110 with U6 modifier.			
Z00111	Routine newborn exam, 8 through 28 days				Mental Health Screening			
Z00129	Routine child exam				Mental Health Screening in adolescents with the use of the PSC 17, PSC-35, Y-PSC, PHQ-9, PHQ-A (depression screen), CRAFFT, PHQ-A (Anxiety, mood, substance use) or RAAPS is reported using procedure code 96160 or 96161. Only one procedure code (96160 or 96161) may be reimbursed per client per calendar year.			
Z00121	Routine child exam, abnormal				Postpartum depression screening with the use of a validated screening tool including the Edinburgh Postnatal Depression Scale, PHQ-9 or Postpartum Depression Screening Scale is reported using procedure code G8431 or G8510. Only one procedure code (G8431 or G8510) may be reimbursed per client.			
Z0000	General adult exam				Modifiers			
Z0001	General adult exam, abnormal				Performing Provider			
Point-of-Care Lead Testing					Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.			
Use procedure code 83655 with QW modifier to report that an initial blood lead level screening test was completed using point-of-care testing.					AM (Physician)	SA (Nurse Practitioner)	TD (Nurse)	U7 (Physician Assistant)
Immunizations Administered					Exception to Periodicity			
Use code Z23 to indicate when immunizations are administered.					Use with Texas Health Steps medical checkups procedure codes to indicate the reason for an exception to periodicity.			
Procedure Codes		Vaccine			23 (Unusual Anesthesia)	32 (Mandated Services)	SC (Medically Necessary)	
90632 or 90633 [†] with (90460/90461 or 90471/90472)		Hep A			FQHC and RHC			
90620 [†] or 90621 [†] with (90460/90461 or 90471/90472)		MenB			Federally qualified health center (FQHC) providers must use modifier EP for Texas Health Steps medical checkups. Rural health clinic (RHC) providers must bill place of service 72 for Texas Health Steps medical checkups.			
90636 with (90460/90461 or 90471/90472)		Hep A/Hep B			Vaccine/Toxoids			
90644		Hib-MenCY			Use to indicate a vaccine/toxoid <i>not available</i> through TVFC and the number of state defined components administered per vaccine.			
90647 [†] or 90648 [†] with (90460/90461 or 90471/90472)		Hib			U1	Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available		
90650 or 90651 [†] with (90460/90461 or 90471/90472)		HPV			Vaccine Administration and Preventive E/M Visits			
90630, 90654, 90655 [†] , 90656 [†] , 90657 [†] , 90658 [†] , 90685 [†] , 90686 [†] , 90687 [†] or 90688 [†] with (90460/90461 or 90471/90472); 90660 [†] or 90672 [†] with (90460/90461 or 90473/90474); 90661, 90673, 90674, 90682 or 90756 [†] with (90471/90472)		Influenza			Use with Texas Health Steps preventive visit checkup procedure codes to indicate a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration.			
90670 [†] with (90460/90461 or 90471/90472)		PCV13			25	Significant, separately identifiable evaluation		
90680 [†] or 90681 [†] with (90460/90461 or 90473/90474)		Rotavirus			Condition Indicator Codes			
90696 [†] with (90460/90461 or 90471/90472)		D'TaP-IPV			One of the Condition Indicators below is required whether a referral was made or not.			
90698 [†] with (90460/90461 or 90471/90472)		D'Tap-IPV-Hib			Referral Status	Indicator Codes	Description	
90700 [†] with (90460/90461 or 90471/90472)		D'TaP			N	NU	Not used (no referral)	
90702 [†] with (90460/90461 or 90471/90472)		DT			Y	ST	New services requested	
90707 [†] with (90460/90461 or 90471/90472)		MMR			Y	S2	Under treatment	
90710 [†] with (90460/90461 or 90471/90472)		MMRV						
90713 [†] with (90460/90461 or 90471/90472)		IPV						
90714 [†] with (90460/90461 or 90471/90472)		Td						
90715 [†] with (90460/90461 or 90471/90472)		Tdap						
90716 [†] with (90460/90461 or 90471/90472)		Varicella						
90723 [†] with (90460/90461 or 90471/90472)		D'Tap-Hep B-IPV						
90732 [†] with (90460/90461 or 90471/90472)		PPSV23						
90733 or 90734 [†] with (90460/90461 or 90471/90472)		MPSV4						
90743, 90744 [†] , or 90746 with (90460/90461 or 90471/90472)		Hep B						
90748 [†] with (90460/90461 or 90471/90472)		Hib-Hep B						
90758 with (90471/90472)		Ebola Virus						

[†] Indicates a vaccine distributed by TVFC

Appendix M – State Fair Hearing/External Medical Review Request Form

State Fair Hearing and External Medical Review Request Form

To ask for a state fair hearing and external medical review, you can call us at 1-844-787 5437 (TTY: 711), email us at TXMemberAdvocate@aetna.com, or mail or fax this form to us.

Mail: P.O. Box 81139
5801 Postal Road
Cleveland, OH 44181
Fax: 1-877-223-4580

You must request a state fair hearing by <date 120 Days from the date this notice is mailed>.

If you kept receiving services during your health plan appeal, you may be able to keep getting your services during your state fair hearing. Make your request by <date must be the later of the following: date 10 Days from the date this notice is mailed, or the date services will change> only if you kept services during your health plan appeal.

Mark the state fair hearing option you want:

Only select one.

- State fair hearing
- State fair hearing and external medical review
- Emergency state fair hearing*
- Emergency state fair hearing and emergency external medical review*

*Emergency state fair hearings and emergency external medical reviews should only be requested if you believe your health will be seriously harmed by waiting for your fair hearing or external medical review decisions.

<Denial Reference Number: Number>

Do you want your services to continue? Yes No

Your services can only be continued if they were also continued during your health plan appeal. If you want your services to continue, you must request a state fair hearing and ask to keep your services by **<date must be the later of the following: date 10 Days from the date this notice is mailed or the date services will change>**.

You can make this request by phone. Call us at 1-844-787-5437 (TTY: 711) if you believe this form will not reach us by mail before the deadline.

Your Personal Information*

Member last name:	Member first name:
Parent or guardian last name:	Parent or guardian first name:
Member Medicaid ID and subscriber number:	Preferred phone number:

*If any of your contact information has changed, call the enrollment broker at 1-800-964 2777 and Aetna Better Health of Texas at 1-844-787-5437 (TTY: 711).

Your Hearing Representative’s or Parent’s Information

You can represent yourself. If you would like someone to represent you, such as, parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

Name:
Address:
Phone number:

Reason for the State Fair Hearing

This section is optional. You can fill it out to tell us about your services under appeal and why you think they’re needed.

Services under appeal:
Why you need them:

Sign this form

By signing this form, you or your representative are requesting a state fair hearing and giving the Texas Health and Human Services Commission authorization to get your medical records and to contact a representative if you listed one.

Member/Authorized representative signature

Printed Name

Date
