AETNA BETTER HEALTH®

Family Health Plan & Integrated Care Program

Provider Handbook

aetna®

IL-17-04-10 Revision Date: June 2017

Helpful information

Provider Relations
1-866-212-2851 (TTY: 711)
Representatives available 24 hours a day, 7 days a week

Address
Aetna Better Health Premier Plan 333 West Wacker Drive, Suite 2100
Chicago, IL 60606

Enrollment and Application Services Illinois
Client Enrollment Broker (ICEB) 1-877-912-8880
TTY: 1-866-565-8576

Dental Services
DentaQuest
1-800-416-9185

Behavioral Health Services
1-866-600-2139 (TTY: 711)

Vision Services
March Vision
1-844-456-2724

Pharmacy Services
1-866-600-2139 (TTY: 711)

Language Interpretation Services
Including Sign Language Interpretation and CART Reporting
1-866-600-2139 (TTY: 711)
Representatives available 24 hours a day, 7 days a week

Appeals and Grievances
Aetna Better Health Premier Plan
Attn: Appeals and Grievances Manager 333 West Wacker Drive, Suite 2100
Chicago, IL 60606
1-866-600-2139 (TTY: 711)

To make a request for a fair hearing: Illinois Department of Healthcare and Family Services Bureau of Assistance Hearings 401 South Clinton, Sixth Floor Chicago, IL 60607
1-800-435-0774
TTY: 1-877-734-7429

Fraud and Abuse Hotline
1-877-436-8154

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CHAPTER 1: INTRODUCTION TO AETNA BETTER HEALTH OF ILLINOIS

Welcome

Welcome to the Aetna Better Health® of Illinois. Our ability to provide excellent service to our Members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Illinoisans who need us the most.

About Aetna Better Health

Aetna Medicaid has been a leader in Medicaid managed care since 1986 and currently serves more than 2 million people in states. Aetna Medicaid and its affiliates currently own plans and administer Medicaid services in California, Louisiana, Michigan, Maryland. Aetna Medicaid also provides Medicaid-related administrative services to.

Aetna Medicaid has more than 25 years of experience in managing the care of the most medically vulnerable, using innovative approaches to achieve both successful health care results and maximum cost outcomes. Aetna Medicaid has particular expertise in serving high-need Medicaid and LTC Members, including those who are dually eligible for Medicaid and MedicareMember.

About the Integrated Care Program

The Integrated Care Program is one of Illinois' managed care programs for Medicaid recipients. It currently serves approximately Members in the counties of Boone, DuPage, McHenry, Kane, Kankakee, Lake, Will, Winnebago and Cook.

Member

The Integrated Care Program, includes all standard Medicaid medical services as noted in Service Package I, as well as Service Package II (https://www.illinois.gov/hfs/Pages/default.aspx) services which include Long Term Supports and Services (LTSS), including those in nursing facilities or those who receive Home and Community-Based Services (HCBS) waivers.

About the Family Health Plan

Members who are enrolled with the Aetna Better Health of Illinois Family Health Plan, which is a program that provides temporary financial assistance for pregnant women and families with one or more dependent children.

The full array of benefits and supportive services under the program include, vision, dental and pharmacy benefits.

The benefit information provided is a brief summary, not a complete description of the benefits. For more information contact our Provider Services Department at **1-866-212-2851**.

About this Provider Handbook

Through the Provider Handbook, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health. If you have a question, problem, or concern that the Provider Handbook does not fully address, please call our Provider Services Department at **1-866-212-2851**.

Aetna Better Health will update the Provider Handbook at least annually and will distribute bulletins as needed to incorporate any changes. Please check our website at **www.aetnabetterhealth.com/Illinois** for the most recent version of the Provider Handbook and/or updates. The Aetna Better Health Provider Handbook is available in or electronic at no charge by contacting our Provider Services department at **1-866-212-2851**.

Service Area's

Aetna Better Health of Illinois' Integrated Care and Family Health Plan are offered in the following counties:

Integrated Care Program and Family Health Plan:

Counties	
Boone	Lake
Cook	McHenry
DuPage	Will
Kane	Winnebago
Kankakee	

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the Integrated Care Program, Family Health Plan, and with your Aetna Better Health provider agreement, including all requirements described in this Handbook, in addition to all federal and state regulations governing a provider. While this Handbook contains basic information about Aetna Better Health, the Illinois Department of Healthcare and Family Services (HFS) and the Centers for Medicare and Medicaid Services (CMS), providers are required to fully understand and apply HFS and CMS requirements when administering covered services

Please refer to **https://www.illinois.gov/hfs/Pages/default.aspx** and **t** for further information on the HFS and CMS, respectively.

Aetna Better Health Policies and Procedures

Our comprehensive and robust policies and procedures are in place throughout our entire Health Plan to assure all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and required updates are made as needed.

Model of Care

Our model of care offers an integrated care management approach, which offers enhanced assessment and management for enrolled Members. The processes, oversight committees, provider collaboration, care management and coordination efforts applied to address Member needs result in a comprehensive and integrated plan of care for the Member.

The integrated model of care addresses the needs of Members who are often frail, elderly, and coping with disabilities, compromised activities of daily living, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues.

CHAPTER 2: CONTACT INFORMATION

Providers who have additional questions can refer to the following phone numbers:

Important Contacts	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
Aetna Better Health of Illinois Integrated Care Program and Family Health Program	**1-866-212-2851**	Individual departments are listed below	8 a.m.-5 p.m. CT Monday-Friday 8 a.m.-5 p.m. CT Monday-Friday 24 hours / 7 days per week
Aetna Better Health of Illinois Prior Authorization Department	See Program Numbers Above and Follow the Prompts	**1-855-684-5259**	8 a.m. -5 pm CT - Monday -Friday
Aetna Better Health of Illinois Compliance Hotline (Reporting Fraud, Waste or Abuse)	**1-877-436-8154**	N/A	24 hours / 7 days per week through Voice Mail inbox
Aetna Better Health Special Investigations Unit (SIU) (Reporting Fraud, Waste or Abuse)	**1-800-338-6361**	N/A	24 hours / 7 days per week
Claims Inquiry/Claims Research Department (CICR) • Claims questions inquiries and reconsiderations • Remittance advice questions • Recent update questions	**1-866-212-2851**, Option #2 (Providers), #2 (Claims Inquiry)	N/A	24 hours / 7 days per week

Aetna Better Health of Illinois Department Fax Numbers	Fax Number
Member Services	**1-855-802-4291**
Provider Services	**1-860-754-0435**
Provider Claim Disputes	**1-860-754-0435**
Case Management/IP/OP Hospital Notification	**1-855-320-8445**
Medical Prior Authorization	**1-855-684-5259**
Pharmacy Prior Authorization	**1-855-684-5250**
Dental Prior Authorization	N/A (call **1-800-416-9185**)
Behavioral Health, including Behavioral Health Crisis Line	N/A (Call **1-866-212-2851**)

Community Resource	Contact Information
Illinois Tobacco "Quitline"	1-866-QUIT-YES (**1-866-784-8937**) Website: http://www.quityes.org/

Contractors	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
DentaQuest Add brief description	**1-800-416-9185**	N/A	8 a.m.-6 p.m. CT.M-F
CVS CAREMARK Add brief description	**1-855-271-6603**		8 a.m.-8 p.m. ET.M-F
Interpreter Services Language interpretation services, including sign language, special services for the hearing impaired and CART reporting	Please contact Member Services at **1-866-212-2851** (for more information on how to schedule these services in advance of an appointment)	N/A	24 hours / 7 days per week
March Vision Care, Inc. Add brief description	**1-844-456-2724** **1-877-627-2456** TTY	**1-877-MARCH 88** (**1-877-627-2488**)	8 a.m.-5 p.m. CT Monday – Friday

Contractors	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
Medical Transportation Management, Inc. (MTM/Ride Right) Please note that this number is for requesting non-emergency transportation only. Emergency transportation services are covered for emergencies only, and Members who experience a medical emergency should call **911**	**1-866-212-2851** **1-888-513-1612** Ride Right/MTM	N/A	8am-6pm CT Monday-Saturday

Agency Contacts & Important Contacts	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
Illinois Department of Healthcare and Family Services (HFS)	**1-800-447-4278** Email: hfswebmaster@illinois.gov		
Division of Rehabilitation Services within (DHS-DRS)	**1-877-761-9780** Voice **1-866-264-2149** TTY **1-866-588-0401** VP		
Illinois Department on Aging (DoA)	**1-217-785-3356**	**217-785-4477**	
The Department of Health, Office of Inspector General (OIG)	**1-800-368-1463**		
Emdeon Customer Service Email Support: hdsupport@webmd.com	**1-800-845-6592**	N/A	24 hours / 7 days per week

Agency Contacts & Important Contacts	Phone Number	Facsimile	Hours and Days of Operation (excluding State holidays)
Illinois Client Enrollment Broker	**1-877-912-8880** **1-866-565-8576** (TTY) Spanish **1-877-912-8880** **1-866-565-8576** (TTY)	N/A	8 a.m.-7 p.m. CT Monday-Friday
IL Relay	Dial **711**	N/A	24 hours / 7 days per week
Reporting Suspected Abuse			
The Department of Health, Office of Inspector General (OIG) OIG Abuse Hotline	**1-800-368-1463**	N/A	24 hours / 7 days per week
24-Hour Elder Abuse Hotline	**1-866-800-1409** **1-888-206-1327** (TTY)	N/A	24 hours / 7 days per week
Department of Public Health Abuse Hotline (LTC & NFs)	**1-800-252-4343**	N/A	24 hours / 7 days per week
Department of Children and Family Services Child Abuse Hotline	1-800-25-ABUSE Or **1-800-252-2873** **1-800-358-5117** (TTY)	N/A	24 hours / 7 days per week

Important Addresses	
Aetna (Provider Claim Disputes)	Aetna Better Health Attention: Provider Disputes or Appeals 333 West Wacker Drive Mail Stop F646 Chicago, IL 60606
Aetna (Claims Submission & Resubmission)	Aetna Better Health PO Box 66545 Phoenix, AZ 85082
DentaQuest Claims Address www.dentaquestgov.com	12121 Corporate Parkway Mequon, WI 53092-9838
March Vision Claims Address www.marchvisioncare.com	March Vision Care Group 6701 Center Drive West, Suite 790 Los Angeles, CA 90045
Medical Transportation Management, Inc. (MTM/Ride Right)	16 Hawk Ridge Drive
www.mtm-inc.net	Lakes Saint Louis, MO 63367

Below is a list of services specific to the LTSS program:

Agency	Waiver Program	Services
Illinois Department on Aging (IDoA)	Elderly Waiver also known as the Aging Waiver Community Care Program	• Adult Day Service • Homemaker • Emergency Home Response
Division of Rehabilitation Services within DHS (DHS-DRS)	Persons with Disabilities Waiver also known as the Disabilities Waiver	• Adult Day Service • Environmental Accessibility Adaptations • Home Delivered Meals • Home Health Aide • Homemaker • Nursing, Intermittent • Personal Care (Personal Assistant) • Personal Emergency Response System • Physical, Occupational, and Speech Therapy • Respite • Skilled Nursing • Specialized Medical Equipment and Supplies
The Division of Rehabilitation Services within DHS (DHS-DRS)	Persons with Brain Injury Waiver also known as the Brain Injury Waiver or TBI Waiver	• Adult Day Service • Behavioral Services • Day Habilitation • Environmental Accessibility Adaptations • Home Delivered Meals • Home Health Aide • Homemaker • Nursing, Intermittent • Personal Care (Personal Assistant) • Personal Emergency Response System • Physical, Occupational, and Speech Therapy • Prevocational Services • Respite • Skilled Nursing • Specialized Medical Equipment and Supplies • Supported Employment

Agency	Waiver Program	Services
Division of Rehabilitation Services within DHS (DHS-DRS)	People with HIV or AIDS Waiver also known as the AIDS Waiver	• Adult Day Service • Environmental Accessibility Adaptations • Home Delivered Meals. • Home Health Aide • Homemaker • Nursing, Intermittent • Personal Care (Personal Assistant) • Personal Emergency Response System • Physical, Occupational, and Speech Therapy • Respite • Skilled Nursing • Specialized Medical Equipment and Supplies
Illinois Department of Healthcare and Family Services (HFS)	Supportive Living Facilities Waiver also known as the SIL Waiver	Also known as Assisted Living Service

CHAPTER 3: PROVIDER SERVICES

Provider Services Overview

Our Provider Services Department serves as a liaison between the Health Plan and the provider community. Provider Services Staff conduct onsite provider training, problem identification and resolution, site visits, accessibility audits and develop provider communication materials, including the Provider Handbook.

Provider Representatives are available by phone to check the update of a previously submitted claim or email to provide telephonic or electronic support to all providers. Notification of change of any change is required Below are some examples of changesthe areas where we provide assistance:

Notification of change of any change is required

- Advise of an address change
- View recent updates
- Locate Forms
- Notify the plan of a provider termination
- Notify the plan of changes to your practice
- Advise of a Tax ID or NPI change
- Obtain a secure web portal or Member care Login ID
- EFT ERA (electronic funds transfer/Electronic Remittance Advice)
- Network participation request

Provider Orientation

Aetna Better Health provides initial orientation for newly contracted providers within one month after they join our network. In follow up to initial orientation, Aetna Better Health provides a variety of forums for ongoing provider training and education, such as routine site visits, group or individualized training sessions on select topics (Reminttance Advice, Member benefits, Aetna Better Health website navigation), distribution of periodic provider newsletters and bulletins containing updates and reminders, and online resources through our website at **www.aetnabetterhealth.com/Illinois**.

CHAPTER 4: PROVIDER RESPONSIBILITIES AND MEMBER ELLIGIBILITY

Providers are contractually obligated to adhere to and comply with all terms of the ICP and Family Health Program, Provider Contract and requirements in this Handbook. Aetna Better Health may or may not specifically communicate such terms in forms other than the Provider Contract and this Handbook. **https://www.aetnabetterhealth.com/Illinois/providers/notices**

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of an Member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Advice given to potential or enrolled Members should always be given in the best interest of the Member.

Providing Member Care

Providers Member must be enrolled as a Medicaid provider with the Illinois Department of Healthcare and Family Services and credentialed per Aetna Better Health plan policy.

Providers that have been excluded from participation in any federally or state funded health care program are not eligible to become network providers.

Appointment Availability Standards

Providers are required to schedule appointments for eligible Members in accordance with the minimum appointment availability standards, and based on the acuity and severity of the presenting condition in conjunction with the Member's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek corrective action plans, such as panel or referral restrictions, from providers that do not meet accessibility standards.

Provider Type	Urgent Care	Preventative & Routine Care	Post-hospitalization or Emergency Department Visit
PCP	Within 24 hours	5 weeks from the date of request for care Non-urgent complaints within 3 week	7 days from discharge

Prenatal Care. Members shall be seen within the following timeframes:
Initial Prenatal Visit without expressed problems shall be made available within two (2) weeks after a request for an Member in her first trimester
Routine, preventive care: Within two (2) weeks for infants under age six (6) months, from the date of request.
Within one (1) week for a Member in her second trimester
Within three (3) days for a Member in her third trimester

Behavioral Health. Members shall be seen within the following timeframes:
Routine, within seven (7) Calendar days of request
Non-Life Threatening Emergency, within six (6) hours
Immediate treatment for potentially suicidal individual

Telephone Accessibility Standards

Providers have the responsibility to make arrangements for after-hours coverage in accordance with applicable state and federal regulations, either by being available or having on-call arrangements in place with other qualified participating Aetna Better Health Providers for the purpose of rendering medical advice, determining the need for emergency and other after-hours services including, authorizing care, and verifying Member enrollment with us.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on call coverage. On call coverage response for routine, urgent, and/or emergent health care issues are held to the same accessibility standards regardless if after hours coverage is managed by the PCP, current service provider, or the on-call provider.

All Providers must have a published after hours telephone number and maintain a system that will provide access to primary care 24-hours-a-day, 7-days-a-week. In addition, we will encourage our providers to offer open access scheduling, expanded hours and alternative options for communication (e.g., scheduling appointments via the web, communication via e-mail) between Members, their PCPs, and practice staff. We will routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will continually evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if an Member may need care management intervention.
- Our compliance and provider management teams will evaluate Member, caregiver, and provider grievances regarding after hour access to care to determine if a PCP is failing to comply on a monthly basis.

Provider must make certain that their hours of operation are convenient to, and do not discriminate against, Members. This includes offering hours of operation that are no less than those for non-Members, commercially insured or public fee-for-service individuals.

In the event that a PCP fails to meet telephone accessibility standards, a Provider Services Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.

Covering Providers

Our Provider Services Department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health. This notification must occur in advance of providing authorized services.

Verifying Member Eligibility

All providers, regardless of contract status, are responsible for must verifing an Member's enrollment status benefit coverage prior to the delivery of non-emergent, covered services. Member Providers will not be reimbursed for services rendered to Members who are no longer are elidigble.

Member eligibility can be verified through our web portal, state & federal eligibility and Aetna Better Health of Illinois Service department.

Secure Web Portal

The Secure Web Portal is a web-based platform that allows us to communicate Member healthcare information directly with participating providers. The following information can be accessed through the Secure Web Portal:

- Member Eligibility Search - Verify current eligibility of one or more Members.
- MemberClaims Status Search - Search for provider claims by Member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- Remittance Advice Search - Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user's account provider ID will be displayed.
- Authorization List - Search for provider authorizations by Member, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed.
- Submit Authorizations - Submit an authorization request on-line.
- Healthcare Effectiveness Data and Information Set (HEDIS) - Check the status of the Member's compliance with any of the HEDIS measures. MemberMember

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website. **https://www.aetnabetterhealth.com/Illinois/providers/portal**

It is the providers responsability to verify eligibility prior to rendering service. Faliure to verify can result in denial of claim. As with all eligibility, final enrollment is determined by the State of Illinois and subjected to change. An ID Card is not a garauntee of benefit, eligibility or payment of service

Coverage of Renal Dialysis - Out of Area

Aetna Better Health pays for renal dialysis services obtained by a Member from a contracted or non-contracted certified physician or health care professional while the Member is temporarily out of our service area (up to six months).

Preventive or Screening Services

Providers are responsible for providing appropriate preventive care to Members. These preventive services include, but are not limited to:

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations.
- Well woman visits (female Members may go to a network obstetrician/gynecologist for a well woman exam once a year without a referral)
- Age and risk appropriate health screenings.

Behavioral Health Screening/Services

Providers are responsible for conducting a behavioral health screen to determine whether an Member needs behavioral health services.

Educating Members on their own Health Care

Aetna Better Health does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of an Member and to advise them on:

- The Member's health status, medical care or treatment options, including any alternative treatment that may be self-administered;
- Any information the Member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and,
- The Member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Emergency Services

Authorizations are not required for emergency services. In an emergency, please advise the Member to go to the nearest emergency department.

Urgent Care Services

For non emergant services members may utilize As a in network provider,Member; you are required to adhere to the all appointment availability standards. In some cases, it may be necessary for you to refer Members to one of our network urgent care centers (after hours in most cases). Please reference the Find A Provider link on our website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in our network. Link to portal link to find a provider

Primary Care Providers (PCPs)

The primary role and responsibilities of primary care providers (PCPs) include, but are not be limited to:

- Providing primary and preventive care and acting as the Member's advocate;
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of Member care, and including, as appropriate, transitioning young adult Members from pediatric to adult providers;
- Maintaining the Member's medical record.

PCPs are responsible for rendering, or ensuring the provision of, covered preventive and primary care services for our Members. These services will include, at a minimum, the treatment of routine illnesses, immunizations, health screening services, and maternity services, if applicable.

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to Members assigned to them, and attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring Members to behavioral health providers, providers or hospitals within our network, as appropriate, and if necessary, referring Members to out-of-network specialty providers;
- Coordinating with our Prior Authorization Department with regard to prior authorization procedures for Members;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned Members by other providers, specialty providers and/or hospitals; and
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- Coordinating the medical care for the programs the Member is assigned to, including at a minimum:
  - Oversight of drug regimens to prevent negative interactive effects
  - Follow-up for all emergency services
  - Coordination of inpatient care
  - Coordination of services provided on a referral basis, and
  - Assurance that care rendered by specialty providers is appropriate and consistent with each Member's health care needs.

PCPs are responsible for establishing and maintaining hospital admitting privileges that are sufficient to meet the needs of Members, or entering into formal arrangements for management of inpatient hospital admissions of Members. This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

PCPs may not close their panels immediately upon contracting with Aetna Better Health. Aetna Better Health manages each PCP's panel to automatically stop accepting new Members after the limit of 600 recipients (cumulative across the Integrated Care Program and FHP has been reached. If the PCP/PCP site employs Certified Registered Nurse Practitioners/Physician Assistants, then the Provider/Provider site will be permitted to add an additional 600 Members to the panel.

Self-Referrals

Aetna Better Health does not require referrals from primary care providers (PCP), or treating practitioner/providers. Members may self-refer access some services without an authorization from their PCP. These services include behavioral health care, vision care; Medicaid approved Alcohol and Drug Addiction facilities, dental care, family planning, and women's health care services. The Member must obtain these self-referred services from Aetna Better Health's provider network, except in the case of family planning.

Members may access family planning services from any qualified provider. Members also have direct access to Women's Health Care Provider (WHCP) services. Members have the right to select their own women's health care provider, including nurse midwives participating in Aetna Better Health's network, and can obtain maternity and gynecological care without prior approval from a PCP.

Women's Health Care Providers

PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health care provider (obstetrician, OB/GYN, gynecologist, family practitioner) for Covered Services related to this type of routine and preventive care. In some instances, a women's health care provider can be chosen to serve as a member's PCP if the provider's credentials are appropriate.

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists are required to coordinate with the PCP when Members need a referral to another specialist. The specialist is responsible for verifying Member eligibility as well as securing and needed prior authorizations prior to providing services.

When a specialist refers the Member to a different specialist or provider, then the original specialist must share these records, upon request, with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the Member, other specialists or other providers.

Primary Care Providers (PCPs) should only refer Members to Aetna Better Health network specialists. If the Member requires specialized care from a provider outside of our network, a prior authorization is required.

Specialty Providers Acting as PCPs

In limited situations, an Member may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. A specialist may be requested to serve as a PCP under the following conditions:

- When the Member has a complex, chronic health condition that requires a specialist's care over a prolonged period of time.
- When an Member's health condition is life threatening or so degenerative and/or disabling in nature to warrant a specialist serve in the PCP role.
- In unique situations where terminating the clinician-Member relationship would leave the Member without access to proper care or services or would end a therapeutic relationship that has been developed over time leaving the Member vulnerable or at risk for not receiving proper care or services.

Self-Referrals/Direct Access

Members may self-refer/directly access some services without an authorization from their PCP. These services include behavioral health care, vision care, dental care, family planning, and services provided by Women's Health Care Providers (WHCPs). The Member must obtain these self-referred services from an in network Aetna Better Health provider.

Family planning services do not require prior authorization. Members may access family planning services from any qualified provider. Members also have direct access to WHCP services. Members have the right to select their own WHCP, including nurse midwives who participate in Aetna Better Health's network, and can obtain maternity and gynecological care without prior approval from a PCP.

Skilled Nursing Facility (SNF) Providers

Nursing Facilities (NF), Skilled Nursing Facilities (SNFs), or Nursing Homes provide services to Members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of Members.

SNFs are responsible for making sure that Members residing in their facility are seen by their PCP in accordance with the following intervals:

- For initial admissions to a nursing facility, Members must be seen by their PCP once every 30 days for the first 90 days and at least once every 60 days thereafter.
- Members that become eligible while residing in a SNF must be seen by their PCP within the first 30 days of becoming eligible, and at least once every 60 days thereafter. (confirm with Nicole)

Members in a nursing facility must contribute a Share of Cost, also known as "Patient Pay", to the facility based on the amount determined by the State. The Plan receives Share of Cost information from the State on monthly files. These dollars will be subtracted from Nursing Home claims that come in for Members in Custodial or Nursing Home stay. Share of Cost is not deducted on skilled stays.

Home and Community Based Services (HCBS)

Home and Community Based Providers are obligated to work with Aetna Better Health Case Managers. Case Managers will complete face-to-face assessments with our Members, in their residence, every 90 days. Based on the assessment, Case Managers will then identify the appropriate services that meet the Members functional needs, including determining which network provider may be available in order to provide services to the Member in a timely manner. Upon completion, the Case Managers will then create authorizations for the selected Provider and fax/ e-mail these authorizations accordingly. Case Managers will also follow up with the Member the day after services were to start to confirm that the selected Provider started the services as authorized.

There may be times when an interruption of service may occur due to an unplanned hospital admission or short-term nursing home stay for the Member. While services may have been authorized for caregivers and agencies, providers should not bill for any days that fall between the admission date and the discharge date or any day during which services were not provided. This could be considered fraudulent billing.

Example:
Member is authorized to receive 40 hours of Personal Assistant per week over a 5-day period. The Member is receiving 8 hours of care a day.

The Member is admitted into the hospital on January 1, 2010 and is discharged from the hospital on January 3, 2010. There should be no billable hours for January 2, 2010, as no services were provided on that date since the Member was hospital confined for a full 24 hours.

Caregivers would not be able or allowed to claim time with the Member on the example above, since no services could be performed on January 2, 2010. This is also true for any in-home service.

Personal Assistants and Community Agencies are responsible for following this process. If any hours are submitted when an Member has been hospitalized for the full 24 hours, the Personal Assistants and Agencies will be required to pay back any monies paid by Aetna Better Health. Aetna Better Health will conduct periodic audits to verify this is not occurring.

Supportive Living Facilities

Supportive living facilities are obligated to collect room and board fees from ICP/FHP Members (includes alternative residential settings). Room and board includes but is not limited to:

- Debt service costs
- Maintenance costs
- Utilities costs
- Food costs (includes three meals a day or any other full nutritional regimen)
- Taxes
- Boarding costs (includes room, hotel and shelter-type of expenses)

Federal regulations prohibit Medicaid from paying room and board costs.

Please be aware that:
- Payments issued are always the contracted amount minus the Member's room and board;
- The room and board agreement identifies the level of payment for the setting, placement date, and room and board amount the Member must pay and is completed by the Aetna Better Health Case Manager at the time of placement;
- The room and board amount may periodically change based on an Member's income; and
- The Room and Board agreement form is completed at least once a year or more often if there are changes in income.

Note - Home and Community Based Services (HCBS) providers may not submit claims when the Member has been admitted to a hospital or nursing home. The day of admission or discharge is allowed, but the days in between are not. Providers submitting claims in the days in between may be subject to Corrective Action.

Second Opinions

An Member may request a second opinion from a provider within our network. Providers should refer the Member to another network provider within an applicable specialty for the second opinion.

Non-Compliant Members

Providers should strive to manage Members and ensure compliance with treatment plans and with scheduled appointments. If you need assistance helping noncompliant Members, please contact our Provider Services Department.

If you elect to remove the Member from your panel rather than continue to serve as the Member's medical home, you must provide the Member at least a thirty (30) days written notice prior to removal and ask the Member to contact Member Services to help them find a new provider. The Member will NOT be removed from a provider's panel unless the provider's efforts and those of our Health Plan do not result in the Member's compliance with medical instructions. If you need more information about this process, please contact our Provider Services Department.

Medical Records Review

Aetna Better Health's standards for medical records have been adopted from the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within the Aetna Better Health provider network. Below is a list of Aetna Better Health medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of the Aetna Better Health QM initiatives to maintain continuity and effective, quality patient care.

Provider records must be maintained in a legible, current, organized, and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health Members immediately and completely available for review and copying by the Department and/or federal officials at the provider's place of business, or forward copies of records to the Department upon written request without charge.

Medical records must reflect the different aspects of patient care, including ancillary services. The Member's medical record must be legible, organized in a consistent manner and must remain confidential and accessible to authorized persons only.

All medical records, where applicable and required by regulatory agencies, must be made available electronically.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements:

- Member identification information on each page of the medical record (i.e., name, Medicaid or Demonstration Identification Number)
- Documentation of identifying demographics including the Member's name, address, telephone number, employer, Medicaid and or Demonstration Identification Number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Complying with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including, but not limited to obtaining any required written Member consents to disclose confidential medical records for complaint and appeal reviews
- Initial history for the Member that includes family medical history, social history, operations, illnesses, accidents and preventive laboratory screenings (the initial history for Members under age 21 should also include prenatal care and birth history of the Member's mother while pregnant with the Member)
- Past medical history for all Members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received
- Immunization records (recommended for adult Members if available)
- Dental history if available, and current dental needs and/or services
- Current problem list (The record shall contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions, and health maintenance concerns are identified in the medical record.)
- Patient visit data - Documentation of individual encounters must provide adequate evidence of, at a minimum:
  - History and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints.
  - Plan of treatment
  - Diagnostic tests
  - Therapies and other prescribed regimens
  - Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or visit. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits.
  - Referrals, recommendations for specialty, behavioral health, dental and vision care, and results thereof.
  - Other aspects of patient care, including ancillary services
- Fiscal records - Providers will retain fiscal records relating to services they have rendered to Members, regardless of whether the records have been produced manually or by computer.
- Recommendations for specialty care, as well as behavioral health, dental and/or vision care and results thereof
- Current medications (Therapies, medications and other prescribed regimens - Drugs prescribed as part of the treatment, including quantities and dosages, shall be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to the effect.)

- Documentation, initialed by the Member's PCP, to signify review of:
  - Diagnostic information including:
    - Laboratory tests and screenings;
    - Radiology reports;
    - Physical examination notes; and
    - Other pertinent data.
- Reports from referrals, consultations and specialists
- Emergency/urgent care reports
- Hospital discharge summaries (Discharge summaries are included as part of the medical record for (1) hospital admissions that occur while the patient is enrolled in Aetna Better Health and (2) prior admissions as necessary.)
- Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when an Member's health status changes or new medications are prescribed, and behavioral health history.
- Documentation as to whether or not an adult Member has completed advance directives and location of the document (Illinois advance directives include Living Will, Health Care Power Of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated.)
- Documentation related to requests for release of information and subsequent releases, and
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific Member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the Member's health care.
- Entries - Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider shall countersign care rendered by ancillary personnel. Alterations of the record will be signed and dated.
- Provider identification - Entries are identified as to author.
- Legibility - Again, the record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

Medical Record Audits

Aetna Better Health or Illinois Department of Health and Family Services may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of an Member or provider, administrative responsibilities or quality of care issues. Providers must respond to these requests promptly. Medical records must be made available to the Illinois Department of Healthcare and Family Services (HFS) or CMS for quality review upon request and free of charge. In the event the HP cannot obtain records by process mentioned above the plan reserves the right to review records on site.

Access to Facilities and Records

Medicare laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to a Members or their contract with Aetna Better Health for inspection, evaluation, and audit for the longer of:

- A period of 10 years from the end of the contract with Aetna Better Health;
- The date the HFS or their designees complete an audit; or
- The period required under applicable laws, rules, and regulations.

Documenting Member Appointments

When scheduling an appointment with a Member over the telephone or in person (i.e. when an Member appears at your office without an appointment), providers must verify eligibility and document the Member's information in the Member's medical record. PAR providers access our secure portal to electronically verify Member eligibility and benefits or call the Member Services Department at **1-866-212-2851**.

Missed or Cancelled Appointments

Providers must:

- Document in the Member's medical record, and follow-up on missed or canceled appointments.
- Conduct outreach to a Member who misses an appointment.
- Notify our when an Member continually misses appointments. (Nicole)

Confidentiality and Accuracy of Member Records

Providers must have appropriate procedures to safeguard/secure the privacy and confidentiality of and ensure the accuracy of any information that identifies an Aetna Better Health Member. Providers must comply with all federal and State laws, court orders, or subpoenas.

Provider must follow both required and voluntary provision of medical records must be consistent with HIPAA privacy statute and regulations (http://www.hhs.gov/ocr/privacy/).

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit **http://www.hhs.gov/ocr/hipaa/**. In accordance with HIPAA guidelines, providers may not interview Members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and Member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA;
- Keep patient records, papers and computer monitors out of view; and
- Have electric shredder or locked shred bins available.

The following Member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

- "Individually identifiable health information" is information, including demographic data, that relates to:
  - The individual's past, present or future physical or mental health, or condition.
  - The provision of health care to the individual.
  - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
  - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
  - Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health.
  - Release of data to third parties requires advance written approval from the Department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by Members or releases required by court order, subpoena, or law.
  - Additional privacy requirements are located throughout this Handbook. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records.

For additional training or Q&A, please visit the following site at **http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm**

Member Privacy Rights

Aetna Better Health's privacy policy states that Members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide Member privacy rights and place restrictions on uses and disclosures of protected health information.

Our policy also assists Aetna Better Health personnel and providers in meeting the privacy requirements of HIPAA when Members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to Members or their representatives about Aetna Better Health's practices regarding their PHI
- Maintaining a process for Members to request access to, changes to, or restrictions on disclosure of their PHI
- Providing consistent review, disposition, and response to privacy requests within required time standards
- Documenting requests and actions taken

Member Privacy Requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice of Privacy Practices

A privacy request must be submitted by the Member or Member's authorized representative. An Member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the Member or the deceased Member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from Members or an Member's representative must be submitted to Aetna Better Health in writing.

Advance Directives

Providers are required to comply with federal and state law regarding advance directives for adult Members. The advance directive must be prominently displayed in the adult Member's medical record. Requirements include:

- Providing written information to adult Members regarding each individual's rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the Member's medical record whether or not the adult Member has been provided the information and whether an advance directive has been executed.
- Not discriminating against an Member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.

Illinois advance directives include Living Will, Health Care Power Of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated.

Provider Marketing

Direct marketing to potential Members will be performed by Illinois Client Enrollment Sercies and is prohibited by the provider.

Cultural Competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health expects providers to treat all Members with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on our Members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that Members encounter, and we develop and implement proven methods for responding to those challenges.

Providers receive education about such important topics as:
- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage Members from such backgrounds to seek needed treatment.
- The impact that an Member's religious and/or cultural beliefs can have on health outcomes (e.g., belief in non-traditional healing practices).
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular, etc.).
- History of the disability rights movement and the progression of civil rights for people with disabilities.
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care.

Our Provider Service Representatives will conduct initial cultural competency training during provider orientation meetings. On an annual basis, Providers are required to complete our online cultural competency course. The Quality Interactions® course series is designed to help you:
- Bridge cultures
- Build stronger patient relationships
- Provide more effective care to ethnic and minority patients
- Work with your patients to help obtain better health outcomes

To access the online cultural competency course, please visit: **http://www.aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html**

To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ Program. Aetna Better Health supports the Ask Me 3™ Program, as it is an effective tool designed to improve health communication between Members and providers.

For an Ask Me 3 poster to be displayed in your office, visit the following website: **http://www.npsf.org/askme3/pdfs/AskMe_poster_APost-E.pdf**.

Health Literacy - Limited English Proficiency (LEP) or Reading Skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and State requirements, Aetna Better Health is required to ensure that Limited English Proficient (LEP) Members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all Members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all Members, including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- The homeless
- Individuals with physical and mental disabilities

Providers are required to identify the language needs of Members and to provide oral translation, oral interpretation, and sign language services to Members. To assist providers with this, Aetna Better Health makes its telephonic language interpretation service available to providers to facilitate Member interactions. These services are free to the Member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible to associated costs.

Our language interpreter vendor provides interpreter services at no cost to providers and Members.

Language interpretation services are available for use in the following scenarios:

- If an Member requests interpretation services, Aetna Better Health Member Services Representatives will assist the Member via a three-way call to communicate in the Member's native language.
- For outgoing calls, Member Services Staff dial the language interpretation service and use an interactive voice response system to conference with an Member and the interpreter.
- For face-to-face meetings, Aetna Better Health staff (e.g., Case Managers) can conference in an interpreter to communicate with an Member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health to link with an interpreter.

Aetna Better Health provides alternative methods of communication for Members who are visually impaired, including large print and/or other formats. Contact our Member Services Department for alternative formats.

We strongly recommend the use of professional interpreters, rather than family or friends. Further, we provide Member materials in other formats to meet specific Member needs. Providers must also deliver information in a manner that is understood by the Member.

Aetna Better Health offers sign language and over-the-phone interpreter services, as well as CART reporting, at no cost to the provider or Member. Please contact Aetna Better Health at **1-866-212-2851** for more information on how to schedule these services in advance of an appointment.

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

Section 1557 has been in effect since its enactment in 2010 and the HHS Office for Civil Rights has been enforcing the provision since it was enacted.

For more information please click here: **https://www.aetnabetterhealth.com/non-discrimination**

Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. Regular site visits will be conducted by our Provider Services staff to ensure that network providers are compliant.

Clinical Guidelines

Aetna Better Health has Clinical Guidelines and treatment protocols available to provider to help identify criteria for appropriate and effective use of health care services and consistency in the care provided to Members and the general community. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the Member
- Constitute procedures for or the practice of medicine by the party distributing the guidelines; or,
- Guarantee coverage or payment for the type or level of care proposed or provided.

Clinical Guidelines are available on our website at **https://www.aetnabetterhealth.com/Illinois/providers/resources/clinical-practice**

Additions or Provider Terminations

In order to meet contractual obligations and State and Federal regulations, providers who are in good standing, are required to report any terminations or additions to their agreement at least 120 days prior to the change in order for Aetna Better Health to comply with CMS requirements. Providers are required to continue providing services to Members throughout the termination period.

CMS requires that Aetna Better Health make effort to provide written notice of a termination of a network provider at least thirty (30) days before the termination effective date to all Members who are patients seen on a regular basis by the provider whose contract is terminating. However, please note that all Members who are patients of that PCP must be notified when a provider

termination occurs.

Continuity of Care

Providers terminating their contracts without cause are required to follow termination requ in provider contract or agreementbefore terminating with Aetna Better Health. Provider must also continue to treat our Members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. Aetna Better Health is not responsible for payment of services rendered to Members who are not eligible. You may also contact our Case Management Department for assistance.

Credentialing/Re-Credentialing

Aetna Better Health uses current NCQA standards and guidelines for review, credentialing and re-credentialing of in network providers, and uses CAQH Universal Credentialing DataSource as Primary Source Verification for all provider types..

Timely Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to an Member must be received in a timely manner. Our timely filing limitations are as follows:

- **New Claim Submissions** - Claims must be filed on a valid claim form within 120 days from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the Member.
- **Claim Resubmission** - Claim resubmissions must be filed within 180 days or according to contractual guidelines for participating providers. The only exception to this is if a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Please submit any additional documentation that may effectuate a different outcome or decision.

Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial.

Please note you may not render services to Members until you are credentialed.

How to File a Claim

1) Select the appropriate claim form (refer to table below).

Service	Claim Form
Medical and professional services	**CMS 1500 Form**
Hospital inpatient, outpatient, skilled nursing and emergency room services	**CMS UB04 Form (APL Services)**
Dental services that are considered medical services (oral surgery, anesthesiology)	**CMS 1500 Form**

Instructions on how to fill out the claim forms can be found on our website.

2) Complete the claim form.
   a) Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
   b) The claim form may be returned unprocessed (unaccepted) if illegible or poor quality

copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

3) Submit original copies of claims electronically or through the mail to Arizona address (do NOT fax). Please include supporting documentation, such as Members' medical records, clearly label and send to Aetna Better Health at the correct address.
   a) Electronic Clearing House
   In Network providers have the option to submit claims electronically . Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
   - Emdeon is currently Aetna Better Health preferred EDI vendor
   - Contact your software vendor directly for further questions about your electronic billing.
   - Contact our Provider Services Department for more information about electronic billing.

   All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health policies and procedures.
   b) Through the Mail

Claims	Mail To	Electronic Submission
Medical	Aetna Better Health P. O. Box 66545 Phoenix, AZ 85082	Electronic Clearinghouse Emdeon Payer ID 26337
Refunds	Aetna Better Health Attention: Finance Department 333 West Wacker Drive, Suite 2100 Chicago, IL 60606	Not Applicable

Correct Coding Initiative

Aetna Better Health follows the same standards as Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit **http://www.cms.hhs.gov/NationalCorrectCodInitEd/**.

Aetna Better Health utilizes ClaimCheck as our comprehensive code auditing solution that will assist payors with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Provider Remittance Advice

Aetna Better Health processes check run on a weekly basis. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. Providers have the opportunity to request ERA/EFT setup by submitting the EFT/ERA enrollment form found on the ABH website to the Provider Services Department via mail or fax. For assistance interpreting remittance advice sent by the health plan, please contact CICR.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
  - Member Name
  - ID
  - Birth Date
  - Account Number,
  - Authorization ID, if Obtained
  - Provider Name,
  - Claim Status,
  - Claim Number
  - Refund Amount, if Applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Services Department for assistance with this process.

Checking Status of Claims

Providers may check the status of a claim by accessing our secure website or by calling the Claims Inquiry Claims Research (CICR) Department.

Online Status through Aetna Better Health's Secure Website

Aetna Better Health encourages providers to take advantage of using online status, as it is quick, convenient and can be used to determine status for multiple claims.

Calling the Claims Inquiry Claims Research Department

The Claims Inquiry Claims Research (CICR) Department is also available to:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing:
  - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
  - Excludes rebilling a claim (the entire claim must be resubmitted with corrections.
  - Please be prepared to give the service representative the following information:
    - Provider name or NPI number with applicable suffix if appropriate.
    - Member name and Member identification number.
    - Date of service.
    - Claim number from the remittance advice on which you have received payment or denial of the claim.

Claim Resubmission

Providers have twelve (12) months for non-participating providers from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute a reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Include the following information when filing a resubmission:

- Use the Resubmission Form located on our website.
- An updated copy of the claim. All lines must be rebilled. A copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as "Resubmission" at the top of the claim in black ink and mail to appropriate claims address.

Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to deny as a duplicate.

Instruction for Specific Claims Types:
Aetna Better Health General Claims Payment Information

Our claims are always paid in accordance with the terms outlined in your provider contract. Prior authorized services from Non-Participating Health Providers will be paid in accordance with Original Medicare claim processing rules.

TAG Itemized Billing

Please note that although clean claims will pay within 30 days for 90% of all claims, some claims may be flagged for pre-payment review. In such cases, additional documentation such as medical records and/or itemized bills supporting billed charges will be requested. The request may come directly from Aetna Better Health or may come from our third party forensic review vendor, The Assist Group (TAG). Claims payment in these cases will be within 30 days of receipt of requested documentation.

Skilled Nursing Facilities (SNF)

Providers submitting claims for SNFs should use CMS UB-04 Form.

Providers must bill in accordance with standard Medicare RUGS billing requirement rules for Aetna Better Health, following consolidated billing. For additional information regarding CMS Consolidated Billing, please refer to the following CMS website address: **http://www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp**.

Home Health Claims

Providers submitting claims for Home Health should use CMS 1500 Form.

Providers must bill in accordance with contract. Non-Participating Health Providers must bill according to CMS HHPPS requirement rules for Aetna. For additional information regarding CMS Home Health Prospective Payment System (HHPPS), please refer to the following CMS website address: **http://www.cms.gov/HomeHealthPPS/**.

Durable Medical Equipment (DME) Rental Claims

Providers submitting claims for DME Rental should use CMS 1500 Form.

DME rental claims are only paid up to the purchase price of the durable medical equipment.

There is a billing discrepancy rule difference between Days versus Units for DME rentals between Medicaid and the Demonstration Program. Units billed for the FAD equal 1 per month. Units billed for Medicaid equal the amount of days billed. Since appropriate billing for CMS is 1 Unit per month, in order to determine the amount of days needed to determine appropriate benefits payable under Medicaid, the claim requires the date span (from and to date) of the rental. Medicaid will calculate the amount of days needed for the claim based on the date span.

Same Day Readmission

Providers submitting claims for inpatient facilities should use CMS UB-04 Form.

There may be occasions where an Member may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission with 24 hours.

Example: Discharge Date: 10/2/10 at 11:00 a.m.
Readmission Date: 10/3/10 at 9:00 a.m.

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

HCPCS Codes

There may be differences in what codes can be billed for Medicare versus Medicaid. We follow Medicare billing requirement rules, which could result in separate billing for claims under Aetna. While most claims can be processed under both the Demonstration Program, and Medicaid, there may be instances where separate billing may be required.

CHAPTER 5: COVERED AND NON-COVERED SERVICES

Under the Integrated Care and Family Health Plan Programs, Aetna Better Health is responsible for administering services to covered Members.

Services must meet medical necessity criteria and some services require prior authorization. Medical necessity criteria are guidelines that provide a recommended guide to help practitioners make decisions about appropriate health care for specific clinical circumstances. Aetna Better Health uses only evidence-based clinical guidelines.

- **https://www.aetnabetterhealth.com/Illinois/providers/resources/clinical-practice**

Covered services must be provided in accordance with your contract with Aetna Better Health. From time to time, a covered service may be changed. If you have any questions please visit our website at **www.aetnabetterhealth.com/Illinois** or contact our call our Provider Services Department at **1-866-212-2851**. Aetna Better Health will give you at least 60 days advance notice of any changes to the Integrated Care Program, including new services, expanded services or eliminated services. You will be notified by one or more of the following methods: provider newsletter; e-mail, updates to the Aetna Better Health website; letter (U.S. Mail), telephone call; or office visit.

Aetna Better Health works with HFS and their vendors to coordinate services that are covered by entities other than Aetna Better Health. If you have an Aetna Better Health Member that needs one or more of these services and you are not sure how to reach an HFS vendor, please contact HFS at **1-800-447-4278** or our Member Services Department at **1-866-212-2851**.

You can view a current list of the services that require authorization on our website at **https://www.aetnabetterhealth.com/Illinois/providers/resources/priorauth**

Interpretation Services

Telephone interpretive services are provided at no cost to Members or providers. Personal interpreters can also be arranged in advance. Sign language and CART reporting services are also available. These services can be arranged in advance by calling Aetna Better Health Member Services at **1-866-212-2851**. Sign language and CART reporting services are available at no charge to Members and providers.

Community Resources

Aetna Better Health works closely with various community service providers that serve Integrated Care Program eligible Members and support our providers. We encourage communication between our providers and these organizations and assist with coordinating services. Please contact our Member Services Department at **1-866-212-2851** if you would like information on community resources.

The Illinois Client Enrollment Broker

The Illinois Client Enrollment Broker (ICEB) is responsible for the enrollment of potential Members, including provision of health care plan choice education and enrollment by auto-assignment.

CHAPTER 6: MEMBER RIGHTS AND RESPONSIBILITES

Aetna Better Health is committed to treating Members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers, and Members each year.

Treating an Member with respect and dignity is good business for the provider's office and often can improve health outcomes. Your contract with Aetna Better Health requires compliance with Member rights and responsibilities, especially treating Members with respect and dignity. Understanding Members' rights and responsibilities is important because you can help Members to better understand their role in and improve their compliance with treatment plans.

It is Aetna Better Health's policy not to discriminate against Members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of Member rights and responsibilities below. Please see that your staff is aware of these requirements and the importance of treating Members with respect and dignity.

In the event that Aetna Better Health is made aware of an issue with an Member not receiving the rights as identified above, Aetna Better Health will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.

In the event Aetna Better Health is made aware of an issue when the Member is not demonstrating the responsibilities as outlined above, Aetna Better Health will make good faith efforts to address the issue with the Member; educate the Member on their responsibilities.

Members have the following rights and responsibilities: **https://www.aetnabetterhealth.com/non-discrimination**

Member Rights Under Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to organizations that receive financial assistance from any federal department or agency, including hospitals, nursing homes, mental health centers, and human service programs.

Section 504 prohibits organizations from excluding or denying individuals with disabilities an equal opportunity to receive benefits and services. Qualified individuals with disabilities have the right to participate in, and have access to, program benefits and services.

Under this law, individuals with disabilities are defined as persons with a physical or mental impairment that substantially limits one or more major life activities. People who have a history of physical or mental impairment, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments that may substantially limit major life activities, even with the help of medication or aids/devices, are: AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

In addition to meeting the above definition, for purposes of receiving services, qualified individuals with disabilities are persons who meet normal and essential eligibility requirements.

Providers treating Members in the Integrated Care Program may not, on the basis of disability:

- Deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits
- Deny access to programs, services, benefits or opportunities to participate as a result of physical barriers

Tools to Identify and Track At-Risk Members

Aetna Better Health uses data-driven tools to provide early detection of Members who are at risk of going to the emergency room or hospital, have actionable gaps or errors in care, have high cost utilization of services and/or might benefit from case management. These tools have two main components. The first is our predictive modeling tool. The second, more comprehensive component is known as the CORE model, or Consolidated Outreach and Risk Evaluation. We add information from these tools to the data collected from Health Risk Questionnaires (HRQs). We also track information in a customized care management tracking application.

The tools, described below, help us to work closely with providers, Members and their families or caregivers to improve clinical outcomes and enhance the quality of Members' lives.

Predictive Modeling

Aetna Better Health's predictive modeling software identifies and stratifies Members who are eligible for our care management programs. It sorts, analyzes, and interprets historical claims, pharmacy, clinical and demographic data to identify gaps in care and to make predictions about future health risks for each Member. The application funnels information from these various sources into a Member profile that allows our Case Managers to access a 12-month summary of activity. This data then links to our customized care management tracking application.

Once analyzed, our predictive modeling software ranks Members and provides a monthly report that identifies the Members most likely to require care management services. In addition to the scoring methodology, predictive modeling also looks at certain "triggers" to alert Case Managers to potential risk factors, including but not limited to:

- Members with new hospital authorizations (currently inpatient) or authorizations for certain scheduled services (i.e. home health or selected surgical procedures)
- New chronic or life threatening diagnosis
- Call tracking from Aetna Better Health's Member Services Department

CORE Model

The CORE (Consolidated Outreach and Risk Evaluation) accesses predictive modeling information and provides a more detailed analysis, including each Member's risk of using inpatient and/or emergency department services in the near future. By using the CORE, Aetna Better Health can further drill down to identify specific health factors and at-risk Members who may benefit from intervention by our care management team.

Health Risk Questionnaires (HRQs)

Aetna Better Health also assesses Members through HRQs. Aetna Better Health staff go over the HRQ with the Member or caregiver during a telephone call or face to face visit made to each Member to welcome them to the health plan. The HRQ gathers:

- Member contact information
- PCP or medical home information
- Member's health history
- Frequency of ER use
- Medication usage

CM Business Application Systems

Our care management business application system stores and retrieves Member data, claims data, pharmacy data, and history of Member interventions and collaboration. It houses the HRQ, comprehensive assessment, condition-specific questionnaires, care plan and service plan for each member. It also allows care management staff to set tasks and reminders to complete actions specific to each Member. The care management business application provides a forum for clear and concise documentation of communication with providers, Members, and caregivers. The system also provides a care consideration function, in which the Case Manager can view and respond to correspondence with the providers on recommended standards of practice and HEDIS interventions for certain conditions and medications. The system interfaces with our authorization business application system, predictive modeling software, the inpatient census tool and allows documents to be linked into the case. It also provides multiple queries and reports that measure things from staff productivity and interventions to coordination,collaboration and outcomes in care management.

Medical Necessity

Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

Any such services must be clinically appropriate, individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-Demonstration approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary".

Determination of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the Member, the Member's family/caregiver and the PCP, as well as any other providers, programs, agencies that have evaluated the Member. Medical necessity determinations must be made by qualified and trained health care providers.

CHAPTER 8: CONCURRENT REVIEW

Concurrent Review Overview

Aetna Better Health conducts concurrent utilization review on each Member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the Member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Milliman Care Guidelines®. Admission certification is conducted within one business day of receiving notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. Our nurses conduct these reviews. The nurses work with the medical directors in reviewing medical record documentation for hospitalized Members. Our medical directors make rounds on site as necessary.

Milliman Care/Locus Guidelines

Aetna Better Health uses the Milliman Care/Locus Guidelines® to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of Member care and describe best practices for treating common conditions. The Milliman Care Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the Member and for involving the Member and family in implementing the plan.

Our Concurrent Review Nurse (CRN) works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for Members with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of network providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

Discharge from a Skilled Nursing Facility

All discharges from a SNF must be coordinated with the Member's Case Manager. In accordance with Section 83 of Title 42 of the code of Federal Regulations, resident rights, any discharge or transfer of an Member must be based on a medical reason, for his or her welfare, for the welfare of other patients, or for nonpayment (except as prohibited by Medicare (Title XVIII) or Medicaid (XIX) of the Social Security Act). Regardless of reason, the Member, his or her representative, and the Member's Case Manger must be involved in discharge planning.

CHAPTER 9: PRIOR AUTHORIZATION

Primary care providers (PCP) or treating practitioner/providers are responsible for initiating and coordinating an Members request for authorization. However, specialists and other practitioners/providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization.

The requesting practitioner or provider is responsible for complying with Aetna Better Health's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health will not prohibit or otherwise restrict practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and Member of Aetna Better Health about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

A prior authorization request must include the following:

- Current, applicable codes may include:
  - Current Procedural Terminology (CPT),
  - International Classification of Diseases, 9th Edition (ICD-10),
  - Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the Member
- Primary care provider or treating practitioner
- Name, address, phone and fax number and signature, if applicable, of the referring practitioner or provider
- Name, address, phone and fax number of the consulting practitioner or provider
- Problem/diagnosis, including the ICD-10 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

Timeliness of Decisions and Notifications to Practitioners, Providers, and/or Members

Aetna Better Health makes prior authorization decisions and notifies practitioners and/or providers and applicable Members in a timely manner. Unless otherwise required by HFS or CMS, Aetna Better Health adheres to the following decision/notification time standards.

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Seventy-two (72) hours from receipt of request	Practitioner/Provider	Oral or Electronic/ Written

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service denial	Seventy-two (72) hours from receipt of request	Practitioner/Provider Member	Oral and Electronic/ Written
Non-urgent pre-service approval	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider	Oral or Electronic/Written
Non-urgent pre-service denial	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider Member	Electronic/Written
Urgent concurrent approval	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent concurrent denial	Twenty-four (24) hours of receipt of request	Practitioner/Provider	Oral and Electronic/ Written
Post-service approval	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider	Oral or Electronic/ Written
Post-service denial	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider Member	Electronic/Written
Termination, Suspension Reduction of Prior Authorization	At least ten (10) Calendar Days before the date of the action.	Practitioner/Provider Member	Electronic/Written

If Aetna Better Health approves a request for expedited determination, a notification will be sent to the Member and the physician involved, as appropriate, of its determination as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receiving the request.

If Aetna Better Health denies a request for an expedited determination, the request will automatically be transferred to the standard time frame. Aetna Better Health will promptly provide the Member oral notice of the denial of an expedited review and of their rights. Aetna Better Health will subsequently deliver to the Member seventy-two (72) hours, a written letter of the Members' rights.

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Aetna Better Health will assign a prior authorization number, which refers to and documents the approval. Aetna Better Health sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, an Member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes such decisions on a case-by-case basis in consultation with Aetna Better Health's medical director.

Prior Authorizations List

Primary care providers (PCP) or treating practitioner/providers must request authorization for certain medically necessary services. Prior authorization is required for, but not limited to:

- Laboratory Services: Prior authorization is NOT required for approved in office lab procedures that are Clinical Laboratory Improvement Amendments (CLIA) certified. Radiology Services: Prior authorization IS required for certain radiology services. The prior authorization summary on our website contains additional information on services that require prior authorization.
- Infusion or Enteral Therapy Services: Prior authorization is required for any medically necessary services rendered by an infusion or enteral provider.
- Durable Medical Equipment (DME): DME equipment and related services may require prior authorization.

For a completed and current list of services which require prior authorization can be found online at **www.aetnabetterhealth.com/Illinois**

Unauthorized services will not be reimbursed and authorization is not a guarantee of payment. All out of network services must be authorized.

Prior Authorization and Coordination of Benefits

If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 Secure Provider Web Portal located on the Aetna Better Health's website, or
- Fax the request form to **1-855-320-8445** (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing, or

Call us directly at **1-866-212-2851**

Pharmacy Prior Authorization

CVS Caremark will process coverage determinations and exception requests in accordance with Medicare Part D regulations and/or Medicaid regulations. Requests will be handled through the prior authorization review process. The prior authorization staff will adhere to approved criteria. The Pharmacy Benefit Manager establishes clinical guidelines, and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines.

Providers can submit prior authorization requests by phone or fax. Providers will be required to submit pertinent medical/drug history, prior treatment history, and any other necessary supporting clinical information with the request.

Coverage determination requests will be determined seventy-two (72) hours after receipt of complete information from the provider for Standard determinations. Expedited reviews will be determined within twenty-four (24) hours after receipt of complete information from the provider. Conditions meeting expedited review include an imminent or serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Determination notices will be faxed to the provider's office once the decision is made.

To submit a coverage determination or exception request, complete the Coverage Determination form and fax to **1-855-364-8109** or call **1-866-212-2851**.

CHAPTER 10: QUALITY MANAGEMENT

Overview

Our Quality Management (QM) Program is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care. Aetna Better Health uses this approach to measure conformance with desired medical standards and develop activities designed to improve patient outcomes.

Aetna Better Health performs QM through a Quality Assessment and Performance Improvement (QAPI) Program with the involvement of multiple organizational components and committees. The primary goal of the QM Program is to improve the health status of Members or maintain current health status when the Member's condition is not amenable to improvement.

Aetna Better Health's QM Program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively review our clinical and operational programs and processes to identify opportunities for continued improvement. Our continuous QM process enables us to:

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

The use of data in the monitoring, measurement and evaluation of quality and appropriateness of care and services is an integral component of Aetna Better Health's quality improvement process.

Aetna Better Health's QM Program uses an integrated and collaborative approach, involving our senior management team, functional areas within the organization and committees from the Board of Directors to the Member Advisory subcommittee. This structure allows Members and providers to offer input into our quality improvement activities. Our Medical Director oversees the QM program. The Medical Director is supported in this effort by our QM Department and the Quality Management and Utilization Management (QM/UM) Committee.

Major functions of the QM/UM Committee include:

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

Additional committees such as Service Improvement (SIC), Credentialing, Appeals/Grievance, and Quality Management Oversight Committees (QMOC) further support our QM Program. Aetna Better Health encourages provider participation on key medical committees. Providers may contact the Medical Director or inform their Provider Services Representative if they wish to participate. You can reach Aetna Better Health by calling **1-866-212-2851**.

Aetna Better Health's QM staff develops and implements an annual work plan, which specifies projected QM activities. Based on the work plan, we conduct an annual QM Program evaluation, which assesses the impact and effectiveness of QM activities.

Aetna Better Health's QM Department is an integral part of Medical Management and internal operations. The focus of our QM staff is to review and trend services and procedures for compliance with nationally recognized standards, and recommend and promote improvements in the delivery of care and service to our Members. Our QM and MM departments maintain ongoing coordination and collaboration regarding quality initiatives, case management, and disease management activities involving the care of our Members.

Aetna Better Health's QM activities include, but are not limited to, medical record reviews, site reviews, peer reviews, satisfaction surveys, performance improvement projects, and provider profiling. Utilizing these tools, Aetna Better Health, in collaboration with providers, is able to monitor and reassess the quality of services provided to our Members. Providers are obligated to support and meet Aetna Better Health is QM/UM program standards.

Note: Providers must also participate in the CMS and DHHS quality improvement initiatives. Any information provided must be reliable and complete.

Identifying Opportunities for Improvement

Aetna Better Health identifies and evaluates opportunities for quality improvement and determines the appropriate intervention strategies through the systematic collection, analysis, and review of a broad range of external and internal data sources. The types of data Aetna Better Health monitors to identify opportunities for quality improvements include:

- Formal Feedback from External Stakeholder Groups: Aetna Better Health takes the lead on reaching out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (CAHPS), or focus groups with individuals, such as Members and families, providers, and state and community agencies.
- Findings from External Program Monitoring and Formal Reviews: Externally initiated review activities, such as an annual external quality program assessments or issues identified through a state's ongoing contract monitoring oversight process assists Aetna Better Health in identifying specific program activities/processes needing improvement.
- Internal Review of Individual Member or Provider Issues: In addition to receiving grievances and appeals from Members, providers, and other external sources, Aetna Better Health proactively identifies potential quality of service issues for review through daily operations (i.e. member services, prior authorization, and care management). Through established formalized review processes (i.e., grievances, appeals, assessment of the timeliness of our care management processes, access to provider care and covered services, and quality of care), Aetna Better Health is able to identify specific opportunities for improving care delivered to individual Members.
- Findings from Internal Program Assessments: Aetna Better Health conducts a number of formal assessments/reviews of program operations and providers that are used to identify opportunities for improvement. This includes, but is not limited to: provider record reviews of contracted providers, credentialing/re-credentialing of providers, oversight reviews of delegated activities, inter-rater reliability audits of medical review staff, annual quality management program evaluation, cultural competency assessment, and assessment of provider accessibility and availability.

- Clinical and Non-Clinical Performance Measure Results: Aetna Better Health uses an array of clinical and non-clinical performance standards (e.g., call center response times, and claim payment lag times) to monitor and evaluate operational performance. Through frequent monitoring and trending of our performance measure results, Aetna Better Health is able to identify opportunities for improvement in clinical and operational functions. These measures include:
  - Adherence to nationally recognized best practice guidelines and protocols
  - Service authorization (e.g., timeliness of decisions, notices of action, service/care plan appeals)
  - Provider availability and accessibility, including:
    - Length of time to respond to requests for referrals
    - Timeliness of receipt of covered services
    - Timeliness of the implementation of Members' care plans -Availability of 24/7 telephonic assistance to Members and caregivers receiving home care services
- Data Trending and Pattern Analysis: With our innovative information management systems and data mining tools, Aetna Better Health makes extensive use of data trending and pattern analysis for the identification of opportunities for improvement in many levels of care.
- Other Service Performance Monitoring Strategies: Aetna Better Health uses a myriad of monitoring processes to ensure effective delivery of services to all of our Members, such as provider and Member profiles, service utilization reports, and internal performance measures. Aspects of care that Aetna Better Health monitors include, but are not limited to:
  - High-cost, high-volume, and problem prone aspects of the long-term care services our Members receive
  - Effectiveness of the assessment and service planning process, including its effectiveness in assessing an Member's informal supports and treatment goals, planned interventions, and the adequacy and appropriateness of service utilization
  - Delivery of services enhancing Member safety and health outcomes and prevention of adverse consequences, such as fall prevention programs, skin integrity evaluations, and systematic monitoring of the quality and appropriateness of home services

Potential Quality of Care (PQoC) Concerns

Aetna Better Health has a process for identifying PQoC concerns related to Home and Community-Based Services (HCBS), researching and resolving these care concerns in an expeditious manner, and following up to make sure needed interventions are implemented. This may include referring the issue to peer review and other appropriate external entities. In addition, Aetna Better Health tracks and trends PQoC cases and prepares trend reports that we organize according to provider, issue category, referral source, number of verified issues, and closure levels. Aetna Better Health will use these trend reports to provide background information on providers for whom there have been previous complaints. These reports also identify significant trends that warrant review by the Aetna Credentialing and Performance Committee, or identify the need for possible quality improvement initiatives.

Performance Improvement Projects (PIPS)

Performance improvement projects (PIPs), a key component of our QM Program, are designed to achieve and sustain a demonstrable improvement in the quality or appropriateness of services over time. Our PIPs follow CMS protocols. Aetna Better Health participates in state-mandated PIPs and selects PIP topics that:

- Target improvement in areas that will address a broad spectrum of key aspects of Members' care and services over time
- Address clinical or non-clinical topics
- Identify quality improvement opportunities through one of the identification processes described above
- Reflect Aetna Better Health enrollment in terms of demographic characteristics, prevalence of disease and potential consequences (risks) of the disease

Our QM department prepares PIP proposals that are reviewed and approved by our Medical Director, QM/UM Committee, and the Quality Management Oversight Committee (QMOC) prior to submission to the HFS for review and approval. The committee review process provides us with the opportunity to solicit advice and recommendations from other functional units within Aetna Better Health, as well as from network providers who are Members of our QM/UM Committee.

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

Peer Review

Peer review activities are evaluated by the Credentialing and Performance Committee. Providers who have been reviewed and disagree with the results are given an opportunity to appeal the committee's recommendation. Written appeals stating the reasons why the provider does not agree may be submitted. At any time, the provider may request all profiling data that was used during the provider's performance evaluation.

Performance Measures

Aetna Better Health collects and reports clinical and administrative performance measure data to HFS. The data enable Aetna Better Health and HFS to evaluate our adherence to practice guidelines, as applicable, and/or improvement in Member outcomes.

Satisfaction Survey

Aetna Better Health conducts Member and provider satisfaction surveys to gain feedback regarding Members and providers' experiences with quality of care, access to care, and service/operations. Aetna Better Health uses Member and provider satisfaction survey results to help identify and implement opportunities for improvement. . Each survey is described below.

Member Satisfaction Surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS) are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (Adult and Children) are subsets of HEDIS reporting. Aetna Better Health contracts with an NCQA-certified vendor to administer the survey according to HEDIS survey protocols. The survey is based on randomly selected Members and summarizes satisfaction with the health care experience.

Provider Satisfaction Surveys

Aetna Better Health conducts an annual provider survey to assess satisfaction with our operational processes. Topics include claims processing, provider training and education, and Aetna Better Health's response to inquiries.

External Quality Review (EQR)

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c), (2) [42 U.S.C. 1396u-2] for states to contract with an independent external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including the evaluation of quality outcomes, timeliness, and access to services. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders.

Aetna Better Health cooperates fully with external clinical record reviews assessing our network's quality of services, access to services, and timeliness of services, as well as any other studies determined necessary by the HFS. Aetna Better Health assists in the identification and collection of any data or records to be reviewed by the independent evaluation team Members. Aetna Better Health also provides complete records to the External Quality Review Organization (EQRO) in the time frame allowed by the EQRO. Aetna Better Health's contracted providers are required to provide any records that the EQRO may need for its review.

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

Provider Profiles

In an effort to promote and ensure the provision of quality care, Aetna Better Health profiles providers who meet the minimum threshold of Members in their practices, as well as the minimum threshold of Members for specific profiling measures. Individual providers and practices are profiled for multiple measures and results are compared with colleagues in their specialty. In addition, we profile providers to assess adherence to evidence-based guidelines for their patients enrolled in disease management.

The Provider Profiling Program is designed to share standardized utilization data with physicians in an effort to improve clinical outcomes. Aetna Better Health's profiling program is intended to support clinical decision-making and patient engagement as physicians often have little access to information about how they are managing their Members or about how practice patterns compare to those of their peers. Additional goals of the Provider Profiling Program are to improve the provider- patient relationship to reduce unwanted variation in care and improve efficacy of patient care.

Aetna Better Health includes several measures in the provider profile, which include but are not limited to:

- Frequency of individual patient visits to the PCP
- EPSDT services for the pediatric population
- HEDIS-type screening tests and evidence-based therapies (i.e. appropriate asthma management linked with correct use of inhaled steroids)
- Use of medications;
- ER utilization and inpatient service utilization
- Referrals to specialists and out-of-network providers

Each quarter, Aetna Better Health distributes profile reports to providers so they can evaluate:

- Potential gaps in care and opportunities for improvement
- Information indicating performance for individual cases or specific disease conditions for their patient population
- A snapshot of their overall practice performance relative to evidence-based quality metrics

Aetna Better Health's CMO and medical directors regularly visit individual network providers to interpret profile results, review quality data, and discuss any new medical guidelines. Our CMO and medical directors investigate potential utilization or quality of care issues that may be identified through profiles. Aetna Better Health's medical leadership is committed to collaborating with providers to find ways to improve patient care.

Clinical Practice Guidelines

Aetna Better Health uses evidence-based clinical practice guidelines. The guidelines consider the needs of Members, opportunities for improvement identified through our QM Program, and feedback from participating providers. Guidelines are updated as appropriate.

CHAPTER 11: ENCOUNTERS

Aetna Better Health processes claims for covered services provided to Members in accordance with applicable policies and procedures and in compliance with applicable state and federal laws, rules and regulations. Aetna Better Health will not pay claims submitted by a provider who is excluded from participation in Integrated Care or Family Health Plan, or any program under federal law, or is not in good standing with the HFS.

Encounters
Aetna Better Health is required to process claims in accordance with State and Federal payment rules and regulations.

Providers must use valid International Classification of Disease, 9th Edition, Clinical Modification (ICD-10CM) codes, and code to the highest level of specificity. Complete and accurate use of CMS' Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk-Adjustment Processing System. Important notes:

- The ICD-10 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Report any and all secondary diagnoses that impact clinical evaluation, management, and/or treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should indicate all diagnoses that were addressed were reported.

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

CMS Risk Adjustment Data Validation

Risk Adjustment Data Validation (RADV) is an audit process to ensure the integrity and accuracy of risk-adjusted payment. CMS may require us to request medical records to support randomly selected claims to verify the accuracy of diagnosis codes submitted. Demonstration Programs like Aetna Better Health's, are annually selected for data validation audits by CMS.

It is important for providers and their office staff to be aware of risk adjustment data validation activities because we may request medical record documentation. Accurate risk-adjusted payment depends on the accurate diagnostic coding derived from the Member's medical record.

The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no later than January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to fairly and accurately adjust payments made to Aetna Better Health by CMS based on the health status and demographic characteristics of an Member. CMS requires us to submit diagnosis data regarding physician, inpatient, and outpatient hospital encounters on a quarterly basis, at minimum.

CMS uses the Hierarchical Condition Category payment model referred to as CMS-HCC model. This model uses the ICD-10CM as the official diagnosis code set in determining the risk-adjustment factors for each Member. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-10CM codes by disease groups known as HCCs.

Providers are required to submit accurate, complete, and truthful risk adjustment data to us. Failure to submit complete and accurate risk adjustment data to CMS may affect payments made to Aetna and payments made by Aetna to the provider organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for an Member can increase their medical costs. The CMS hierarchical condition categories HCC model for coexisting conditions that should be coded for hospital and physician services are as follows:

- Code all documented conditions that coexist at time of encounter/visit and that require or affect Member care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Providers and hospital outpatient departments should not code diagnoses documented as "probable"", suspected", "questionable," "rule out" or "working" diagnosis. Rather, providers and hospital outpatient departments should code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted by Aetna Better Health. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient, and physician diagnoses submitted by the provider to us. In addition, regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules, and regulations. CMS may adjust payments to us based on the outcome of the medical record review.

For more information related to risk adjustment, visit the Centers for Medicare and Medicaid Services website at **http://csscoperations.com**/.

Correct Coding Initiative

Aetna Better Health follows the same standards as Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit **http://www.cms.hhs.gov/NationalCorrectCodInitEd/**.

Aetna Better Health utilizes ClaimCheck as our comprehensive code auditing solution that will assist payors with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimCheck. It enables us to share with our providers the claim auditing rules and clinical rationale inherent in ClaimCheck.

Providers will have access to Clear Claim Connection through our website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of incorrect coding include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

- **Modifier 59** - Distinct Procedural Services - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).
- **Modifier 25** - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.
- **Modifier 50** - Bilateral Procedure - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. We follow the same billing process as CMS and HFS when billing for bilateral procedures. Services should be billed on one line reporting one unit with a 50 modifier.

- **Modifier 57** - Decision for Surgery - must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners indicate:
  - "Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier "-57" to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period."

Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

CHAPTER 12: GRIEVANCE & APPEALS FOR ICP AND FHP

A Grievances is defined as any expression of disfatisfaction including complaints directed to the HP Grievance means an expression of dissatisfaction by a Member, including Complaints and requests for disenrollment, about any matter other than a matter that is properly the subject of a member appeal or provider dispute.

A grievance may be filed with Aetna Better Health orally or in writing by the Member or the Member's authorized representative, including providers. In most cases, a decision on the outcome of the grievance is reached within thirty (30) calendar days of the date of receipt of the grievance not to exceed 90 days. We may ask to extend the grievance decision date.

Members will receive a notice acknowledging the grievance within 3 business days of the receipt of the grievance. Members are advised in writing of the outcome of the investigation of the grievance resolution. The Notice of Resolution includes the decision reached and the reasons for the decision and the telephone number and address where the Member can speak with someone regarding the decision. The notice also tells the Member how to obtain information on filing a request for an External Review or requests for a State Fair Hearing. Appeals of the grievance determination, State Fair Hearings, and external independent reviews must be requested according to the following timeframes: standard or expedited appeals must be requested within 60 days of the date of the denial/Notice of Action letter. External independent review for non-waiver services only must be requested within 30 days of the appeal decision letter date and can be requested at the same time as or instead of a State Fair Hearing. State Fair Hearings must be requested within 120 days of the Appeal Decision letter date and may be requested at the same time as or instead of the External Independent Review. The appeal decision letter will give the enrollee information regarding how to request a State Fair Hearing and will include the External Independent Review form.

Enrollees may designate a representative to act on their behalf at any time during the grievance process. Representatives can be anyone the enrollee chooses (e.g., family, friend, guardian, primary care physician, other provider, or attorney).

Expedited Grievance Resolution

Aetna Better Health resolves grievances effectively and efficiently as the Member's health requires. On occasion, certain issues may require a quick decision. These issues, are known as expedited grievances.

In most cases, a decision on the outcome of an expedited grievance is reached within forty-eight (48) hours of the date the grievance was received. Members are advised orally of the resolution within the forty-eight (48) hours followed by a written notification of resolution within two (2) calendar days of the decision. The Notice of Resolution includes the decision reached, the reasons for the decision, the telephone number and the address where the Member can speak with someone regarding the decision.

Appeals

A Member may file an appeal, a formal request to reconsider a decision that is the result of a Notice of Action (ex.., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with Aetna Better Health. Authorized Member representatives, including providers, may also file an appeal on the Member's behalf with the written consent of the Member. Appeals must be filed no later than sixty (60) days from denial and or Notice of Action. The expiration date to file an appeal is included in the Notice of Action.

The Notice of Action informs the Member of the following:
- Our decision and the reasons for our decision
- The requirement and timeframes for filing an appeal
- The availability of assistance in the filing process
- The toll-free numbers that the Member can use to file an appeal by phone
- The procedures for exercising the rights to appeal and upon completion to request an External Review and a State Fair Hearing
- That the Member may represent himself or designate a legal counsel, a relative, a friend, a provider or other spokesperson to represent them
- The specific regulations that support, or the change in Federal or State law that requires the action
- The fact that, when requested by the Member:
  - Benefits will continue if the Member files an appeal or a request for a State Fair Hearing within the timeframes specified for filing
  - 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

Member appeals may be filed either verbally by contacting the Member Services Department or by submitting a request in writing. If the Member is requesting an expedited appeal resolution, a verbal appeal request must be followed by a written request.

Examples of decisions members may appeal:
- The denial or limited approval of a requested service (pre-service), including the type or level of service
- The reduction, suspension, or termination of a previously approved service
- The failure to provide services in a timely manner
- The denial of an Member's request to obtain services outside of the contracting area when Aetna Better Health is the only health plan servicing a rural area

Members may file an appeal by:
- Calling Member Services at **1-866-212-2851** TTY/TTD **1-877-734-7429** or the IL Relay **7-1-1**
- Writing Aetna Better Health at:
  Aetna Better Health
  Attn: Appeals and Grievance
  333 West Wacker Drive, Suite 2100
  Mail Stop F646
  Chicago, IL 60606

If the Member requests services to continue while the appeal is reviewed, the appeal must be filed no later than ten **(10) calendar** days from the date of Aetna Better Health's Notice of Action letter, or the effective date of our proposed termination, suspension or reduction of previously authorized Medicaid-covered services. We will also provide Members with access to necessary medical records and information to file their appeals.

A brief overview of the member appeal process follows:

- Verbal appeals must be put into writing and signed
- Aetna Better Health notifies Members of receipt of the appeal within three (3) business days via an acknowledgment letter
- Members are advised of their or their authorized representative's rights to provide more information and documention for their appeal, either in person or in writing
- Members are advised of their or their authorized representative's right to view their appeal file.
- Members or their authorized representative's may be present either onsite or via telephone when the Appeal Committee reviews their appeal
- Member Appeals will be resolved within fifteen (15) business days or fifteen (15) business days plus fourteen (14) calendar days if an extension is granted and we provide a reason for the extension, or the Member or their authorized representative requests the extension after Aetna Better Health receives the appeal.
- Aetna Better Health makes reasonable efforts to provide verbal notice and will mail the decision letter, including an explanation for the decision, If the member does not agree with Aetna Better Health's decision the Member can ask for an External Review and or a State Fair Hearing and request to receive benefits while the hearing is pending. Members can also request that the appeal be reviewed by DHS.
- If Aetna Better Health reverses our original decision and grants the appeal, services will begin immediately.

Expedited Resolution

Aetna Better Health resolves appeals effectively and efficiently as the Member's health requires. On occasion, certain issues may require an expedited decision. These issues, known as expedited appeals, occur in situations where an Member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the Member's condition cannot be adequately managed without urgent care or services. If the Member's ability to attain, maintain, or regain maximum function is not at risk the request to process the appeal in an expedited time frame may be denied and the appeal processed within the standard fifteen **(15) business day time frame**. A Member or their authorized representative, including providers, may request an expedited appeal either verbally or in writing within sixty (60) calendar days from the day of the decision or Notice of Action.. If Aetna Better Health is unable to resolve an expedited appeal within twenty-four (24) hours of receipt of all information, we may extend the twenty-four (24) hour time period by up to fourteen (14) calendar days. In these cases, we will provide information describing the reason for the delay in writing to the Member and, upon request, to DHS.

Upon receipt of an expedited appeal, we begin the appeal process immediately. Initial review of the issue begins in order to determine if the issue meets the definition of an expedited appeal. If the issue fails to meet the definition of an expedited appeal, the issue is transferred to the standard appeal process. We make reasonable efforts to give the Member prompt verbal notice of the denial and follow up within two (2) calendar days with a written notice.

In cases where the health plan determines a Member's request meets expedited urgency or a provider supports the Member's request Aetna Better Health will request all necessary information within twenty-four (24) hours of receipt and the Aetna Better Health's medical director renders a decision as expeditiously as the Member's health requires, but no later than twenty-four (24) hours from the receipt of the expedited appeal request.

If Members request services to continue while their appeal is reviewed they must request the appeal within ten (10) calendar days from the date of the Notice of Action letter or the intended effective date of the action. If Aetna Better Health reverses our original decision and approves the appeal, services will begin immediately.

Failure to Make a Timely Decision
Member Appeals must be resolved within stated timeframes and parties must be informed of Aetna Better Health's decision. If a determination is not made by the above timeframes, the Member's request will be deemed to have been approved as of the date upon which a final determination should have been made. This does not apply to post-service provider appeals and/or payment disputes.

External Review
An Member may file a request for External Review, a request to have an outside reviewer reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with Aetna Better Health. Authorized Member representatives, including providers, may also file a request for an external review. Requests for an external review must be made in writing within thirty (30) days of the date of the final adverse determination (Appeal Decision Letter). The timeline of thirty (30) days is stated in the Appeal Decision Letter. A Member or their authorized representative can only ask one time for an external review about a specific action.

A Member or their authorized representative can request an external review by completing the external review form or by sending in a letter. The letter the Member sends in **must be specific and address the request for an external review**. The form or the letter must be sent to:

Aetna Better Health
Attn: Grievance and Appeals Dept.
333 West Wacker Drive, Suite 2100, Mail Stop F646
Chicago, IL 60606

Aetna Better Health has five (5) business days to review the request to determine if the request meets the qualifications for external review. Aetna Better Health will send the Member and their representative, (if designated) a letter letting them know if their request meets these requirements. If the request meets the requirements, the letter will inform the Member of the name of the external review organization and provide further details related the request.

The external reviewer has five (5) calendar days from the date completeinformation is received to make a decision and send the Member and/or the Members representative and Aetna Better Health a letter with their decision. If the Member disagrees with the external reviewer's decision, the Member can ask for a State Fair Hearing with HFS if they have not already done so. If a Member requests both an External review and a State Fair Hearing, the decision most favorable to the Member is the one that applies

Expedited External Review

A Member may file a request for an Expedited External Review, a request to have an outside reviewer reconsider a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue), with Aetna Better Health. Authorized Member representatives, including providers, may also file a request for an expedited external review. On Certain issues may require an expedited decision. These issues, known as expedited external reviews, occur in situations where an Member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the Member's condition cannot be adequately managed without urgent care or services. Members can only ask one time for an expedited external review about a specific action.

The Member or their authorized representative can ask for an expedited external review by phone or in writing by completing the external review form.. To ask Member's or their authorized representative can request an expedited review over the phone by callingl Member Services toll-free at **1-866-212-2851**.

If the Member elects to request in writing, the letter **must be specific and address the request for an expedited external review**. The form or the letter must be sent to:

Aetna Better Health
Attn: Grievance and Appeals Dept.
333 West Wacker Drive, Suite 2100, Mail Stop F646
Chicago, IL 60606

Aetna Better Health will immediately review the request to see if it meets the criteria for expedited external review. If the request meets the requirements, the letter will inform the Member of the name of the external review organization and provide further details related the request.

If Aetna Better Health determines that the Members request does not meet the requirements for an expedited external review, the Member can appeal that decision to the Director of the Department of Insurance (DOI). The Member can call the Department of Insurance to make this request.

As quickly as the Member's health condition requires, but no more than two (2) business days after it receives complete information the external review organization will make a decision about the Member's request. They will let the Member and/or the Member's representative and Aetna Better Health know what their decision is verbally. They will also follow up with a letter to the Member and/or the Member's representative and Aetna Better Health with the decision within forty-eight (48) hours. If the Member disagrees with the reviewer's decision, the Member can ask for a State Fair Hearing with HFS if they have not already done so. If a Member requests both an External review and a State Fair Hearing, the decision most favorable to the Member is the one that counts.

DHS State Fair Hearing

The Member and/or the Member's representative acting on behalf of the Member may request a State Fair Hearing through the HFS Bureau of Hearings, if it is within thirty (30) calendar days from Aetna Better Health's appeal decision letter.

If Members wish services to continue while their State Fair Hearing is reviewed, they must request a State Fair Hearing within ten (10) calendar days from the date of the appeal decision letter. At the State Fair Hearing, Members may represent themselves or be represented by a lawyer, their provider or other authorized representative, with the Member's written permission. To request a State Fair Hearing, Members must:

- Submit a request for a State Fair Hearing to the HFS Human Services Bureau of Assistance Hearing, or
- Call **1-800-435-0774** (Voice) or **1-877-734-7429** (TTY) toll free.

To submit a request in writing, Members should write to:

HFS Bureau of Hearings
401 S Clinton, 6th Floor
Chicago, IL 60607

HFS Bureau of Assistance Hearings renders the final decision about services. If the decision agreed with Aetna Better Health's previous decision, and the Member **continued to receive services**, the Member may be responsible for cost of services received during the review. If the hearing decision favors the Member, then Aetna Better Health will commence the services immediately.

Provider Disputes

A **Dispute** is defined as an expression of a providers dissatisfaction with the ajudacation of a claim (ex. Rate, REV/CPT alignment modifiers, payment discrepancies etc.) or the determination of medical necessity (denied post-service authorization or retrospective review).

In the case of a claim dispute, the provider must complete and submit the Provider Dispute Form and any appropriate supporting documentation to Aetna Better Health's Provider Services Department at 333 W. Wacker, Mail Code 2100 Attn: Provider Disputes, Chicago, IL 60606.

The Provider Dispute Form is accessible on Aetna Better Health's website or by mail.

Providers have 60 days from date of notice of adverse action or as outlined in your Provider contract, whatever is less.

CHAPTER 13: FRAUD, WASTE, AND ABUSE

Fraud and Abuse

Aetna Better Health has an aggressive, proactive Fraud, Waste, and Abuse Program that complies with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. A Special Investigations Unit (SIU) is a key element of the program. This SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste or waste to appropriate state and federal agencies as mandated by Illinois Administrative Code. During the investigation process, the confidentiality of the patient and or people referring the potential fraud and abuse case is maintained.

Aetna Better Health uses a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as providers and Members, shares the responsibility to detect and report fraud. Review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste and abuse, and in responsible to investigate cases of alleged fraud, waste and abuse. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators; field fraud (claims) analysts; a full-time, a dedicated information technology organization; and supporting management and administrative staff.

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information, or want to report potential fraud, waste, or abuse. The number is **1-800-338-6361**. The hotline has proven to be an effective tool, and Aetna Better Health encourages providers and contractors to use it.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna's huge volume of claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment, or Member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely both internally with the compliance department and externally with law enforcement as appropriate, to conduct in-depth analyses of case-related data.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to Aetna Better Health all cases of suspected fraud, waste, and abuse, inappropriate practices, and inconsistencies of which they become aware within the ICP and Demonstration Programs.

Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone to the confidential Aetna Better Health Compliance Hotline at **1-877-436-8154**
- By phone to our confidential Special Investigation Unit (SIU) at **1-800-338-6361**.

Note: If you provide your contact information, your identity will be kept confidential.

CMS requires us to have a compliance plan that guards against potential fraud, waste and abuse under 42 C.F.R. §422.503 (b) (4) (vi) and 42 C.F.R §423.504(b) (4) (vi).

CMS combats fraud by:
- Close coordination with contractors, provider, and law enforcement agencies.
- Developing compliance requirements that protect stakeholders.
- Early detection through medical review and data analysis.
- Effective education of providers, suppliers, and Members.

A provider's best practice for preventing fraud, waste, and abuse (also applies to laboratories as mandated by 42 CFR 493) is to:
- Develop a compliance program.
- Monitor claims for accuracy - ensure coding reflects services provided.
- Monitor medical records - ensure documentation supports services rendered.
- Perform regular internal audits.
- Establish effective lines of communication with colleagues and Members.
- Ask about potential compliance issues in exit interviews.
- Take action if you identify a problem.
- Re-Member that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

Fraud, Waste and Abuse Defined

- **Fraud**: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.
- **Waste**: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- **Abuse**: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of Fraud, Waste, and Abuse include:
- Charging in excess for services or supplies.
- Providing medically unnecessary services.
- Billing for items or services that should not be paid for by the ICP or Demonstration Programs.
- Billing for services that were never rendered.
- Billing for services at a higher rate than is actually justified.
- Misrepresenting services resulting in unnecessary cost to Aetna Better Health due to improper payments to providers, or overpayments.
- Physical or sexual abuse of Members.

Fraud, Waste and Abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions.
- Switching an Member's prescription based on illegal inducements rather than based on clinical needs.
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider.
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing login information.
- Falsifying information in order to justify coverage.
- Failing to provide medically necessary services.
- Offering Members a cash payment as an inducement to enroll in a specific plan.
- Selecting or denying Members based on their illness profile or other discriminating factors.
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring an Member to an appropriate provider).
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the Members fail to keep. Another example is a "multi patient" in which a provider visits a nursing home billing for 20 nursing home visits without furnishing any specific service to the Members.
- Double billing such as billing both the Member, or billing Aetna Better Health and another Member.
- Misrepresenting the date services were rendered or the identity of the Member who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-covered service that was rendered.

Fraud, Waste and Abuse can incur risk to Members as well:

- Unnecessary procedures may cause injury or death.
- Falsely billed procedures create an erroneous record of the Member's medical history.
- Diluted or substituted drugs may render treatment ineffective or expose the Member to harmful side effects or drug interactions.
- Prescription narcotics on the black market contribute to drug abuse and addition.

In addition, Member fraud is also reportable and examples include:

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit.
- Attempting to use an Member ID card to obtain prescriptions when the Member is no longer covered under the drug benefit.
- Looping (i.e., arranging for a continuation of services under another Members ID).
- Forging and altering prescriptions.
- Doctor shopping (i.e., when an Member consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote Aetna Better Health's commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
2. Designation of a Compliance Officer: Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
3. Effective Compliance Training: Development and implementation of regular, effective education, and training.
4. Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
5. Disciplinary Mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the ICP or Demonstration Program.
6. Effective Lines of Communication: Between the Compliance Officer and the organization's employees, managers, and directors and Members of the compliance committee, as well as related entities.
    a. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, will maintaining confidentiality.
    b. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health.
7. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

Relevant Laws that Apply to Fraud, Waste, and Abuse

Providers contracted with Aetna Better Health must agree to be bound by and comply with all applicable state and federal laws and regulations. There are several relevant laws that apply to Fraud, Waste, and Abuse:

The False Claims Act (FCA)

- The Federal False Claims Act was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:
  – Knowingly presenting a false or fraudulent claim for payment or approval
  – Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
  – Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid
  – "Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.
- Anti-Kickback Statute
  – The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

- Self-Referral Prohibition Statute (Stark Law)
  - Prohibits providers from referring Members to an entity with which the provider or provider's immediate family Member has a financial relationship, unless an exception applies.
- Red Flag Rule (Identity Theft Protection)
  - Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.
- Health Insurance Portability and Accountability Act (HIPAA) requires:
  - Transaction standards
  - Minimum security requirements
  - Minimum privacy protections for protected health information
  - National Provider Identification (NPIs) numbers
- Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program Prohibits identified entities and or providers excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

Administrative Sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable).
- Suspension of provider payments.
- Being added to the OIG List of Excluded Individuals/Entities database.
- License suspension or revocation.

Potential Civil and Criminal Penalties

- False Claims Act - For each false claim, the penalty could range from $5,500.00 - $11,000.00. If the government proves it suffered a loss, the provider is liable for three times the loss.
- Anti-Kickback Statute - Up to five years in prison and fines of up to $25,000.00 for violations of the Anti-Kickback Statute. If an Member suffers bodily injury as a result of the scheme, the prison sentence may be 20+ years.

Remediation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
  - Automatic disbarment
  - Prison time

Exclusion Lists & Death Master Report

We are required to check the Office of the Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any other such databases as HFS may prescribe.

Aetna Better Health does not participate with or enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs, who have a relationship with excluded providers and/or who have been terminated from the Medicaid or any programs by HFS for fraud, waste, or abuse. The provider must agree to assist Aetna Better Health as necessary in meeting our obligations under the contract with the HFS to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

CHAPTER 14: MEMBER ABUSE AND NEGLECT

Mandated Reporters

As mandated by Illinois General Assembly revised code § 2151.421, and Illinois Administrative Code, all providers who work or have any contact with an Aetna Better Health Member, are required to report any suspected incidences of physical abuse, neglect, mistreatment, and any other form of maltreatment.

Although anyone may make a report, mandated reporters are professionals who may work with children, elderly, or persons with disabilities. The following outlines the abuse, neglect, and exploitation reporting requirements for Illinois citizens.

Children (Under the Age of 18)

As mandated by the Abuse and Neglect Child Reporting Act, providers must report suspected or known child abuse, and or neglect to the Illinois Department of Child and Family Services (DCFS) or the law enforcement agency where the child resides. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, Members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

If the child is in immediate danger, call **911**. Providers may also contact the Illinois Department of Child and Family Services' (DCFS) 24 hour Child Abuse Hotline at 1-800-25-ABUSE. When you call, a trained Hotline social worker will listen to your report, ask questions, and determine whether to take a formal report. If a formal report is taken, you will be asked to send written confirmation. DCFS will provide a form to use and tell you where to send it.

A full version of the Abused and Neglected Child Reporting Act can be found on the Illinois General Assembly website at the following hyperlink: **http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1460&ChapAct=325%26nbsp%3BILCS%26nbsp%3B5%2F&ChapterID=32&ChapterName=CHILDREN&ActName=Abused+and+Neglected+Child+Reporting+Act%2E**

Vulnerable Adults (Between the Age of 18 and 59)

As mandated by Illinois Administrative Code, providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, death and or financial exploitation of a vulnerable adults within 24 hours of the initial discovery of the incident to one the following state agencies:

- The Department of Health Office of Inspector General (OIG) at **1-800-368-1463**; or to
- The appropriate law enforcement.

A full version of Illinois' Administrative Code can be found within the following hyperlink: **http://www.ilga.gov/commission/jcar/admincode/059/059000500000200R.html**

Elders (Ages 60 and Over)

As mandated by the Elder Abuse and Neglect Act, and the Adult Protective Services Act, providers, facilities and caretakers are obligated to report suspect or known physical abuse (domestic violence), neglect, maltreatment, and or financial exploitation of a vulnerable adults within 4 hours of the initial discovery of the incident to one the following state agencies:

- The Department of Aging (DoA) at **1-866-800-1409**; or
- The Department of Health Office of Inspector General (OIG) at 1-368-1463; or
- The appropriate law enforcement.
- For Long Term Care Facilities, report to the Department of Public Health (DPH) Long Term Care/ Nursing Home Hotline at **1-800-252-4343**

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer, or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death (four hours if Abuse or Neglect is suspected).

A full version of Illinois' Administrative Code and Illinois General Assembly can be found within the following hyperlink:

- **http://www.ilga.gov/commission/jcar/admincode/059/059000500000200R.html**
- **http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1452&ChapAct=320%26nbsp%3BILCS%26nbsp%3B20%2F&ChapterID=31&ChapterName=AGING&ActName=Elder+Abuse+and+Neglect+Act%2E**
- **http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1222&ChapAct=210%26nbsp%3BILCS%26nbsp%3B30%2F&ChapterID=21&ChapterName=HEALTH+FACILITIES&ActName=Abused+and+Neglected+Long+Term+Care+Facility+Residents+Reporting+Act%2E.**

Information to Report

When reporting the incident, please be prepared to provide the following information:

- Names, birth dates (or approximate ages), race, genders, etc.
- Addresses for all victims and perpetrators, including current location.
- Information about family Members or caretakers if available
- Specific information about the abusive incident or the circumstances contributing to risk of harm (e.g., when the incident occurred, the extent of the injuries, how the Member says it happened, and any other pertinent information)

After reporting the incident, concern, issue, or complaint to the appropriate agency, the provider office must notify Aetna Better Health of Illinois's Compliance hotline at 1_**877-436-8154**.

Examinations to Determine Abuse or Neglect

When a State agency notifies us of a potential case of neglect and/or abuse of an Member, our Case Managers will work with the agency and the Primary Care Provider (PCP) to help the Member receive timely physical examinations for determination of abuse or neglect. In addition, we also notify the appropriate regulatory agency of the report.

Examples, Behaviors and Signs:

Abuse

Examples of Abuse

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (Bed sores)
- Missing teeth
- Broken Bones / Sprains
- Spotty balding from pulled hair
- Marks from restraints

Behaviors of Abusers (Caregiver and /or Family Member)

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Neglect

Types of Neglect

- The intentional withholding of basic necessities and care
- Not providing basic necessities an care because of lack of experience, information , or ability

Signs of Neglect

- Malnutrition or dehydration
- Unkempt appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of Neglect

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

Financial Exploitation

Examples of Financial Exploitation

- Caregiver, family Member, or professional expresses excessive interest in the amount of money being spent on the Member
- Forcing Member to give away property or possessions
- Forcing Member to change a will or sign over control of assets

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