Aetna Better Health of Louisiana (ABHLA)
Aetna’s Values

**Integrity**
We do the right thing for the right reason.

**Excellence**
We strive to deliver the highest quality and value possible through simple, easy and relevant solutions.

**Inspiration**
We inspire each other to explore ideas that can make the world a better place.

**Caring**
We listen to and respect our customers and each other so we can act with insight, understanding and compassion.

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Agenda

- Provider Information
- Provider Portal
- Cultural Sensitivity
- Member Services
- Behavioral Health
- Medical Management
- Quality Management
- Grievances and Appeals
- Aetna Better Health Website Review
- Questions
PROVIDER INFORMATION
Aetna Better Health of Louisiana
Service Area

Administrative Regions
- Region 1 - Greater New Orleans Area
- Region 2 - Capital Area
- Region 3 - South Central Louisiana
- Region 4 - Acadiana
- Region 5 - Southwest Louisiana
- Region 6 - Central Louisiana
- Region 7 - Northwest Louisiana
- Region 8 - Northeast Louisiana
- Region 9 - Northshore Area

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## Aetna Better Health® of Louisiana Program Service Area

<table>
<thead>
<tr>
<th>Region</th>
<th>Provider Relations Liaison and Email Address</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Kathleen Dickerson <a href="mailto:DickersonK2@aetna.com">DickersonK2@aetna.com</a></td>
<td>504-462-9986</td>
</tr>
<tr>
<td>2</td>
<td>Aieta Davis <a href="mailto:DavisA12@aetna.com">DavisA12@aetna.com</a></td>
<td>225-316-3106</td>
</tr>
<tr>
<td>3</td>
<td>Eve Serbert <a href="mailto:SerbertE@aetna.com">SerbertE@aetna.com</a></td>
<td>504-220-1413</td>
</tr>
<tr>
<td>4</td>
<td>Brandy Wilson <a href="mailto:WilsonB8@aetna.com">WilsonB8@aetna.com</a></td>
<td>504-264-4016</td>
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<td>5</td>
<td>Adrian Lozano <a href="mailto:LozanoA@aetna.com">LozanoA@aetna.com</a></td>
<td>504-402-3417</td>
</tr>
<tr>
<td>6</td>
<td>Jennifer Thurman <a href="mailto:ThurmanJ@aetna.com">ThurmanJ@aetna.com</a></td>
<td>318-413-0725</td>
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<tr>
<td>7</td>
<td>Chemeka Turner <a href="mailto:TurnerC7@aetna.com">TurnerC7@aetna.com</a></td>
<td>318-349-6493</td>
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<tr>
<td>8</td>
<td>Chemeka Turner <a href="mailto:TurnerC7@aetna.com">TurnerC7@aetna.com</a></td>
<td>318-349-6493</td>
</tr>
<tr>
<td>9</td>
<td>Marion Dunn <a href="mailto:DunnM7@aetna.com">DunnM7@aetna.com</a></td>
<td>504-444-6569</td>
</tr>
</tbody>
</table>
Provider Information

Eligibility Verification
• Please contact us at 1-855-242-0802. If you are a participating provider, you may log into our Secure Web Portal to verify a member’s eligibility. You may also contact the Healthy Louisiana Member Hotline at 1-855-229-6848.

• Online Provider & Pharmacy Search Tool
• For a list of participating providers, including behavioral health, please access our online search tool located on www.aetnabetterhealth.com/louisiana

• Tools & Resources
• Website
• Provider Manual
• Member Handbook
• 24/7 Secure Web Portal
• Clinical Guidelines Forms
• Provider Education
Join our network

There are many great reasons to join the Aetna Better Health of Louisiana network. Our provider relations staff works hard to understand your business issues and meet your needs. Whether you are a primary care physician or provide home- and community-based services:

- You benefit from ongoing support and learning opportunities
- Your claims are processed in a timely and efficient manner
- You receive competitive compensation
- You have access to advanced technology that can help you enhance patient care

If you would like to join our network, contact our provider relations department at 1-855-242-0802. You can also email it to us.
Adding a new provider to existing practice (Physician/Mid-Levels)

- Each new provider must be credentialed before he/she can render care to a Member
- Utilize CAQH for credentialing or the Louisiana Standardized Credentialing Application
- Contact Provider Relations with the applicable CAQH number
Provider Claims Information

Claim Inquires
Participating providers may review the status of a claim by checking the Secure Provider Web Portal located on our website or by calling our Claims Investigation and Research Department (CICR) at 1-855-242-0802

Claims & Resubmissions
Aetna Better Health of Louisiana requires clean claims submissions for processing. To submit a clean claim, the participating provider must submit:

- Member’s name
- Member’s date of birth
- Member’s identification number
- Service/admission date
- Location of treatment
- Service or procedure code
Provider Claims Information cont.

Please Note

New Claim Submission

Claims must be submitted within 365 calendar days from the date of services (per HCAPPA) were performed, unless there is a contractual exception. For hospitals inpatient claims, date of service means the date of discharge of the member.

For our FQHC and RHC providers, you will need to list the rendering provider on your claims.

Claim Resubmission

Claim resubmissions must be filed within 90 days from the date of adverse determination of a claim.

Providers may resubmit a claim that
Was originally denied because of missing documentation, incorrect coding, or was incorrectly paid or denied because of processing errors
Electronic Claims Submission

Providers who are contracted with us can use electronic billing software. Emdeon is the EDI vendor we use. Emdeon has the ability to connect with other clearinghouses such as Relay Health. To establish connectivity with Emdeon call 1-800-845-6592 (Please run a test claim prior to submitting batches)

Paper Claims Submissions and/or Resubmissions

Please use the following address when submitting claims to Aetna Better Health of Louisiana

Aetna Better Health of Louisiana
P.O. Box 61808
Phoenix, AZ 85082-1808

For resubmissions, please stamp or write one of the following on the paper claims AND on the envelope:

- Resubmission, Rebill, Corrected Bill, Corrected or Rebilling

90% of clean EDI claims adjudicated within 30 days of receipt
99% of clean paper claims adjudicated within 90 days of receipt
Online Pharmacy Tools

- Pharmacy Authorization Guidelines
  - ADD/ADHD Clinical Guidelines
- Pharmacy Prior Authorization Forms
- Specialty Medications
- Step Therapy and Quantity Limits
- Formulary search and download links
Online Pharmacy Formulary Search Tool

For our fully integrated members:

• Please review our formulary for any restrictions or recommendations regarding prescription drugs before prescribing a medication to an Aetna Better Health of Louisiana patient.

Aetna Better Health of Louisiana pharmacy online search tool is located at www.aetnabetterhealth.com/louisiana/providers/pharmacy

• Formulary drugs are generally covered under the plan as long as they are medically necessary.

• Members must fill their prescriptions at an Aetna Better Health of Louisiana network pharmacy and follow other plan rules.
Discharge Notification

• Inpatient facilities must notify Aetna Better Health of all discharge medications PRIOR to a member’s planned discharge from all Inpatient stays
  - IP MH
  - IP Detox
  - Residential

• When properly notified, we will allow all behavioral health discharge medications to be dispensed by overriding prior authorization restrictions for a ninety (90) day period.
Behavioral Health
Pharmacy

All of our prescribers and dispensers of medicines for members with substance use disorders are encouraged to register for and use the Louisiana Board of Pharmacy Prescription Monitoring Program (PMP). Depending on the specific member’s medical history and diagnosis, other PMP queries should be conducted at the prescriber’s discretion, or at the request of DHH (e.g., for DCFS involved members).
ABHLA is not responsible for covering member medications if they are a Behavioral Health only member. These medications are covered by the member’s medical carrier.

For fully integrated members: Providers, you must be part of the DHH FFS Network or when the member presents the prescription at retail or the claim will deny.
### Internal Classification of Diseases, 10th revision (ICD-10)

- **Provider Resources**
- **Road to 10**
- **Quick Start Guide**
- **CMS ICD-10 Industry Email Updates**

#### ICD-9 to ICD-10 Translator

This tool comes from AAPC, a nationally recognized coding organization, and is based on the General Equivalency Mapping (GEM) files published by CMS. It is not intended to be used as an ICD-10 conversion, ICD-10 mapping, or ICD-9 to ICD-10 crosswalk tool. Keep in mind that while many codes in ICD-9-CM map directly to codes in ICD-10, in some cases, a clinical analysis may be required to determine which code or codes should be selected for your mapping. Always review mapping results before applying them.

Please Note: The online translator tool only converts to ICD-10-CM codes. It does not convert to ICD-10-PCS.

#### ICD-10 Code Translator

![ICD-10 Code Translator](image)

#### Emergency Room Sudden and Serious List

**ICD-10 Emergency Room Sudden and Serious List**
Behavioral Health Provider Forms

Aetna Better Health of Louisiana will accept your behavioral health assessments, LOCUS Score Sheet, Plan of Care documentation, if appropriate, in whatever format you choose to use.

For your convenience, we are adding the Bayou Health Behavioral Health Assessment to our website.

Our Prior Authorization form, www.aetnabetterhealth.com/louisiana/providers/priorauth, is used for both adults and children.
Behavioral Health
Provider Forms

Behavioral health

Aetna Better Health of Louisiana covers behavioral health services. These services include specialized behavioral health services provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, and mental health rehabilitation service providers (public or private). We also cover inpatient hospital services for acute medical detoxification.

If you are interested in being part of our Behavioral Health provider network, complete our [Behavioral Health Contracting and Credentialing Packets](https://example.com).

Aetna Better Health of Louisiana is committed to having an integrated care model that looks at all that affects a person – physical, emotional, lifestyle, beliefs and values. We treat behavioral and physical health together.

We work with members and providers to focus on prevention and wellness:

- Screening for issues that could lead to illness and treating them early with whole-person approach
- Providing classes and services with providers and others to help members learn to better manage their own care

Basic behavioral health

Specialized behavioral health

Claims for FQHC & RHC

Pharmacy

Behavioral health prior authorization

Training for behavioral health providers

Forms
Contact Us: 1-855-242-0802

- CLAIMS:
  - Option 2,
  - then Option 4

- PRIOR AUTHORIZATION:
  - Option 2,
  - then Option 5

- PROVIDER RELATIONS:
  - Option 2,
  - then Option 6
Provider Portal
On the Provider portal you can

• Access ProPAT directly to see if a service code requires authorization
• View panel roster, claims & member eligibility information
• Send & receive secure messages
• Submit authorization requests
• View remittance advice status
• Sign up to receive electronic funds transfer and remittance advices
Provider portal

Our enhanced, secure and user-friendly web portal is now available. This HIPAA-compliant portal is available 24 hours a day and it supports the functions and access to information that you need to take care of your patients. Popular features include:

- **Single sign-on** – One login and password allows you to move smoothly through various systems.
- **Mobile interface** – Enjoy the additional convenience of access through your mobile device.
- **Personalized content and services** – After log-in, you will find a landing page customized for you.
- **Real-time data access** – View updates as soon as they are posted.
- **Better tracking** – Know immediately the status of each claim submission and medical PA request.
- **eReferrals** – Go paperless. Refer patients to registered specialists electronically and communicate securely with the provider.
- **Auto-Approvals** – Depending on the auth type and service location, it is possible to receive an auto-approval on your request.
- **Detailed summaries** – Find easy access to details about denied PA requests or claims.
- **Enhanced information** – Analyze, track and improve services and processes.
- **Access to Member Care** – You can connect to your patients and their care teams. You can access:
  - A real-time listing of your patients
  - Information on your practice
  - Email capability with care managers

**SECURE PORTAL LOGIN**

Sign up today. It’s easy.
Provider groups must first register a principal user known as the "Provider Representative." Once registered, the "Provider Representative" can add authorized users within each entity or practice.

To get started, you can call Provider Services at 1-855-242-0802 to sign up over the phone. You can also submit your registration via fax. Just download the form or request a copy from Provider Services. Remember, internet access with a valid e-mail is required for registration.
If you are a provider, please register for access with our Provider Services Department by calling 1-855-242-0902 (TTY: 711).
Aetna Better Health® of Louisiana Medicaid Provider Portal Provider Documents

![Portal Screenshot]

**About Provider Documents**

This page contains provider related documents that can be downloaded.

**Files to be uploaded**

[Browse]  [Submit]

**Provider Documents**

<table>
<thead>
<tr>
<th>From</th>
<th>Documents</th>
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<tr>
<td>Aetna Better Health of Louisiana</td>
<td>FLU Informational Article for Provider Newsletters.pdf</td>
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<tr>
<td>Aetna Better Health of Louisiana</td>
<td>LA-Notice/Pregnancy.pdf</td>
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Delete

Showing 1 - 10 of 35 provider documents 1 2 3 4
Aetna Better Health® of Louisiana Medicaid Provider Portal New Feature
In the Provider Deliverable Manager (PDM) you can submit the following

- Notice of Pregnancy Form
- Adverse Incident Report
- NEAT (Non-Emergency Ambulance Transportation) Prior Authorization

*Please note: In the Provider Documents section of the Provider Portal, there is a Provider Deliverable Manager User Manual to assist you with navigating the PDM.
Cultural Sensitivity
Cultural Competency
Viewing the World Through a Cultural Lens
Cultural Competency
What is Cultural Sensitivity in Health Care?

Cultural Sensitivity Is:

The ability to respect and appreciate the values, beliefs, and practices of all individuals; including those who are culturally different than oneself and to perceive such individuals through their own cultural lens rather than that of oneself.

An Individual Defines Their Culture Through Multiple Lenses, including:

- Age
- Ethnicity
- Race
- National Origin
- Sex
- Gender Identity
- Sexual Orientation
- Linguistic Needs (primary, preferred language)
- Tribal Affiliation
- Disability
- Behavioral Health Diagnosis
Cultural Competency
Practicing Cultural Sensitivity-Example

Social Context:
A young white woman has recently moved to the city from a rural area. She is 4 months pregnant and has four children, whom she brings with her to her prenatal visits. She is always an hour late for her appointments and the office policy is that she must wait until everyone else is seen before she is seen. She refuses to fill out her medical history forms and states that she requested her previous records to be transferred. Her children are impatient in the waiting room. The office staff members complain about this situation and make disparaging comments on days when she is scheduled for a visit.

Culturally Sensitive Approach:
When the patient is an hour late for her first appointment, a staff member takes some time to inquire about why she is so late. She explains that she is new to the city, has no reliable transportation, and she has to take two buses to get to the clinic. She explains her living situation and that she has no one to watch her children. She also reveals that she is unable to read. A peer counselor arranges for help with learning the bus route and planning her trips. She also is referred to a literacy program for help. One of her first triumphs is learning to recognize the signs on the buses. Over the course of her pregnancy, she learns to read the bus route map and schedule.

Cultural Sensitivity Resources

National Center for Cultural Competence-Georgetown University
http://nccc.georgetown.edu/

U.S. Department of Health and Human Services-Think Cultural Health (CLAS Standards)
https://www.thinkculturalhealth.hhs.gov/content/clas.asp

Are you practicing Cultural Humility

Association of State and Territorial Health Officials Health Equity
http://www.astho.org/Programs/Health-Equity/

Unnatural Causes Documentary
http://www.unnaturalcauses.org/

Office of Minority Health
http://minorityhealth.hhs.gov/Default.aspx

Institute of Medicine – Unequal Treatment: Confronting Racial and Ethnic Disparities

Aetna Team Member
Margaret Mitchell, Recovery and Resiliency Administrator, mitchellm1@aetna.com
Member Services
Member ID Cards

AETNA BETTER HEALTH®

Healthy Louisiana
Member ID# 00000000-00  Date of Birth 00/00/0000
Member Name Last Name, First Name  Sex X
PCP Last Name, First Name
PCP Phone/24 Hours 000-000-0000  Effective Date 00/00/0000

RxBIN: 610591  RxPCN: ADV  RxGRP: RX8834
Pharmacist Use Only: 1-855-364-2977

www.aetnabetterhealth.com/louisiana

THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

Aetna Better Health of Louisiana  2400 Veterans Memorial Blvd., Suite 200
Kenner, LA 70062

Members
Member Services & Filing Grievance 24/7  1-855-242-0802, TTY 711
Fraud & Abuse Hotline 1-855-725-0288  Report Medicaid Fraud 1-800-488-2917
Nurse Line 24/7 1-855-242-0802  Pharmacy 1-855-242-0802
Behavioral Health Crisis Line 24/7 1-855-242-0802

Emergency care: If you are having an emergency, call 911 or go to the closest hospital. You don’t need preapproval for emergency transportation or emergency care in the hospital.

Providers
Provider Services and Prior Authorization  1-855-242-0802

Send medical and behavioral health claims to:
Aetna Better Health
P.O. Box 61808
Phoenix, AZ 85082-1808

Electronic claims
Payer ID 128LA

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Behavioral Health only
Member ID Cards

AETNA BETTER HEALTH®

Healthy Louisiana - Behavioral Health Services
Member ID# 0000000000-00 Date of Birth 00/00/0000
Member Name Last Name, First Name

Sex X
Effective Date 00/00/0000

www.aetnabetterhealth.com/louisiana
THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

Aetna Better Health of Louisiana
2400 Veterans Memorial Blvd., Suite 200
Kenner, LA 70062

Members
Member Services & Filing Grievance 24/7
Fraud & Abuse Hotline 1-855-725-0288
Nurse Line 24/7 1-855-242-0802
Behavioral Health Crisis Line 24/7

Emergency care: If you are having an emergency, call 911 or go to the closest hospital.
You don’t need preapproval for emergency transportation or emergency care in the hospital.

Providers
Provider Services and Prior Authorization 1-855-242-0802

Send medical and behavioral health claims to:
Aetna Better Health
P.O. Box 61808
Phoenix, AZ 85082-1808

Electronic claims
Payer ID 128LA

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Member Eligibility

Total Membership as of 7/20/2017: 113,256

For eligibility issues members should contact the Healthy Louisiana Member Hotline:

1-855-229-6848
Member portal

Track your personal health care with My Care Information

Did you know that you can set up your own personal health care website? You can, and it’s easy. It’s called My Care Information.

First, you need to register. You need your Medicaid ID number to register. If you’re already registered, just log in.

My Care Information can help you manage your health care. It allows you to:

- See your health record
- View your conditions and medications
- Track your health care visits
- See information on your health care providers
- Update your profile

Plus, if you’re in care management, you can:

- View your care plan
- Connect with your case manager and care team

Your information is safe

You create your own protected account and choose your own password. Only Aetna Better Health of Louisiana providers and people you choose can see your information.

Talk to your case manager or call Member Services 1-855-242-0802, TTY 711, if you have questions.
Aetna Better Health® of Louisiana
Member portal
Aetna Better Health® of Louisiana Member portal
Aetna Better Health® of Louisiana
Member Services

- Provides New Member Orientation
- Assists members in the resolution of grievances and appeals, or billing
- Serves as an advocate for members

Available 24 Hours/7 Days
1-855-242-0802
711 TTY
Member Services
Options available for Members

Language Services
• If a member on your panel requires information in another format or language, please call Member Services at 1-855-242-0802, TTY 711, a few days prior their appointment for more information.

LogistiCare
• Our transportation vendor, provides our members with a free ride to and from your office. Members can call LogistiCare at 1-877-917-4150, TTY 1-866-288-3133, at least three days before their appointment. 24-hour Ride Assistance 1-877-917-4151.

Block Vision
• Our vision vendor is available to members by calling 1-800-879-6901.

CVS Caremark
• Our pharmacy vendor and any prior authorizations are handled by Aetna Better Health of Louisiana directly. Call 1-855-242-0802 (TTY 711) and follow the prompts.

DentaQuest
• Our dental vendor is available to members by calling 1-844-234-9834.
Behavioral Health
Behavioral Health
MCG Behavioral Health Guidelines

- Effective September 1, 2016, Aetna Better Health of Louisiana implemented the Milliman Care Guidelines Behavioral Health Guidelines (MCG BHG) as the primary medical necessity criteria for behavioral health.

- Our move to MCG BHG is part of the Aetna Medicaid Standard Operating Model, and will continue to facilitate the appropriate level of care, accurately manage episodes of care and enhance the discharge planning process for our health plan members.

- MCG BHG are nationally recognized, evidence-based clinical guidelines used for determining medical necessity, appropriate levels of care, managing episodes of care and the discharge planning process for our health plan members with behavioral health needs: [www.mcg.com/content/behavioral-health-care](http://www.mcg.com/content/behavioral-health-care)
Aetna Better Health of Louisiana has two (2) forms of Behavioral Health Services

• Basic Behavioral Health
• Specialized Behavioral Health
Behavioral Health
Basic Covered Services

Basic Behavioral Health Services

- Are provided in medical clinics, such as primary care or OB/GYN clinics, by medical professionals or behavioral health consultants. Non-specialized behavioral health providers will be covered by the member’s medical carrier.

Common basic services include:

- screening for common mental health conditions,
- screening for alcohol or substance use issues,
- medication management,
- coordination of referrals to specialized behavioral health services.
Specialized Behavioral Health Services

• Crisis intervention services do not require PA
• Special Health Care Needs members are eligible for services formerly known as 1915(i) SPA
• Levels of behavioral health care range from home and outpatient clinics to residential and inpatient acute care as determined by medical necessity criteria.

Our Behavioral Health Crisis Line is available at 1-855-242-0802, 24/7
Behavioral Health Medical Management Services

Medical Management services ensure that quality healthcare services are provided to our members when and where they need them.

Services include:

• Integrated Care Management (includes disease management)
  • Intensive
  • Supportive
• Utilization management
  • Prior authorizations, Concurrent reviews, Retro Reviews
  • Discharge Planning
• Transition of care from Magellan Behavioral Health
• Systems of Care for Adults and Children
Behavioral Health
Prior Authorizations

If you are a behavioral health provider, you may fax your behavioral health prior authorization requests, assessments, and LOCUS, CASII (CALOCUS), ASAM summaries to us at

1-844-634-1109
Behavioral Health Only Prior Authorizations Fax Line

Prior Authorizations must be submitted using ICD-10 codes vs. DSM-5 codes. Coding with DSM-5, will delay or deny your prior authorization request.
Behavioral Health
Services that require Prior Authorization

- Residential
- IOP (Substance Abuse and Mental Health)
- ACT
- ECT
- PRTF
- Substance Use and Psychiatric Inpatient
- Therapeutic Group Homes

Per our list, some of the other additional intensive services will require authorization
Behavioral Health
BH Services, LA Medicaid -- STATE PLAN AMENDMENT (SPA)

There are 5 service types:

1. Inpatient Psychiatric (Acute care)
2. Residential (PRTF*, Substance Use Res, Group homes*, etc.)
3. IOP (Intensive Outpatient)
4. Outpatient
5. HCBS (Home & Community Based, = 51+% not in an office)

* A Service for Children Only
Evidence-Based Models of Treatment
Some BH services are provided using a tested model...

Evidence Based Practices (EBP’s) are validated as effective, & must follow their model. Fidelity is monitored regularly.

1. MST – Multi-Systemic Therapy (for children/families)
2. FFT – Functional Family Therapy (for children/families)
3. Homebuilders (for children/families)
4. Assertive Community Treatment (ACT) (for adults 18+)
Medical Management
Medical Management
Concurrent Review Process

- 95% of concurrent review determinations within (1) business day
- 99.5% of concurrent review determinations within (2) business days of obtaining the appropriate medical information

Rehabilitation Facilities
- Concurrent reviews will be conducted on a schedule dictated by the member’s diagnosis and condition either by phone, fax or onsite

Skilled Nursing Facilities
- Concurrent reviews will be conducted either by phone, fax or onsite, dictated by the member’s diagnosis and condition
Care Management
Integrated Care Management Program (ICM)

Integrates physical health, behavioral health and wraparound psychosocial services for our most vulnerable and highest risk members

• Care Managers partner with members in making meaningful changes in their lives to improve their health

• Care Managers provide member care and service coordination through our Chronic Conditions Management Program

• Care Managers are Registered Nurses and Licensed Mental Health Professionals
Specialized telephonic and in-person care management

Individualized condition-specific care plans for conditions that increase health risks

- COPD
- Asthma
- HIV/AIDS
- Sickle Cell
- Depression and other SMI s
- Heart Failure
- Diabetes
- Substance Use Disorders
- Hepatitis C
The Maternal-Child Program goals are:

- Early identification of all pregnant members and any associated risk factors (previous preterm birth, history of 17-P)
- Increase the utilization of prenatal and postpartum care
- Identify early signs of Postpartum Depression to coordinate appropriate care
- Reduce early elective deliveries prior to 39 weeks gestation
- Decrease preterm births and poor birth outcomes
- Reduce NICU readmissions
- Reduce postpartum ER utilization
Care Management
Notification of Pregnancy (NOP)

- The notification of pregnancy form has been standardized by LDH and can be found on the ABHLA website. We are encouraging providers to fill these out for our pregnant members as soon as pregnancy is confirmed.
- ABHLA Obstetrical Care Managers will outreach the members and connect them with community resources and active care management. Community resources may include WIC, Nurse Family Partnership (NFP), Parents as Teachers (PAT), and coordination of specialized prenatal care such as 17P administration.

Fax completed forms to ABHLA: 1-866-776-2813.
Care Management
Notification of Pregnancy Form

Notification of Pregnancy

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. Please complete clearly in black ink. Use the submit button to send the form by email or print and fax to: Aetna Better Health of Louisiana 1-866-776-2813.

Member Info *required field
Last Name
First Name
Date of Birth (mmddyyyy)
Mailing Address
City
Home Phone
Cell Phone
Email Address
Due Date* (mmddyyyy)
Preferred Language (if other than English)

Pregnancy Risk Assessment
Are any of the following risk factors present? * If there are no known risk factors, please fill in here

History (fill in all that apply):

- Pre-Term Birth (<37 weeks) delivery
- If yes, was the delivery spontaneous?
- Is the member a candidate for progesterone injections?
- Recent Delivery (within the past 12 months)
- Previous C-Section
- Diabetes (prior to pregnancy)
- Sickle Cell
- Asthma
- High Blood Pressure (prior to pregnancy)
- HIV Positive
- Seizure Disorder
- Seizure within the last 6 months
- Previous alcohol or drug abuse

Date (mmddyyyy)
OR Provider Name*
TIN/ID number*
Mailing Address:

This form was completed by: Provider Member Member Rep
Aetna Standard Program

• Multi-disciplinary consortium (CMO, Care Management, Pharmacy Director)

The objectives of the Member Restriction Program are to:

• Identify potential for abuse or misuse of medical and/or pharmacy benefits
• Use objective evidence to identify members for the Member Restriction Program
• Assist the members to receive safe and effective care to decrease or discontinue the use of controlled substances
Criteria for inclusion are:

- Multiple PCP changes within 12 months
- More than 3 visits to the ER related to pain within 90 days
- Consistent early refill requests for controlled substances
- Prescriptions for controlled substances from multiple prescribers within 90 days
- Consistent misuse or overuse of controlled substances
- Cash purchases for extra narcotics as reported by member or third party source
- Hospitalization for overdose or narcotic-related poisoning
- Violation of a pain contract or care management agreement related to pain issues
Medical Management
Prior Authorizations

Aetna Better Health of Louisiana requires prior authorization for select physical and behavioral health outpatient/inpatient services, DME and surgeries, as well as acute hospital admissions and planned rehabilitation services. Prior authorization is not required for emergency services.

The provider portal allows you to:

• Check a current list of the services that require authorization
• Request an authorization
• Check on the status of an authorization

If you have questions about what is covered, consult your provider manual, the provider authorization list, or call 1-855-242-0802.
Case Management Care Coordination
We can help - Physical and Behavioral Health Conditions

- Transportation coordination
- Single-case agreements
- Specialist referrals
- Housing support
- Pharmacy coordination
- Substance abuse referrals
- Smoking cessation
Providers can make referrals directly to Aetna Better Health of Louisiana Care Management via:

1. Email: AetnaBetterHealthofLA-CMReferral@aetna.com
2. Phone: 855-242-0802
3. Fax: 866-776-2813
Medical Management (Physical Health) 
Prior Authorization Determination Times

- **Urgent Pre-service:** 72 hours of receipt of request

- **Non-urgent Pre-service:** Standard requests with appropriate medical information submitted will be processed within 2 business days; requests with insufficient clinical information will be processed no later than 14 days from the receipt of the request

- **Fax:** 844-227-9205

- **Changes to IP pre-certs:** Notification needs to be made to the health plan within 24 hours
Quality Management
Quality Management
How is data collected for HEDIS reporting?

• HEDIS measures are specified for one or more data collection methods: Administrative method, Hybrid method, Survey method, and Electronic Clinical Data Systems (ECDS)
• Each measure specifies the data collection method
• Some measures include both the Administrative and Hybrid methods, in which case, either method can be used
  • **Administrative method**: reported thru claims/encounter data from office visits, procedures, pharmacy data, etc.
  • **Hybrid method**: plans look for member measure compliance through both the administrative and the hybrid method. For members not meeting compliance requirements from administrative data, medical record data is reviewed during the annual HEDIS medical records review project
  • Survey method: data collected thru a survey
  • ECDS method: supplemental data
Quality Management
How is data collected for HEDIS reporting?

The Ultimate Goal

• The ultimate goal is for providers to submit claims/encounters with coding that administratively captures all required HEDIS data via claims. This decreases or removes the need for medical record (hybrid) review

• Please see HEDIS Tips for PCPs located on our website at www.aetnabetterhealth.com/louisiana/providers/

HEDIS Tips & Billing Guides

We strongly encourage you to print and post our HEDIS Tips for Pediatricians and PCPs to assist you with claims submission and adjudication concerns.

• HEDIS Billing Guide & Tips H2018
• Behavioral Health Measures HEDIS Tips H2018
• HEDIS Tips for PCPs H2018
• HEDIS Tips for Pediatricians H2018
• Woman's Health Tip Sheet H2018
Quality Management
HEDIS Measures

1. Adolescent Well Care
2. Adult BMI Assessment
3. Antidepressant Medications – Acute Phase
4. Antidepressant Medications – Continuation Phase
5. Appropriate Testing for Pharyngitis
6. Appropriate Treatment for Upper Respiratory Infection
7. Asthma Medication Ratio
8. Breast Cancer Screening
9. Cervical Cancer Screening
10. Childhood Immunizations
11. Chlamydia Screening
12. Comprehensive Diabetes Care
   1. A1C Testing
   2. A1C<8
   3. A1C>9
   4. Blood Pressure under 140/90
   5. Diabetic Eye Exam
   6. Attention to Nephropathy
13. Controlling High Blood Pressure
14. Diabetes Screening for Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
15. Follow Up After Mental Health Hospitalization Seven Days
16. Follow Up After Mental Health Hospitalization Thirty Days
17. Follow Up Care ADHD Medication – Initiation Phase
18. Follow Up Care ADHD Medication – Continuation and Maintenance Phase
19. Immunizations Adolescents - including HPV
20. Inappropriate Treatment of Bronchitis
21. Initiation and Engagement AOD
22. Lead Screening
23. Medical Management of Asthma
24. Pharmacy Management of COPD Bronchodilators
25. Pharmacy Management of COPD Systemic Corticosteroids
Quality Management
HEDIS Measures

26. Timeliness of Prenatal care
27. Postpartum Care
28. Use of Imaging for Low Back Pain
29. Child Weight Assessment Counseling
   1. BMI
   2. Nutritional Counseling
   3. Physical Activity Counseling
30. Well Child Visits Birth to 15 months – six visits
31. Well Child Visits Ages 3 – 6 Years Annual Visit
32. Adherence to Antipsychotic Medications for Individuals with Schizophrenia
33. Statin Therapy Cardiovascular Disease - Statin Total
34. Statin Therapy Cardiovascular Disease – Adherence Total
35. Stating Therapy for Patients with Diabetes

SURVEYS:
1. Children’s Access to Care – 12-24 Months of Age
2. Children’s Access to Care – Ages 2 to 6
3. Children’s Access to Care – Ages 7 to 11
4. Children’s Access to Care – Ages 12 to 19
5. Flu Shots – Ages 18-64
6. Plan All Cause Readmission
7. Adults Access to Care – Ages 20 to 44
8. Adult Access to Care – Ages 45 to 65
9. Adult Access to Care – Total for ALL Ages
## Incentive Based Performance Measures

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Description</th>
<th>(2017 data measurement year) Target for Improvement</th>
<th>(2018 data measurement year) and Subsequent Years Target for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>#01 (PTB)</td>
<td>Initiation of Injectable Progesterone for Preterm Birth Prevention</td>
<td>20.00</td>
<td>LDH calculated target</td>
</tr>
<tr>
<td>#02 (AWC)</td>
<td>Adolescent Well Care Visit</td>
<td>48.41</td>
<td>NCQA Quality Compass Medicaid National 50th percentile (All LOBs (Excluding PPOs and EPOs): Average) for the year prior to the measurement year</td>
</tr>
<tr>
<td>#03 (ADD)</td>
<td>Follow-up Care for Children Prescribed ADHD Medication- Initiation Phase</td>
<td>42.19 (Initiation)</td>
<td>NCQA Quality Compass Medicaid National 50th percentile (All LOBs (Excluding PPOs and EPOs): Average) for the year prior to the measurement year</td>
</tr>
</tbody>
</table>
# Quality Management

## DHH Incentive Based Performance Measures

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Measure</th>
<th>Measure Description</th>
<th>2018 (2017 data measurement year) Target for Improvement</th>
<th>2019 (2018 data measurement year) and Subsequent Years Target for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>#04 (ADD)</td>
<td>Follow-up Care for Children Prescribed ADHD Medication- Continuation Phase</td>
<td>The percentage of children 6-12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit/hyperactivity disorder (ADHD) medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.</td>
<td>52.47 (Continuation)</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>#05 (AMB-ED)</td>
<td>Ambulatory Care- ED Visits</td>
<td>This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months.</td>
<td>62.76</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>#06 (PPC)</td>
<td>Prenatal and Postpartum Care - Timeliness of Prenatal Care</td>
<td>The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.</td>
<td>MCOs must report data related to the measure in 2018. Performance will be measured beginning in 2019.</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>Identifier</td>
<td>Measure</td>
<td>Measure Description</td>
<td>2018 (2017 data measurement year) Target for Improvement</td>
<td>2019 (2018 data measurement year) and Subsequent Years Target for Improvement</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>#07 (PPC)</td>
<td>Prenatal and Postpartum Care - Postpartum Care (PPC Numerator 2)</td>
<td>The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</td>
<td>60.98</td>
<td>NCQA Quality Compass Medicaid National 50th percentile (All LOBs (Excluding PPOs and EPOs): Average) for the year prior to the measurement year</td>
</tr>
<tr>
<td>#08 (FUH)</td>
<td>Follow-Up After Hospitalization for Mental Illness - Within 30 days of discharge</td>
<td>The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days of discharge.</td>
<td>63.78 (30 Day)</td>
<td>NCQA Quality Compass Medicaid National 50th percentile (All LOBs (Excluding PPOs and EPOs): Average) for the year prior to the measurement year</td>
</tr>
<tr>
<td>#09 (FUH)</td>
<td>Follow-Up After Hospitalization for Mental Illness - Within 7 days of discharge</td>
<td>The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge.</td>
<td>43.94 (7 Day)</td>
<td>NCQA Quality Compass Medicaid National 50th percentile (All LOBs (Excluding PPOs and EPOs): Average) for the year prior to the measurement year</td>
</tr>
</tbody>
</table>
# Quality Management
## DHH Incentive Based Performance Measures

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<th>Identifier</th>
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</tr>
</thead>
</table>
| #10 (CBP) | Controlling High Blood Pressure - Total | The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year based on the following criteria:  
· Members 18-59 whose BP was <140/90  
· Members 60-85 with diagnosis of diabetes whose BP was 150-90  
· Members 60-85 without a diagnosis of diabetes whose BP was 150/90 | MCOs must report data related to the measure in 2018. Performance will be measured beginning in 2019. | NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year |
| #11 (CDC) | Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) testing | The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with a Hemoglobin A1c (HbA1c) test. | MCOs must report data related to the measure in 2018. Performance will be measured beginning in 2019. | NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year |
| #12 (CDC) | Comprehensive Diabetes Care - Eye exam (retinal) performed | The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with an eye exam (retinal) performed. | MCOs must report data related to the measure in 2018. Performance will be measured beginning in 2019. | NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year |
### Quality Management

#### DHH Incentive Based Performance Measures

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</tr>
</thead>
<tbody>
<tr>
<td>#13 (CDC) $$</td>
<td>Comprehensive Diabetes Care - Medical attention for nephropathy</td>
<td>The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with medical attention for nephropathy.</td>
<td>MCOs must report data related to the measure in 2018. Performance will be measured beginning in 2019.</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>#14 (W15) $$</td>
<td>Well-Child Visits in the First 15 Months of Life - Six or more well-child visits.</td>
<td>The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.</td>
<td>MCOs must report data related to the measure in 2018. Performance will be measured beginning in 2019.</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>#15 (W34) $$</td>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
<td>The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.</td>
<td>MCOs must report data related to the measure in 2018. Performance will be measured beginning in 2019.</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
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<td>Identifier</td>
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<td>------------</td>
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<td>-------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>#16 (CPA)</td>
<td>CAHPS Health Plan Survey 5.0H, Adult (Rating of Health Plan, 8+9+10)</td>
<td>This measure provides information on the experiences of Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations.</td>
<td>MCOs must report data related to the measure in 2018. Performance will be measured beginning in 2019.</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
<tr>
<td>#17 (CPC)</td>
<td>CAHPS Health Plan Survey 5.0H, Child (Rating of Health Plan-General Population, 8+9+10)</td>
<td>This measure provides information on parents' experience with their child's Medicaid organization.</td>
<td>MCOs must report data related to the measure in 2018. Performance will be measured beginning in 2019.</td>
<td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td>
</tr>
</tbody>
</table>
Quality Management
DHH Monitored HEDIS Measures

1. Immunizations for Adolescents
2. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
3. Adherence to Antipsychotic Medications for Individuals with Schizophrenia
4. Annual Monitoring for Patients on Persistent Medications
5. Adult BMI Assessment
6. Antidepressant Medication Management
7. Cervical Cancer Screening
8. Asthma Medication Ratio
9. Flu Vaccinations for Adults Ages 18 to 64
10. Medical Assistance With Smoking and Tobacco Use Cessation
11. Medication Management for People with Asthma
12. Chlamydia Screening in Women
13. Breast Cancer Screening
14. Child and Adolescents’ Access to Primary Care Practitioners
15. Colorectal screening
16. Diabetes screening for people with Schizophrenia or Bipolar who are using Antipsychotic medications
17. Statin Therapy for Patients with Cardiovascular Disease
18. Childhood Immunizations
19. Comprehensive Diabetes Care - HbA1c poor control (>9.0%)
20. Comprehensive Diabetes Care - HbA1c control (<8.0%)
Quality Management
DHH Monitored HEDIS Measures

23. Comprehensive Diabetes Care - HbA1c control (<7.0%) for a selected population
24. Comprehensive Diabetes Care - BP control (<140/90 mm Hg)
25. Plan All-Cause Readmissions

Monitored non-HEDIS Measures:
1. Contraceptive Care-Postpartum (ages 15-20)
2. Contraceptive Care-Postpartum (ages 21-44)
3. Diabetes Short Term Complications Admission Rate
4. COPD and Asthma in Older Adults Admission Rate
5. Heart Failure Admission Rate
6. Asthma in Younger Adults Admission Rate
7. Percentage of low birth weight births
8. Elective Delivery – elective vaginal and cesarean section at >37 and <39 weeks of gestation
9. HIV Viral Load Suppression
10. Cesarean Rate for Low-Risk First Birth Women
Quality Management
Monitoring and quality improvement

- Treatment record reviews
- HEDIS and DHH Performance measures (HEDIS and DHH)
- Adoption of clinical practice guidelines
- Fidelity to evidence-based practices
- Provider utilization and quality profiling
- Performance improvement projects
- Adverse incident reporting
- Monitoring over and under utilization
- Addressing health disparities
- Member and provider satisfaction surveys
- Monitoring member access to services
Quality Management
Clinical Practice Guidelines

• To help provide our members with consistent, high-quality care that uses services and resources effectively, we have chosen certain clinical guidelines to help our providers.

• You will find clinical reference material covering behavioral health conditions on our Guidelines webpage located at www.aetnabetterhealth.com/louisiana/providers/guidelines
<table>
<thead>
<tr>
<th>GENERAL MRR REQUIREMENTS</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name or ID present on each page</td>
<td>The patient’s name or ID number should be recorded on each page of the medical record (i.e. all notes, lab reports and consult reports).</td>
</tr>
<tr>
<td>Personal Data</td>
<td>Each record must contain appropriate biographical/personal data including age, sex, race, address, employer, home and work telephone numbers, ICE contact and marital status. All patients must have their own chart – no family charts. (Prenatal only) – An additional section in the medical record for the provision of prenatal care and services.</td>
</tr>
<tr>
<td>Record is legible</td>
<td>The medical record should be complete and legible. Illegible medical record entries can lead to misunderstanding and serious patient injury.</td>
</tr>
<tr>
<td>Physician review of Lab or other study results</td>
<td>There is evidence of physician review of lab, x-ray, or biopsy results or other studies by either signing or initialing reports or documentation of the results in the progress notes. Abnormal lab and imaging study results have an explicit note regarding follow-up plans.</td>
</tr>
<tr>
<td>Documentation of presenting problem, history, symptomatology, suicide risk, substance use, diagnosis, support system, and special health care needs.</td>
<td></td>
</tr>
<tr>
<td>Treatment record reflects continuity and coordination of care.</td>
<td></td>
</tr>
<tr>
<td>Documentation indicating the patient’s preferred language.</td>
<td></td>
</tr>
<tr>
<td>Signed and dated informed consent forms (i.e.; Release of Information forms per 42 CFR 431.306) or refusal documented.</td>
<td></td>
</tr>
<tr>
<td>Medication management documentation- current regimen, dosages, date of dosage changes, medication education.</td>
<td></td>
</tr>
<tr>
<td>Evidence of provider request of consumer authorization or refusal of PCP communication.</td>
<td></td>
</tr>
<tr>
<td>Documentation of offer of a qualified interpreter, and the member’s refusal, if interpretation services are declined.</td>
<td></td>
</tr>
<tr>
<td>Service plan development by mental health rehabilitation providers for member receiving adult mental health rehabilitation services adequately addresses the member’s goals and social, behavioral, and health needs; provided in amount, type, duration and frequency.</td>
<td></td>
</tr>
<tr>
<td>Crisis plan specific to the member that address any risk or presence of suicidal ideation inclusive of interventions to mitigate risk and action steps to be taken if the crisis cannot be averted. Crisis plan indicates participant involvement is service and crisis plan development and updated as needed. Documentation of emergency and/or after hours encounters and follow-up.</td>
<td></td>
</tr>
</tbody>
</table>
Grievances and Appeals
Grievances and Appeals
Terminology

Action
The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner.

Appeal
A request for a review of an action.

Grievance
An expression of member/provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.
Grievances and Appeals
Claims Reconsiderations and Disputes

Appeals & grievances

- Member appeals
- State Fair Hearing
- Member grievance
- Provider appeals
- Provider payment disputes

Network providers may file a payment dispute verbally or in writing directly to Aetna Better Health of Louisiana to resolve billing, payment and other administrative disputes for any reason including, but not limited to:

- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a health care provider
- Inappropriate or unapproved referrals initiated by the provider
- Any other reason for billing disputes

Note: Provider payment disputes do not include disputes related to medical necessity.

Providers can file a verbal dispute with Aetna Better Health of Louisiana by calling Provider Services Department at 1-855-242-0802. To file a dispute in writing, providers should write to:

Aetna Better Health of Louisiana
Attention: Cost containment
P.O. Box 61808
Phoenix, AZ 85082-1808

Providers need to complete and submit the dispute form with any appropriate supporting documentation.
Grievances and Appeals
Claims Reconsiderations and Disputes Form

Form is available at www.aetnabetterhealth.com/louisiana/providers/appeals under Provider payment disputes (purple toolbar, center of page)

### Aetna Better Health® of Louisiana
### Participating Provider Claims Reconsideration/Dispute Form

Please complete the information below in its entirety and mail with supporting documentation and a copy of your claim to the address listed at the top of this form. Please use one form per member. To determine if your issue is a claims reconsideration or appeal, please see criteria below.

Please note: Providers have a total of 365 days from the date of service to submit a claim and 90 days from the remittance advice to submit a corrected claim and/or dispute a claim.

<table>
<thead>
<tr>
<th>Member Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name</td>
<td>Date of Billed Claim</td>
</tr>
<tr>
<td>Member ID</td>
<td>Patient Account No.</td>
</tr>
<tr>
<td>Aetna Better Health</td>
<td></td>
</tr>
<tr>
<td>Claim ID (will contain the</td>
<td></td>
</tr>
<tr>
<td>letter “c” in the middle)</td>
<td></td>
</tr>
</tbody>
</table>

### SUBMISSION INFORMATION (See second page for detailed description)

- **Claim Reconsiderations**
  - Itemized Bill
  - Duplicate Claim
  - Corrected Claim (note “CORRECTED” on claim)
  - Proof of Timely Filing
  - Claim/Coding Reconsideration

- **Examples of Appeals**
  - Prior Authorization Appeal
  - Level of Care Appeal
  - Medical Necessity Appeal
  - Payment Dispute
  - Claim/Coding Edit Appeal (necessary when you have submitted a reconsideration and it was returned denied)
Grievances and Appeals
Claims Reconsiderations and Disputes

Participating Provider Claims Reconsiderations and Disputes

• **Itemized Bill** All claims associated with an Itemized Bill must be broken out per Rev Code to verify charges billed on the UB match the charges billed on the Itemized Bill.

• **Duplicate Claim** Review request for a claim whose original reason for denial was "duplicate." Provide documentation as to why the claim or service is not a duplicate such as medical records showing two services were performed.

• **Corrected Claim** The corrected claim must be clearly identified as a corrected claim by writing or stamping "corrected" claim.

• **Coordination of Benefits** Attach EOB or letter from primary carrier and forward to the claims department identifying as "corrected" claim.

• **Proof of Timely Filing** For electronically submitted claims provide the second level of acceptance report. Refer to Proof of Timely Filing Requirements in your Provider Manual.

• **Claim/Coding Edit** Aetna Better Health of Louisiana uses two (2) claims edit applications. Please refer to the Provider Manual on the Aetna Better Health of Louisiana website [www.aetnabetterhealth.com/louisiana](http://www.aetnabetterhealth.com/louisiana) for more information on claim editing.
Grievances and Appeals
Provider Grievances

Timeframes

- 30 calendar days to file
- Acknowledged within 3 business days
- Resolved no more than 90 calendar days from date of receipt
Grievances and Appeals
Provider Appeals

Timeframes

• 30 calendar days from date on Notice of Action letter
• Acknowledged within 3 business days
• Resolved no more than 30 calendar days from appeal receipt
Grievances and Appeals
Provider Appeal Requirements

• If the member has not already received the requested service an Authorized Representative Form will have to be signed by the member before the appeal can be filed

• Form must be received within the 30 calendar day timeframe
Grievances and Appeals
How to file a Grievance or Appeal

E-mail: LAAppealsandGrievances@aetna.com
Grievances and Appeals
How to file Grievance or Appeal?

Call
Aetna Better Health of Louisiana Grievance and Appeals Department
1-855-242-0802

Email
LAAppealsandGrievances@aetna.com

Fax
1-860-607-7657

Write
Aetna Better Health of Louisiana Grievance and Appeals Department
2400 Veterans Memorial Blvd., Suite 200
Kenner, LA 70062
Review of Aetna Better Health of Louisiana Website
AetnaBetterHealth.com/Louisiana
Aetna Better Health of Louisiana Team Members
## Team Member

| Grievance and Appeals | • Arlene Goldsmith, Grievances and Appeals Manager  
• Autumn Diaz, Grievances and Appeals Coordinator  
• LAAppealsandGrievances@aetna.com |
|-----------------------|------------------------------------------------------------------|
| Medical Management    | • Foley Nash, Behavioral Health Director  
• Jodi Carter Jones, Director Medical Management  
• Tracy Eaglin, Utilization Management Manager  
• Lance Miguez, Care Management Manager  
• AetnaBetterHealthofLA-CMReferral@aetna.com |
| Member Services       | • Courtney Lewis, Member Services Manager  
• Liz Oubre, Member Services Supervisor |
## Team Member

| Network Development | • Tabitha Marchand, Director of Provider Experience  
|                     | • Lindsay Pirie, Network Manager  
|                     | • MBU-LAProviderEnrollmentForm@aetna.com |

| Provider Relations  | • Candi Meredith, Provider Relations Manager  
|                     | • For your specific Provider Relations Liaison, please refer to slide 7  
|                     | • LAProvider@aetna.com |

| Quality Management  | • Arlene Goldsmith, Healthcare Quality Management Director  
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Questions & Thank You