AETNA BETTER HEALTH® OF MISSOURI
Working to improve every life we touch

Provider Manual

www.aetnabetterhealth.com/mo
## Important Aetna Better Health of Missouri numbers

<table>
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<th>Service</th>
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<tr>
<td>Prior-authorization</td>
<td>1-800-566-6444</td>
</tr>
<tr>
<td>Claims Inquiry Claims Research (CICR)</td>
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</tr>
<tr>
<td>Member Services</td>
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</tr>
<tr>
<td>Provider Relations E-mail address</td>
<td>1-800-566-6444 <a href="mailto:MissouriProviderRelations@aetna.com">MissouriProviderRelations@aetna.com</a></td>
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<tr>
<td>Dental Network</td>
<td>1-888-278-7310 (DentaQuest)</td>
</tr>
<tr>
<td>Transportation</td>
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<tr>
<td>24-Hour Nurse line</td>
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<tr>
<td>Medicaid Fraud Control Unit</td>
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<td>MO HealthNet Pharmacy</td>
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## Address/information line

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<td>10 S Broadway, Ste 1200 St. Louis, MO 63102</td>
<td>1-800-566-6444</td>
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<tr>
<td>2420 Hyde Park Rd. Ste B Jefferson City, MO 65109</td>
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<tr>
<td>10991 NW Airworld Dr. Kansas City, MO 64153</td>
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</tr>
<tr>
<td>4500 E. Cotton Center Blvd. Phoenix, AZ 85040</td>
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<td>Provider Web Portal</td>
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SECTION 1: INTRODUCTION

1.1 COMPANY OVERVIEW

Welcome to Aetna Better Health of Missouri, an Aetna owned and administered managed care organization (MCO). Aetna expanded its Medicaid services in 2007, when it purchased Schaller Anderson, an Arizona-based, nationally recognized health care management company with more than two decades of Medicaid experience.

Aetna Medicaid has been a leader in Medicaid managed care since 1986 and currently serves just over 2.9 million individuals in 16 states. Aetna Medicaid affiliates currently own administer or support Medicaid programs in Arizona, Florida, Illinois, Kentucky, Maryland, Missouri, Michigan, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia, Louisiana and West Virginia. Aetna Medicaid has more than 25 years’ experience in managing the care of the most medically vulnerable, using innovative approaches to achieve successful health care results.

About Aetna Better Health of Missouri

We are pleased you have decided to participate with Aetna Better Health of Missouri to provide healthcare services to our extensive population of MO HealthNet members. Aetna Better Health of Missouri is dedicated to developing provider networks and programs to ensure delivery of quality health care to MO HealthNet Managed Care eligible recipients.

Aetna Better Health of Missouri has an understanding of the health care risks of the community we serve and the impact these problems have on our members’ ability to function and live productive lives. It is this understanding and focus on addressing barriers to care created by social needs that makes Aetna Better Health of Missouri relevant to improving member access to quality medical care. 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 Missourians who need us most.

Aetna Better Health of Missouri is a contracted Managed Care Organization (MCO) with the Missouri Department of Social Services (DSS), MO HealthNet Division (MHD) to administer the MO HealthNet Managed Care Program established in Missouri, originally in September 1995. Our health plan and its subcontractors provide medical, behavioral health, dental, and vision care benefits to eligible individuals enrolled through the MO HealthNet Managed Care Program.

Experience and Innovation

We have more than 25 years’ experience in managing the care of the most medically vulnerable. We use innovative approaches to achieve both successful health care results and maximum cost outcomes.

We are dedicated to enhancing member and provider satisfaction, using tools such as predictive modeling, care management, and state-of-the art technology to achieve cost savings and help members attain the best possible health, through a variety of service models.

We work closely and cooperatively with physicians and hospitals to achieve durable improvements in service delivery. We are committed to building on the dramatic improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

Today Aetna Medicaid owns and administers Medicaid managed health care plans for more than two million members. In addition, Aetna Medicaid provides care management services to hundreds of thousands of high-cost, high-need Medicaid members. Aetna Medicaid utilizes a variety of delivery systems, including fully capitated health plans, complex care management, and administrative service organizations.

Meeting the Promise of Managed Care

Our state partners choose us because of our expertise in effectively managing integrated health models for Medicaid that provides quality service while saving costs. The members we serve know that everything we do begins with the people who use our services –we care about their status, their quality of life, the environmental conditions in which they live and their behavioral health risks.

Aetna Medicaid has developed and implemented programs that integrate prevention, wellness, disease management and care coordination.

We have particular expertise in successfully serving children with special health care needs, children in foster care, persons with developmental and physical disabilities, women with high-risk pregnancies, and people with behavioral health issues.
Aetna Medicaid distinguishes itself by:

- More than 25 years’ experience managing the care and costs of the Temporary Assistance for Needy Families (TANF), Children’s Health Insurance Program (CHIP) and Aged, Blind and Disabled (ABD) (both physical and behavioral) populations
- More than 25 years’ experience managing the care and costs of the developmentally disabled population, including over 9,000 members served today through the Mercy Care Plan in Arizona
- 20 years’ experience managing the care and costs of children and youth in foster care or other alternative living arrangements
- Operation of a number of capitated managed care plans
- Participation on the Center for Health Care Strategies (CHCS) Advisory Committee, as well as specific programs and grants, since CHCS’ inception in 1995
- Local approach – recruiting and hiring staff in the communities we serve

1.2 PHILOSOPHY

Our philosophy is based upon strong collaboration with our network of credentialed and contracted providers to administer and manage efficient, effective, and quality health care to members. Members’ health care is centered with the Primary Care Provider (PCP), who manages the complete healthcare needs of the member and arranges for necessary covered medical services through our network of contracted providers.

Aetna Better Health of Missouri ensures high quality, cost effective, outcome-oriented care to our members through integration and balancing three critical components of managed care: medical and behavioral health management, operational management and financial management. Aetna Better Health of Missouri integrates the delivery of behavioral health and physical health covered services.

Our policies, procedures and standards set forth the authority, responsibility and processes to track, monitor and report all functional activities of the organization.

Providers are afforded education and health plan specific information through the Aetna Better Health of Missouri website, and quarterly provider newsletters. Provider relations staff conducts orientation and refresher orientations to provider offices with an emphasis on familiarizing new providers with the contents of the Provider Manual, reviewing key healthplan polices and advantages of utilizing the Provider Secure Web Portal to maximize efficiency in working with Aetna Better Health of Missouri.

Cultural competence is a valued core principle at Aetna Better Health of Missouri. We use comprehensive cultural competency programs designed to eliminate linguistic and cultural barriers to provider participation and members’ access to care. Our door is open to all populations. We collaboratively help members understand healthy practices that lead to optimum health outcomes.

Aetna Better Health of Missouri utilizes industry accepted standards of credentialing, claim adjudication, prior authorization, concurrent and retrospective review, and coordination of discharge planning, case management and quality management evaluation to effectively promote and provide covered services to members. Prior authorization policies and procedures are basic tenets of our managed care program. Participating providers understanding of and adherence to these standards is essential for successful participation in the Aetna Better Health of Missouri provider network.

1.3 PROVIDER AGREEMENT

The Aetna Better Health of Missouri Participating Provider Agreement is the document which includes the signature page, the General Provisions, all Attachments and all documents attached to or incorporated by reference, sometimes referred to as the provider contract.

This manual is intended to be used as an extension of the Aetna Better Health of Missouri Participating Provider Agreement and as a communication tool and reference guide for providers and their office staff. While the provider manual contains basic information about the MO HealthNet (MHD) Managed Care Program and the Centers for Medicare and Medicaid Services (CMS), providers are required to fully understand and apply MHD and CMS requirements when administering covered services. Please refer to Missouri Department of Social Services website is www.dss.mo.gov/ and the CMS website www.cms.hhs.gov.

For the purpose of this manual, “provider” refers to both practitioners (licensed health care professionals who provide health care services) and providers (institutions or organizations that provide services) that have agreed to provide Covered Services to health plan members pursuant to a Participating Provider Agreement (“contract”).
1.4 MODIFICATIONS TO PROVIDER MANUAL

Providers should review the online version of the Provider Manual to access the most current version for reference purposes. Modifications to the Provider Manual may be necessary and will be made to the online version. All modifications will be communicated to participating providers via the quarterly provider newsletters or periodic provider newsflashes. Newsletters and Newsflashes are also saved for reference purposes.

1.5 ACCESS TO PROVIDER MANUAL

The Aetna Better Health of Missouri Provider Manual is made available to providers via the Aetna Better Health of Missouri website at www.aetnabetterhealth.com/mo and the Secure Web Portal. We also distribute a copy to new participating providers and review key information during provider orientations. In addition, Aetna Better Health of Missouri annually notifies all new and existing participating providers via our provider newsletter regarding the availability of the Provider Manual on the Aetna Better Health of Missouri public website.

1.6 SERVICE AREA AND MAP

MHD has established a service area for the MO HealthNet Managed Care Program. The following counties in Missouri, separated into three (3) regions, are designated as the MO HealthNet Managed Care Service area:

Eastern Region:
Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis, Warren, and Washington counties and St. Louis City

Central Region:
Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline and Shelby counties

Western Region:
Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, and Vernon counties

![Service Area Map](attachment:service_area_map.png)
1.7 COVERED MEMBERS UNDER MO HEALTHNET MANAGED CARE

The MO HealthNet Managed Care population consists of various eligibility groups that have been combined into three Categories of Aid (COA) established by the State of Missouri, MO HealthNet Division. The three categories are COA 1, COA 4, and COA 5. MO HealthNet recipients who reside in the service area and are in these categories must enroll into a MO HealthNet Managed Care MCO.

Category of Aid 1: Parents/Caretaker, Children, Pregnant Women and Refugees

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<th>ME Codes</th>
<th>ME Code Description</th>
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<td>05</td>
<td>Caretaker (MHF-AD)</td>
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<td>MHF Dependent (MHF-CD)</td>
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<td>MO HealthNet Poverty Children</td>
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<td>62</td>
<td>MO HealthNet Poverty Children - Health Initiative Fund</td>
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<td>Newborns</td>
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<td>Recipients of Refugee Medical Assistance</td>
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Category of Aid 2: MO HealthNet for Pregnant Women

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<td>SMHB* Pregnant Women-income above 196% and up to 300%</td>
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<td>SMHB*Post-Partum</td>
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*SMHB (Show Me Healthy Babies)

Category of Aid 4: MO HealthNet Children in Care and Custody and Adoption Subsidy

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<tr>
<th>Category of Aid 4</th>
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<td></td>
<td>66</td>
<td>Child Welfare – HIF</td>
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www.aetnabetterhealth.com/mo
Provider Relations 1-800-566-6444
1.8 KEY WEBSITES FOR ADDITIONAL INFORMATION

Additional information can be found on the following websites at:

Aetna Better Health of Missouri: www.aetnabetterhealth.com/mo

Provider Secure Web Portal: www.aetnabetterhealth.com/mo

Aetna: www.aetna.com

MO HealthNet: www.dss.mo.gov/mhd/

1.9 PARTICIPATING PROVIDERS

Aetna Better Health of Missouri maintains an online provider directory on our website, www.aetnabetterhealth.com/mo. This online directory is updated on weekly basis and should be reviewed to obtain information on our participating provider network. Please visit the Aetna Better Health of Missouri website, www.aetnabetterhealth.com/mo and use the “Locate A Provider” to locate participating providers, when needed. It is important to make sure your demographic information is accurate. To update your demographic information, or to report other errors, please call Provider Relations at 1-800-566-6444.

1.10 PROVIDER SELECTION STANDARDS

Aetna Better Health of Missouri utilizes the following provider selection standards to determine the selection of primary and specialty care professionals.

• The applicant’s specialty and practice location meet Aetna Better Health of Missouri’s needs as determined by the provider relations department. Need is determined by the network adequacy reviews and network accessibility studies as completed by provider relations.

• Provider’s practice location is within the MO HealthNet or contiguous to the state-mandated service area.

• Provider is primarily engaged in providing services of the type covered under the benefit contracts for which Aetna Better Health of Missouri is providing or arranging such services.

• Provider holds a current Missouri State professional license without material restrictions, conditions or other disciplinary action taken against applicant’s license to practice.

• Provider maintains hospital privileges at a Aetna Better Health of Missouri participating hospital, if applicant’s practice requires hospital privileges.

• Provider holds a current and valid Federal Drug Enforcement Agency Registration (DEA), if applicable.

• Provider holds a current and valid Missouri Board of Narcotics and Dangerous Drugs (BNDD), if applicable.

• Provider has graduated from an acceptable medical school and completion of post-graduate training program appropriate for the type of participation sought such as graduation from an accredited school of medicine, osteopathy, chiropractic, dentistry, optometry or podiatry, as appropriate, defined as a school listed in the current AAMC Directory of American Medical Education, published by the American Association of Medical Colleges, or in the current World Directory of Medical Schools, published by the World Health Organization; accredited dental education programs as identified by the American Dental Association; accredited chiropractic education programs as identified by the American Chiropractic Association and accredited podiatric education programs as accredited by the American Podiatric Association.

• Provider maintains adequate professional liability insurance coverage. Aetna Better Health of Missouri defines the requirement as: Primary verification is obtained through the receipt of a copy of the insurance certificate displaying dates of coverage and amounts of coverage. In the case of Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) providers, coverage under the Federal Tort Claims Act (FTCA) is acceptable. At a minimum, the coverage must meet state requirements.
• Provider's practice is not substantially oriented toward clinically unsound, experimental or unproven, or otherwise inappropriate modalities of treatment.

• Provider demonstrates a willingness to allow Aetna Better Health of Missouri to conduct reviews, satisfactory to Aetna Better Health of Missouri of applicant’s practice, including office visits, staff interviews and medical record reviews.

1.11 REQUIREMENTS FOR PARTICIPATION

Aetna Better Health of Missouri and its providers are partners in the health care of Aetna Better Health of Missouri’s members. Because of this mutual responsibility, we require Aetna Better Health of Missouri providers to adhere to the following standards:

• Providers must safeguard the privacy of any information that identifies a particular member in accordance with federal and state laws and to maintain the member records in an accurate and timely manner.

• Providers shall provide covered benefits and health care services to members in a manner consistent with professionally recognized standards of health care. Providers must render or order only medically appropriate services.

• Providers will not deny, limit or condition the furnishing of covered health care services to members based on health factors including, but not limited to: mental or physical illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability.

• Providers shall cooperate with Aetna Better Health of Missouri’s medical management activities and procedures to identify, assess and establish a treatment plan for members with complex or serious medical conditions. This includes returning phone calls, answering correspondence and responding to Aetna Better Health of Missouri staff as needed so they can perform their medical management duties.

• Providers must obtain authorizations for all hospitalizations, as well as services specified in this manual and the Authorization Directory as requiring prior authorization.

• Providers must fully comply with the terms of their agreement and maintain an acceptable professional image in the community.

• Providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health of Missouri through the credentialing/recredentialing process. Providers must furnish Aetna Better Health of Missouri with evidence of coverage upon request and must provide the plan with at least fifteen (15) days notice prior to the cancellation, loss, termination or transfer of coverage.

• Providers look solely to Aetna Better Health of Missouri for payment of services furnished to members, and must not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have claim or recourse against a member, or anyone acting on behalf of a member, under any circumstances unless explicitly approved for reason of coordination of benefits or subrogation. Applicable co-payments can be collected at the time of service or billed to the member. Services cannot be denied to any member with co-pay responsibilities if he/she is unable to pay at the time the service is rendered. The member may be billed for the co-pay amount.

• Providers shall ensure the completeness, truthfulness and accuracy of all claims and encounter data submitted to Aetna Better Health of Missouri including medical records data required and ensure the information is submitted on the applicable claim form.

• In the event that the provider or Aetna Better Health of Missouri seeks to terminate the agreement, it must be done in accordance with the contract.

• Providers must submit demographic or payment data changes at least sixty (60) days prior to the effective date of change.

• Providers shall be available to Aetna Better Health of Missouri members as outlined in the “Scheduling Appointments and Waiting Times” section of this guide. Providers will also arrange 24-hour, on-call coverage for their patients by providers that participate with Aetna Better Health of Missouri, as outlined within this guide.

• Providers shall ensure timely and confidential transfer of records between providers as outlined in the “Transfer of Medical Records” section of this guide.

• Providers must become familiar and to the extent necessary, comply with Aetna Better Health of Missouri members’ rights as outlined in the “Members Rights and Responsibilities” section of this manual.
• Participating providers agree to comply with Aetna Better Health of Missouri’s Provider Manual, quality improvement, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures and any other policies that Aetna Better Health of Missouri may implement, including amendments made to the above mentioned policies, procedures and programs from time to time.

• Providers will ensure they honor all Aetna Better Health of Missouri members’ rights, including, but not limited to, treatment with dignity and respect, confidential treatment of all communications and records pertaining to their care and to actively participate in decisions regarding health and treatment options.

• Provider and Subcontractor Disclosure of Ownership and Controlling Interest
  a) To comply with Federal law (42 CFR 455.100 –106), Aetna Better Health of Missouri must obtain certain information about the ownership and control of entities with which it contracts for services for which payment is made under the Medicaid program.
  
  b) The Centers for Medicare & Medicaid Services and the State Medicaid agency require Aetna Better Health of Missouri to obtain this information at initial credentialing and re-credentialing to show that we are not contracting with an entity that has been excluded from Federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid.
  
  c) Aetna Better Health of Missouri requires a completed Provider and Subcontractor Disclosure of Ownership and Controlling Interest worksheet if you want to participate and/or keep your participation active. You must promptly report to Aetna Better Health of Missouri any changes to the information that was originally submitted, and in no event more than 35 days after any such change. Forms are valid for one year from signature date, so updated forms may be required to be submitted annually to Aetna Better Health of Missouri.

• Contracted practitioners and providers are required to:
  a) Cooperate with QI activities
  b) Maintain the confidentiality of member information and records
  c) Allow Aetna Better Health of Missouri to use their performance data
SECTION 2: PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

2.1 PROVIDER RELATIONS DEPARTMENT

Aetna Better Health of Missouri maintains a strong commitment to meeting the needs of our providers. In order to accomplish this, a provider relations representative is assigned to all participating providers. This process allows each practice to become familiar with its representative and form a solid working relationship.

Your provider relations representative will visit or phone you to ensure that your day-to-day experience with Aetna Better Health of Missouri and our members is smooth. We are available to meet with office staff or providers upon your request. Practice Manager Advisory Committee (PMAC) meetings are held along with various training seminars throughout the year. Provider newsletters are sent to providers along with specialized mailings that includes updates to the provider manual, changes in policy, benefits, and general news and information of interest to our provider network. You may also access information via our website at www.aetnabetterhealth.com/mo.

The provider relations department is responsible for the field service and ongoing education and training of Aetna Better Health of Missouri’s provider network. Each provider representative has a thorough understanding of Aetna Better Health of Missouri’s operations and is well versed in the MO HealthNet Managed Care program. Refresher office training is always available.

To contact your local provider relations representative, please call Aetna Better Health of Missouri at 1-800-566-6444, or refer to the “Provider Relations Contact Listing” handout on our website www.aetnabetterhealth.com/mo. To contact the Provider Relations Department, call 1-800-566-6444.

2.1.1 Hours of Operation

Aetna Better Health of Missouri’s Provider Relations Department is available five (5) days per week, Monday-Friday from 8:00 a.m. – 5:00 p.m. CST. Please have your NPI, your Tax Identification number available for HIPAA verification purposes. If your provider relations representative is out of the office, you can leave a message on our department voice mail at 1-800-566-6444, and your call will be returned by close of business the next business day.

Aetna Better Health of Missouri is closed for business on the following days or the observed day:

- New Year’s Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day
- Day after Thanksgiving
- Christmas Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day
- New Year’s Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Veterans Day
- Truman’s Birthday
- Veterans Day
- Truman’s Birthday
- Veterans Day

The following holidays may be utilized for provider relations staff training:

- Lincoln’s Birthday
- Columbus Day

2.1.2 Provider Relations Mission Statement

The Provider Relations Department and the provider relations representatives pledge to provide superior customer service to providers. We will:

- Develop strong relationships with providers, staff and community.
- Proactively communicate accurate information in a timely manner in order to assist providers in delivering high quality health care to our members.
- Be a reliable resource to support and assist providers in the smooth operation of their practice.
- Provide excellent service to both internal and external customers.
- Commit to be leaders of positive change, and to Aetna Better Health of Missouri being known as the best managed care organization.
- Involve all Aetna Better Health of Missouri employees to provide excellent provider customer service.
2.1.3 Top 10 Reasons to Contact your Provider Relations Representative

1. Any change to your practice i.e., practice tax ID, name, phone numbers, fax numbers, address, NPI, taxonomy, ownership/controlling interest, addition/termination of providers or patient acceptance. *(Please utilize Provider Notification Form found on the Aetna Better Health of Missouri website or submit notice in writing.)*

2. Initiate credentialing of new providers

3. Schedule an in-service for new staff

4. Ongoing education for existing staff

5. Clarification of Aetna Better Health of Missouri policies and procedures

6. Order supplies, such as a provider manual, HEDIS Billing Guide, and other collateral materials

7. Clarification of contract

8. Request fee schedule information

9. Membership list questions

10. E-Business. Find out how to use electronic solutions via the Provider Secure Web Portal, to submit/view authorizations, check member eligibility and COB, claims status, electronic remittance advice (ERA), download remittance advices, PCP HEDIS Gaps in Care Reports, and PCP Panel reports.

   Note: Claims Inquiry Claims Research should be contacted for claims, eligibility and benefit questions at 1-800-566-6444.

2.1.4 New Provider Orientation

Aetna Better Health of Missouri provides an initial orientation for newly contracted providers after joining our network. Upon credentialing approval by Aetna, a welcome letter is issued to the provider, and within thirty (30) days of the provider’s effective date, a provider relations representative will contact the practitioner’s office to schedule an orientation in person or by telephone. In addition, Aetna Better Health of Missouri offers webinars and on-line tutorials periodically.

In follow up to initial orientation, Aetna Better Health of Missouri provides a variety of forums for ongoing provider training and education, such as routine visits, group or individualized training sessions on select topics (i.e. Provider Secure Web Portal, HEDIS, EPSDT), distribution of provider newsletters and bulletins containing updates, reminders and online resources through our health plan website www.aetnabetterhealth.com/mo and our Provider Secure Web Portal.

2.1.5 Practice Managers Advisory Committee

Aetna Better Health of Missouri’s Practice Managers Advisory Committee (PMAC) meets three times annually to ensure we are communicating with participating providers on a regular basis. The meetings allow for feedback on the provider’s perceptions of Aetna Better Health of Missouri’s policies and procedures.

The group exchanges ideas, interpretations and information on current issues and topics and is comprised of various provider types, including primary care, specialists, behavioral health, hospital and ancillary. The committee term is for one year and meetings are held in each of the three regions. Interested providers should contact their provider relations representative for nomination to this committee.

2.2 Participating Providers

Please visit our Provider Search option on the Aetna Better Health of Missouri website www.aetnabetterhealth.com/mo or contact your provider relations representative for a participating provider listing. The online provider listing is updated on a weekly basis.

2.2.1 Provider Selection Standards

Aetna Better Health of Missouri utilizes the following provider selection standards to determine the selection of primary and specialty care professionals.

- The applicant’s specialty and practice location meet Aetna Better Health of Missouri’s needs as determined by the provider relations department. Need is determined by the network adequacy reviews and network accessibility studies as completed by provider relations.
- Provider’s practice location is within the MO HealthNet or contiguous to the state-mandated service area.
• Provider is primarily engaged in providing services of the type covered under the benefit contracts for which Aetna Better Health of Missouri is providing or arranging such services.

• Provider holds a current Missouri State professional license without material restrictions, conditions or other disciplinary action taken against applicant's license to practice.

• Provider maintains hospital privileges at a Aetna Better Health of Missouri participating hospital, if applicant's practice requires hospital privileges.

• Provider holds a current and valid Federal Drug Enforcement Agency Registration (DEA), if applicable.

• Provider holds a current and valid Missouri Board of Narcotics and Dangerous Drugs (BNDD), if applicable.

• Provider has graduated from an acceptable medical school and completion of post-graduate training program appropriate for the type of participation sought such as graduation from an accredited school of medicine, osteopathy, chiropractic, dentistry, optometry or podiatry, as appropriate, defined as a school listed in the current AAMC Directory of American Medical Education, published by the American Association of Medical Colleges, or in the current World Directory of Medical Schools, published by the World Health Organization; accredited dental education programs as identified by the American Dental Association; accredited chiropractic education programs as identified by the American Chiropractic Association and accredited podiatric education programs as accredited by the American Podiatric Association.

• Provider maintains adequate professional liability insurance coverage. Aetna Better Health of Missouri defines the requirement as: Primary verification is obtained through the receipt of a copy of the insurance certificate displaying dates of coverage and amounts of coverage. In the case of Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) providers, coverage under the Federal Tort Claims Act (FTCA) is acceptable. At a minimum, the coverage must meet state requirements.

• Provider’s practice is not substantially oriented toward clinically unsound, experimental or unproven, or otherwise inappropriate modalities of treatment.

• Provider demonstrates a willingness to allow Aetna Better Health of Missouri to conduct reviews, satisfactory to Aetna Better Health of Missouri of applicant’s practice, including office visits, staff interviews and medical record reviews.

2.3 DEMOGRAPHIC CHANGES

Providers are required to submit all demographic changes to Aetna Better Health of Missouri in writing at least 60 days prior to the effective date of the change or as soon as possible. All demographic changes are processed within 30 days of receipt. Providers may also utilize the Provider Notification Form to submit changes which can be located on the Aetna Better Health of Missouri website www.aetnabetterhealth.com/mo. Aetna Better Health of Missouri will determine the effective date of the change submitted based on when the change was received. Demographic changes consist of the following:

- Name Change
- Terminations
- NPI Change/Addition
- Tax Identification Number (TIN) Change/Addition
- Ownership
- Address – Location and Billing Change/Addition
- Phone Number Change/Addition
- Fax Number Change/Addition
- Office Hours
- Panel Status
- Age Limitation
- Languages Spoken

Failure to notify Aetna Better Health of Missouri of important changes can result in provider access/availability issues, delay of claims processing, and denial of claims.

2.4 CREDENTIALING PROCESS AND APPLICATION REQUIREMENTS

2.4.1 Application Requirements for Primary Care and Specialty Care Providers

Form UCDS/CAQH shall be used when credentialing or recredentialing health care professionals in a managed care plan. In addition to Form UCDS/CAQH, the applicant must provide the following information:

- Signed Participating Provider Agreements (if applicable)
- Copy of current Federal DEA certification (if applicable)
- Copy of current BNDD certification (if applicable)
- Copy of current malpractice coverage certificate
• Copy of ECFMG certificate (if applicable)
• Copy of board certificate (if applicable)
• Copy of completed IRS W-9 form
• Copy of educational degrees

• Nurse Practitioners and Physician Assistants must submit a copy of physician collaborative practice agreement with a participating Aetna Better Health of Missouri physician in a similar specialty.

• Completed and signed Provider/Subcontractor Ownership/Controlling Interest Worksheet

Upon receipt of the above requested information, the Credentialing Department will verify the provider’s credentials and qualifications through primary sources. Primary sources may include, but are not limited to, The National Practitioner Data Bank, licensing agencies, OIG, EPLS, American Medical Association, American Board of Medical Specialties, and American Osteopathic Association.

2.4.2 Application Requirements for Ancillary/Facility Providers

Requests for an ancillary/facility application should be directed to the provider relations department. The applicant must provide a completed, signed and dated Aetna ancillary/facility application to Aetna Better Health of Missouri to properly verify the provider’s qualifications. Ancillary provider sites may require a facility review if they do not hold an acceptable accreditation. In addition to the ancillary/facility application, the following items must be provided:

• Signed Participating Provider Agreements (if applicable)
• List of licensed services offered
• Copy of current Facility State License, Business Registration or Certificate of Occupancy (if applicable).
• Copy of professional liability insurance or malpractice coverage
• Copy of accreditation certificate(s)
• Copy of accreditation organization’s letter indicating accreditation level
• Copy of CMS certificate or state audit report
• Copy of full CMS audit report
• Copy of completed IRS W-9 form
• Complete listing of service area, including cities and counties

• Completed and signed Provider/Subcontractor Ownership/Controlling Interest Worksheet
• Medicaid certification number

• If facility is not accredited, provide most recent CMS or State Survey/Inspection Report, including Corrective Action Plan and compliance letters.

• Copy of Clinical Lab Improvement Amendment (CLIA) – (for laboratories only).

2.4.3 Recredentialing Requirements

Aetna Better Health of Missouri recredits all participating providers at least every 36 months. The provider is required to submit updated information for their credentialing/recredentialing file. Failure to provide the requested information will result in termination from the network.

Aetna Better Health of Missouri maintains the confidentiality of all information obtained during the credentialing/recredentialing process. All credentialing documents or other written information collected will not be disclosed to any person not directly involved in the credentialing process.

2.4.4 Site Reviews

A site review will be conducted in response to member complaints, upon quality reviews, or for unaccredited ancillary/facility providers. The site review includes but is not limited to the following areas:

• Physical access
• Physical appearance
• Office hours

• Adequacy of waiting and examining areas
• Availability of appointments
• Emergency and safety

• Adequacy of equipment
• Emergency medication
• Medical record review

Providers who do not have an acceptable site review may be required to provide a corrective action plan.
2.4.5 Practitioner Credentialing Rights to Review, Correct and Status of Credentialing Applications

Practitioners have the following rights with regards to the Credentialing and Recredentialing Process:

• Notification of Discrepancies in Credentialing Information

If credentialing information obtained from other sources varies substantially from that provided by the practitioner, Aetna Better Health of Missouri will notify the practitioner of the discrepancy in writing and provide at least 30 days for the practitioner to provide an explanation or provide corrected information.

• Review Information Submitted to Support Their Credentialing Application

Prior to review, additional information may be accepted from practitioner to correct incomplete, inaccurate or conflicting credentialing information. In lieu of having a practitioner re-submit all the documentation, it is acceptable to have the provider re-sign the attestation and authorization and submit with the application verifying that the information is still complete, valid and accurate.

• Correct Erroneous Information

All practitioners have the right to review information submitted to support their credentialing application and to correct erroneous information. Practitioners are notified of their rights via a letter that is mailed from the Credentialing Department upon receipt of the initial credentialing application. Aetna Better Health of Missouri’s credentialing staff will notify the practitioner that they have ten (10) business days from the date they are contacted to respond to the request. Corrections must be submitted in writing to the following address:

Aetna Better Health of Missouri
Attn: Provider Credentialing
10 S. Broadway, Suite 1200
St. Louis, MO 63102
Phone: 1-800-566-6444, option 8

• Receive the Status of Their Credentialing or Recredentialing Application, Upon Request

Aetna Better Health of Missouri is able to communicate with practitioners about their credentialing status upon request and prior to review, accept additional information from practitioners to correct incomplete, inaccurate or conflicting credentialing information. Practitioners should contact Aetna Better Health of Missouri by calling 1-800-566-6444, or email at Missouri Provider Relations@aetna.com if you have any questions regarding your credentialing status.

2.4.6 Provider and Subcontractor Disclosure of Ownership and Controlling Interest

Aetna Better Health of Missouri requires a completed Provider and Subcontractor Disclosure of Ownership and Controlling Interest worksheet if you want to participate and/or keep your participation active. You must promptly report to Aetna Better Health of Missouri any changes to the information that was originally submitted, and in no event more than 35 days after any such change. Forms are valid for one year from signature date, so updated forms may be required to be submitted annually to Aetna Better Health of Missouri.

2.4.7 Providing services during credentialing

While in the credentialing process, Providers should refrain from scheduling or treating Aetna Better Health of Missouri members until they are notified by written correspondence of their participation effective date. Services provided in advance of the participation effective date require prior authorization and if proper authorization was not obtained, the services will be subject to denial and non-payment. These services are not billable to Aetna Better Health of Missouri members.

2.5 PRIMARY CARE PROVIDERS

The Primary Care Provider (PCP) serves as the cornerstone of the Aetna Better Health of Missouri provider network. A PCP is key to ensuring that every Aetna Better Health of Missouri member has a medical home and access to necessary health care, thus providing continuity and coordination of care.

2.5.1 Primary Care Providers – Eligible Specialties

Aetna Better Health of Missouri considers PCPs to include:

• Licensed physicians in the following specialties: family and general practice, pediatrics, OB/GYN, and internal medicine;
• Licensed residents in training and specializing in family and general practice, pediatrics, obstetrics;
• Registered nurses who are advanced practice nurses with specialties in family practice, pediatric practice, and OB/GYN practice.
2.5.2 Primary Care Provider Teams and Clinics

Aetna Better Health of Missouri makes available primary care teams and clinics to serve as primary care providers. The primary care team and clinic must provide the range of services required of all primary care providers. A centralized medical record shall be maintained on each member enrolled with the primary care clinic.

Institutions with teaching programs and primary care provider teams, comprised of residents and a supervising faculty provider, may provide primary care services. The primary care provider teams may include advance practice nurses or physician assistants recognized by the Board of Healing Arts who, at the member’s discretion may serve as the point of first contact for the member. The primary care provider team must ensure continuity of care to members and identify a “lead physician” within the team for each member. The “lead physician” must be an attending physician and not a resident.

2.5.3 Specialists as PCP’s

Aetna Better Health of Missouri allows specialists to serve as primary care providers for members with disabling conditions or chronic conditions which require ongoing care from a specialist if the specialist agrees in writing to accept the member as a primary care patient and accept the responsibilities of a PCP.

2.5.4 Responsibilities of Primary Care Providers

The Primary Care Provider shall serve as the member’s initial and most important contact. As such, the following is an overview of the responsibilities that the PCP assumes in the management of a member’s health care needs:

• Verify member eligibility with MO HealthNet at every visit or encounter prior to rendering services (MO HealthNet ARU line, Infocrossing website: www.emomed.com, Emdeon: www.emdeon.com, or the Aetna Better Health Provider Secure Web Portal.
• Provide, coordinate and/or direct all health care needs of members to maintain continuity of care.
• Perform, track, and report EPSDT exams and other required preventative services for all members.
• Promote access to quality care by utilizing participating Aetna Better Health of Missouri specialists, hospitals and ancillary providers.
• Make referrals for specialty care and other medically necessary services to in network providers and obtain prior authorization from Aetna Better Health of Missouri before utilizing out of network providers, when necessary.
• Obtain prior authorization for services in accordance with the Authorization Directory.
• Contact Aetna Better Health of Missouri for those services that require authorization prior to the services performed.
• Coordinate with Aetna Better Health of Missouri case and disease management staff in developing care plans for members under care management.
• Participate in the health plan’s case management team, as applicable and medically necessary
• Conduct a behavioral health screening to determine whether the member needs behavioral health services.
• Follow the requirements of the utilization management program, quality management program and other policies and procedures set forth in the Provider Manual.
• Provide and/or coordinate twenty-four (24) hour accessibility for members.
• Communicate information to each patient regarding the right to institute an advance directive.
• Maintain a comprehensive and legible medical record; including documentation of all services provided to the member by the PCP, as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens, etc.
• Provide all of the health care services and supplies that are Medically Necessary, generally available by Provider and which Provider is licensed to provide which are covered under the terms of the applicable Benefit Plan.

• Adhere to provider access and availability guidelines.
• Consider referring parents/guardians of members age five (5) and under to their local school district Parents As Teachers (PAT) program. www.dese.mo.gov
• Complete the Missouri Lead Risk Assessment form and conduct mandatory lead testing on members ages 1 and 2 as required by the State of Missouri.
• Participating providers may not discriminate against MO HealthNet Managed Care members or treat them differently than others receiving services.
• Primary care providers may have formalized relationships with other primary care providers to see their members for after-hours care, during certain days, for certain services, or other reasons to extend their practice. Primary care providers may also, in addition to working with the Aetna Better Health of MO case managers, provide additional case management support for
their members. However, the primary care providers shall be ultimately responsible for the activities listed in this section for the members assigned to them. Aetna Better Health shall support primary care providers with resources they may have available to which the PCP does not have access.

- Maintain an open panel. Panel closure to Aetna Better Health of Missouri members should also apply to all payors/patients.

2.5.5 Transfer of Information between Providers

During the orientation process, Aetna Better Health of Missouri’s provider relations representatives will educate the provider and their office staff on the following requirements to ensure continuity of care for members.

When a PCP refers a patient to a specialist or transfers a pediatric member from pediatric care to adult care, they will forward (at no cost to the plan or member), all appropriate notes, x-rays, reports or other medical records to the specialist new provider, within (10) days of the request or prior to the patient’s scheduled appointment, whichever is earlier.

If a Aetna Better Health of Missouri member changes their PCP, the previous PCP will forward (at no cost to the plan or member), the member’s medical records within ten (10) days of request to the member’s new PCP, or prior to the next scheduled appointment with the new primary care provider, whichever is earlier.

2.5.6 Panel Listing

All PCP providers can access their listing of members assigned to their panel via the Secure Web Portal. In addition, a monthly PCP panel listing will be mailed to every PCP to their primary office address. Providers are required to confirm member eligibility and PCP assignment at every date of service.

2.5.7 PCP Panel Changes and Limits

- Panel Closings

Please note that if you close your panel to Aetna Better Health of Missouri members, you must close your panel to all payers/patients. All requests to close your panel must be submitted in writing to Aetna Better Health of Missouri — Provider Relations, with at least sixty (60) days advance notice.

- PCP Panel Limit

Aetna Better Health of Missouri reserves the right to limit the panel size of individual primary care providers in order to provide adequate access and availability for primary care services. For group practices, the panel size limit will be adjusted in accordance with the number of available providers. Any decision by Aetna Better Health of Missouri to limit the panel size due to access or availability concerns will be communicated in writing to the provider.

2.5.8 Verification of PCP Assignment Requirement

Primary Care providers are required to confirm PCP assignment for each date of service prior to rendering services. PCP assignment can be confirmed by using the Provider Secure Web Portal. If a presenting member needs to be moved to your PCP panel, call member services at 1-800-566-6444 or complete the PCP change Fax Form available on the website at www.aetnabetterhealth.com/mo so a PCP change can be completed.

2.5.9 Vaccines for Children

Through the Vaccines for Children (VFC) program, federally-provided vaccines are available at no charge to public and private providers for children ages newborn through 18 years of age. Aetna Better Health of Missouri will pay an administration fee per dose to eligible providers who administer the free vaccine to eligible Aetna Better Health of Missouri members.

Aetna Better Health of Missouri requires all providers administering VFC to report information via a claim for administration fee and/or using ShowMeVax website for logging information.

The Missouri Department of Health and Senior Services website provides access to the Missouri Immunization Registry - ShowMeVax (SMV). Participating providers can access vaccination records using a secure connection. The system allows the provider to:

1. Update and review immunizations administered and entered in the registry.
2. Manage inventory of vaccines (optional feature)
3. Use data warehouse for analysis of information
To access the SMV, the Memorandum of Agreement (MOA) must be completed and approved and the Automated Security Access Processing (ASAP) be completed online. The following provides more information on these steps:

TO OBTAIN THE MOA CONTACT:

MO Dept of Health and Senior Services
PO Box 570
Jefferson City, MO 65109


Access the ASAP or obtain more information at health.mo.gov/living/wellness/immunizations. Select the following: "ShowMeVax", "Registry/Log In," "Read only Tutorial," "Tips for using SMV registry," ASAP instructions for requesting access to SMV. "Family educational Rights and Privacy Act (FERPA).

MO HealthNet requires providers who administer immunizations to qualified MO HealthNet eligible children to enroll in the VFC program. The Missouri Department of Health and Senior Services (DHSS) administers the VFC program and providers should contact the DHSS as follows:

Missouri Department of Health and Senior Services – Section of Vaccine Preventable and Tuberculosis Disease Elimination
P. O. Box 570
Jefferson City, Missouri 65102
1-800-219-3224 or fax 573- 526-5220

2.5.9A VFC IMMUNIZATIONS FOR AETNA BETTER HEALTH OF MISSOURI MEMBERS

Participating providers who administer vaccines must enroll in the VFC program through the DHSS. Participating providers must use the VFC vaccine for Aetna Better Health of Missouri members. For all VFC procedure administration codes, an SL modifier is required for reporting and claim submission. Providers must not use any additional administration procedure code. Valid VFC administration codes are listed below.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90620</td>
<td>SL</td>
<td>Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for IM use</td>
</tr>
<tr>
<td>90621</td>
<td>SL</td>
<td>Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for IM use</td>
</tr>
<tr>
<td>90633</td>
<td>SL</td>
<td>Administration of immunization; hepatitis A vaccine, pediatric/adolescent dosage -2 dose schedule for intramuscular use</td>
</tr>
<tr>
<td>90644</td>
<td>SL</td>
<td>Administration of immunization; Meningococcal conjugate vaccine, serogroups C &amp; Y and Hemophilus influenza B (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months of age</td>
</tr>
<tr>
<td>90647</td>
<td>SL</td>
<td>Administration of immunization; hemophilus influenza B vaccine (Hib), PRP-OMP conjugate (3 dose schedule) for intramuscular use</td>
</tr>
<tr>
<td>90648</td>
<td>SL</td>
<td>Administration of immunization; hemophilus influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule) for intramuscular use</td>
</tr>
<tr>
<td>90649</td>
<td>SL</td>
<td>Administration of immunization; HPV vaccine types 6, 11, 16, 18 (3 dose schedule) for use in individuals 9 and older, for intramuscular use</td>
</tr>
<tr>
<td>90650</td>
<td>SL</td>
<td>Administration of human papilloma virus (HPV) vaccine, 3 dose schedule for intramuscular use</td>
</tr>
<tr>
<td>90651</td>
<td>SL</td>
<td>Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for IM use</td>
</tr>
<tr>
<td>90656</td>
<td>SL</td>
<td>Administration of immunization; influenza virus vaccine, split virus, preservative free, for children 3 years and under</td>
</tr>
<tr>
<td>90658</td>
<td>SL</td>
<td>Administration of immunization; influenza virus vaccine, split virus, for use in individuals 3 years of age and above for intramuscular use</td>
</tr>
<tr>
<td>90660</td>
<td>SL</td>
<td>Administration of immunization; influenza virus vaccine live, for intranasal use</td>
</tr>
<tr>
<td>90670</td>
<td>SL</td>
<td>Administration of immunization; pneumococcal; conjugate vaccine, 13 valent, for intramuscular use</td>
</tr>
<tr>
<td>Code</td>
<td>Type</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>90672</td>
<td>SL</td>
<td>Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use</td>
</tr>
<tr>
<td>90680</td>
<td>SL</td>
<td>Administration of immunization; rotavirus vaccine live for oral use (3 dose schedule)</td>
</tr>
<tr>
<td>90681</td>
<td>SL</td>
<td>Rotavirus Vaccine, two dose vaccine, live for oral use, for children 6 weeks to 32 weeks of age</td>
</tr>
<tr>
<td>90685</td>
<td>SL</td>
<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use</td>
</tr>
<tr>
<td>90686</td>
<td>SL</td>
<td>Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 yrs. of age or older, intramuscular use</td>
</tr>
<tr>
<td>90688</td>
<td>SL</td>
<td>Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use.</td>
</tr>
<tr>
<td>90696</td>
<td>SL</td>
<td>Dtap-IPV Vaccine, booster dose for children 4 to 6 years of age</td>
</tr>
<tr>
<td>90698</td>
<td>SL</td>
<td>DtaP-Hib-IPV Vaccine, children 6 weeks to 4 years of age</td>
</tr>
<tr>
<td>90700</td>
<td>SL</td>
<td>Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DtaP), for use in individuals younger than 7 years for intramuscular use</td>
</tr>
<tr>
<td>90702</td>
<td>SL</td>
<td>Administration of immunization; diphtheria and tetanus toxoids (DT) absorbed for use in individuals younger than 7 years, for intramuscular use</td>
</tr>
<tr>
<td>90707</td>
<td>SL</td>
<td>Administration of immunization; measles, mumps and rubella virus vaccine (MMR) live, for subcutaneous use</td>
</tr>
<tr>
<td>90710</td>
<td>SL</td>
<td>Administration of immunization; measles, mumps, rubella, and varicella vaccine live, for subcutaneous use</td>
</tr>
<tr>
<td>90713</td>
<td>SL</td>
<td>Administration of immunization; polio virus vaccine, inactivated, (IPV) for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90714</td>
<td>SL</td>
<td>Administration of immunization; tetanus and diphtheria toxoids (Td) absorbed, preservative free, for use in individuals 7 years or older, for intramuscular use</td>
</tr>
<tr>
<td>90715</td>
<td>SL</td>
<td>Administration of immunization; tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use</td>
</tr>
<tr>
<td>90716</td>
<td>SL</td>
<td>Administration of immunization; varicella virus vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90723</td>
<td>SL</td>
<td>Administration of Immunization; diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use</td>
</tr>
<tr>
<td>90732</td>
<td>SL</td>
<td>Administration of immunization; pneumococcal polysaccharide vaccine, 23- valent, adult or immunosuppressed patient dosage for use in individuals 2 years or older, for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90734</td>
<td>SL</td>
<td>Administration of immunization; meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use</td>
</tr>
<tr>
<td>90744</td>
<td>SL</td>
<td>Administration of immunization; hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule) for intramuscular use</td>
</tr>
<tr>
<td>90748</td>
<td>SL</td>
<td>Administration of immunization; hepatitis B and Hemophilus influenza B vaccine (HepB-Hib) for intramuscular use</td>
</tr>
</tbody>
</table>

### 2.6 SPECIALTY CARE PROVIDERS

#### 2.6.1 Responsibilities of the Specialty Care Provider

The following is an overview of the responsibilities the specialty care provider assumes when providing care to Aetna Better Health of Missouri members:

- Verify member eligibility with MO HealthNet at every visit or encounter prior to rendering services (MO HealthNet: ARU Line, Infocrossing website: www.emomed.com, Emdeon: www.emdeon.com, or the Provider Secure Web Portal).
- Refer the member to their assigned PCP or contact the PCP for verbal approval for non-emergent visits not directed by the PCP.
- Follow Aetna Better Health of Missouri’s prior authorization guidelines when directing the member to receive diagnostic, home care, inpatient, outpatient or additional services.
- Communicate in writing with the PCP to ensure continuity of health services for ongoing treatment. Mail or fax all summaries, evaluations or recommendations within two (2) weeks from the date of service.
- Coordinate with the PCP the need for additional medical treatment identified during well-woman exams.
• Maintain a comprehensive and legible medical record.
• Adhere to provider access and availability guidelines for scheduling appointments and waiting times.
• Provide all of the health care services and supplies that are Medically Necessary, that are generally available at Provider and which Provider is licensed to provide to Members and that are covered under the terms of the applicable Benefit Plan.
• Provide covered services in accordance with the terms of their applicable Participating Provider Agreement and the bylaws, rules, regulations, policies and procedures of provider and its medical staff.
• Provider agrees to provide or arrange for the provision of covered services in conformity with generally accepted medical and surgical practices in effect at the time of service.
• Participating providers may not discriminate against MO HealthNet Managed Care members or provide treatment differently from other persons receiving services.

2.6.2 Transfer of Information Between Providers

During the orientation process, Aetna Better Health of Missouri’s provider relations representatives will educate the provider and their office staff on the following requirements to ensure continuity of care for members.

If a Aetna Better Health of Missouri member changes their specialty care provider, the current specialty care provider will forward (at no cost to the health plan or member) the member’s medical records within ten (10) days of request to the member’s new specialty care provider, or prior to the next scheduled appointment with the provider, which ever is earlier.

2.7 HOSPITAL PROVIDERS

2.7.1 Responsibilities of the Hospital Provider

The following is an overview of the responsibilities a hospital provider assumes when providing care to Aetna Better Health of Missouri members:

• Verify member eligibility with MO HealthNet at every visit or encounter prior to rendering services (the MO HealthNet: ARU Line, Infocrossing website: www.emomed.com, Emdeon: www.emdeon.com, or the Provider Secure Web Portal).
• Follow Aetna Better Health of Missouri’s prior authorization guidelines.
• Participate in concurrent review process and discharge planning process.
• Promote access to quality care by directing members to utilize Aetna Better Health of Missouri network providers, with the approval of member’s PCP or directing provider.
• Coordinate with the member’s PCP or directing provider the need for additional treatment or medical services by other network providers and obtain authorizations, as needed.
• Maintain a comprehensive and legible medical record and make such record available upon request.
• Provide all of the health care services and supplies that are Medically Necessary, that are generally available by provider and which provider is licensed to provide to members and that are covered under the terms of the applicable Benefit Plan.
• Provide covered services in accordance with the terms of their applicable Participating Provider Agreement and the bylaws, rules, regulations, policies and procedures of provider and its medical staff.
• Provide or arrange for the provision of covered services in conformity with generally accepted medical and surgical practices in effect at the same time of service.
• Send ER reports to the members PCP, as identified by the member or confirmed via the Provider Secure Web Portal.
• Submit medical records to support the authorization and billing of services as requested.
• Obtain prior authorization for services in accordance with the authorization directory.
• Participating providers may not discriminate against MO HealthNet Managed Care members or provide treatment differently from other persons receiving services.
2.8 ANCILLARY PROVIDERS

2.8.1 Responsibilities of the Ancillary Provider

The following is an overview of the responsibilities an ancillary provider assumes when providing care to Aetna Better Health of Missouri members:

- Verify member eligibility with MO HealthNet at every visit or encounter prior to rendering services (the MO HealthNet: ARU Line, Infocrossing website: www.emomed.com, Emdeon: www.emdeon.com, or the Provider Secure Web Portal).
- Follow Aetna Better Health of Missouri’s prior authorization guidelines.
- Promote access to quality care by directing members to utilize Aetna Better Health of Missouri network providers, with the approval of member’s PCP or directing provider.
- Coordinate with the member’s PCP or directing provider the need for additional treatment or medical services by other network providers and obtain authorizations, as needed.
- Maintain a comprehensive and legible medical record.
- Provide all of the health care services and supplies that are Medically Necessary, that are generally available by Provider and which Provider is licensed to provide to Members and that are covered under the terms of the applicable Benefit Plan.
- Provide covered services in accordance with the terms of their applicable Participating Provider Agreement and the bylaws, rules, regulations, policies and procedures of provider and its medical staff.
- Provide or arrange for the provision of covered services in conformity with generally accepted medical and surgical practices in effect at the time of service.
- Participating providers may not discriminate against MO HealthNet Managed Care members or provide treatment differently from other persons receiving services.

2.9 ENCOUNTER DATA/CLAIM SUBMISSION REQUIREMENT

Aetna Better Health of Missouri is mandated by our contract with MO HealthNet to report encounters. Aetna Better Health of Missouri requires claims and encounter data to be submitted using a UB or CMS form. Claims must be received within ninety (90) days from the date of service for office level/outpatient services or from the date of discharge for inpatient services. Corrected claims must be received within 180 days from the initial remittance advice date. It is necessary for corrected claims to include all original claim lines, including those previously paid correctly. Please refer to Section 15: Claims and Reimbursement for additional information.

2.10 PROVIDER ACCESS GUIDELINES

2.10.1 Appointments Scheduling and Availability Standards

The following access and availability standards must be provided by all participating providers:

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>Appointment Type</th>
<th>Access/Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Emergent</td>
<td>Immediately</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Urgent care</td>
<td>Within twenty-four (24) hours</td>
</tr>
<tr>
<td>Routine care</td>
<td>Routine care</td>
<td>Within one (1) week or five (5) business days, whichever is earlier</td>
</tr>
<tr>
<td>Routine care</td>
<td>Routine care</td>
<td>Thirty (30) calendar days of request</td>
</tr>
</tbody>
</table>

www.aetnabetterhealth.com/mo Provider Relations 1-800-566-6444
### Maternity Care

<table>
<thead>
<tr>
<th>Category (Initial Pre-natal Care Services)</th>
<th>Access/appointment standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members within their first trimester</td>
<td>Within seven (7) calendar days of first request</td>
</tr>
<tr>
<td>Members within their second trimester</td>
<td>Within seven (7) calendar days of first request</td>
</tr>
<tr>
<td>Members within their third trimester</td>
<td>Within three (3) calendar days of first request</td>
</tr>
<tr>
<td>Members identified with high-risk pregnancies</td>
<td>Within three (3) calendar days of identification of high-risk factors by Aetna Better Health of Missouri or maternity care provider or immediately if an emergency exists</td>
</tr>
</tbody>
</table>

### Behavioral Health & Substance Abuse Services

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Appointment/Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare appointments (post admission)</td>
<td>Within seven (7) calendar days after hospital discharge</td>
</tr>
<tr>
<td>Care for non-life threatening emergency</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Routine Visits</td>
<td>Within 2 weeks or ten (10) business days</td>
</tr>
<tr>
<td>Follow-up Routine Care</td>
<td>Within 30 calendar days</td>
</tr>
</tbody>
</table>

#### 2.10.2 Waiting Times Standard

The average waiting time for appointments should not exceed one (1) hour from scheduled appointment time. This includes time spent in the lobby and the examination room, prior to being seen by a provider. Appointment log books or sign-in sheets must be maintained for at least one (1) year by providers to demonstrate compliance with this requirement.

Exception: Waiting times may be longer when the provider works in urgent care appointments; a serious problem is identified; or the patient has an unknown need or condition that requires more services or education than was described at the time the appointment was made.

#### 2.10.3 Missed Appointments/Scheduled Appointment Follow-Up Guidelines

Providers should contact members regarding missed appointments. The following guidelines should be used to track compliance and assist members with keeping scheduled appointments:

- Contact phone numbers should be requested and confirmed with the member at each appointment.
- If the member fails to keep his/her scheduled appointment, the provider office staff should document the occurrence in the member’s medical record.
- The office staff may contact Aetna Better Health of Missouri’s Member Services Department at 1-800-566-6444 for assistance when members cannot be reached by telephone to verify appointments.
- Providers should encourage member compliance to minimize no-shows. Provider offices should provide a return appointment card for each member and are encouraged to make a reminder call one (1) day before a scheduled appointment.
- Providers may not bill or collect fees from members for missed appointments.
- Providers should encourage members to contact Member Services to arrange transportation, if the member has the benefit.

#### 2.10.4 24 Hour Access to Care Standard

Providers are required to ensure access to care is provided twenty-four (24) hours a day, seven (7) days a week. Providers are required to arrange and maintain after-hours on call coverage with participating providers. Providers may request Aetna Better Health of Missouri’s Member Services Department call members to educate about chronic missed appointments.

The provider relations department conducts surveys with randomly selected primary care, maternity care and high volume specialty care providers to determine compliance with appointment standards. Our staff makes contact with providers and reviews appointment and after hours access to determine compliance with standards. Continued non-compliance will result in formal corrective action.
2.10.5  **After-Hours Access Standards**

Providers are responsible for providing care or directing access to care twenty-four (24) hours a day, seven (7) days a week. This involvement ensures the overall quality and continuity of care for the member.

Provider relations randomly selects and surveys providers after their normal business hours to monitor compliance. Providers who do not meet the criteria for after-hours access are contacted by their provider relations representative. Continued non-compliance will result in formal corrective action.

- **Aetna Better Health of Missouri 24-Hour Nurse Line: 1-800-475-1142**

  Aetna Better Health of Missouri’s 24-Hour Nurse Line is available to all members to assist with questions regarding medical concerns. The 24-Hour Nurse Line will assist members in obtaining emergency services. Aetna Better Health of Missouri’s participating providers are expected to respond to after-hours calls within thirty (30) minutes of call received.

  After-hours care and services can be coordinated through the Aetna Better Health of Missouri 24-Hour Nurse Line at **1-800-475-1142**. Aetna Better Health of Missouri’s Pre-authorization Department will give authorization on the next business day upon presentation of clinical information for the care provided.

- **Covering Providers**

  Providers may use a back-up provider for on-call coverage in order to provide services twenty-four (24) hours a day, seven (7) days a week. The coordination of on-call coverage and reimbursement of the back-up provider is the sole responsibility of the arranging provider. Providers should utilize other Aetna Better Health of Missouri participating providers for back-up coverage arrangements and ensure they are knowledgeable or have access to Aetna Better Health of Missouri policies and requirements.

- **Phone Line Transfer**

  Phone line is transferred directly to physician’s designated after hours number (i.e. mobile, or answering service).

- **After Hours Message**

  The after hour message provides the answering service phone number or Aetna Better Health of Missouri’s 24-hour Nurse Access Line phone number for the covering/back-up provider.

Note: Aetna Better Health of Missouri does not accept automatic referrals of members to hospital emergency departments or urgent care centers as acceptable after-hours coverage arrangements.

2.10.6  **PCP Capacity & PCP to Member Ratio Standards**

Aetna Better Health of Missouri has established the following primary care provider/extender to member standard in order to measure provider capacity for its provider network and ensure adequate network capacity of primary care providers by region.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>PCP to Member Capacity Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care providers (Pediatrics, General Practice, Family Practice, Internal Medicine, FQHC clinics and RHC clinics)</td>
<td>1: 2000 = 1 Practitioner to 2000 patients</td>
</tr>
<tr>
<td>Physician extenders (Nurse practitioners, Physician Assistants, Certified Nurse Midwife)</td>
<td>1:1000 = 1 Physician Extender to 1000 patients</td>
</tr>
</tbody>
</table>

PCPs are required to notify Aetna Better Health of Missouri in writing with at least 60 days notice when they have reached 85% capacity or if they intend to close their panel to Aetna Better Health of Missouri.

2.10.7  **Geographic Availability Standards**

Aetna Better Health of Missouri utilizes travel distance standards as set forth by the Missouri Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 and as required by contract with MO HealthNet.
2.10.8 Hours of Operation Parity
Providers must offer hours of operation to Aetna Better Health of Missouri members that are no less (in number or scope) than the hours of operation offered to other non-MO HealthNet patients.

2.10.9 Monitoring of Provider Access Standards
Monitoring of network provider access and availability will be completed to ensure that the sufficiency of its network will meet the health care needs of members. To monitor compliance with accessibility and availability standards, Aetna Better Health of Missouri will:

- Reviewing quarterly results of the geo-mapping reports, completed by utilizing industry-standard software, to monitor compliance with geographic availability standards
- Review the annual results of the Consumer Assessment of Health Plans Study (CAHPS), a member satisfaction survey, to monitor compliance with the accessibility standards
- Monitoring of member complaints
- Monitor after-hours telephone accessibility through random after hours phone audits
- Monitor appointment accessibility through secret shopper surveys

2.10.10 Resolution of Insufficiencies
Providers found to be out of compliance will be put under a Corrective Action Plan (CAP) and will be monitored until the deficiency is corrected to the satisfaction of Aetna Better Health of Missouri. Providers with an unresolved CAP or who do not make corrections to the satisfaction of Aetna Better Health of Missouri may be subject to other action by Aetna Better Health of Missouri, including but not limited to termination.

2.11 PROVIDER REIMBURSEMENT
Please refer to your Provider Agreement for information regarding reimbursement rate information.

2.11.1 Balance Billing of Members
Providers shall accept payment in full for covered services rendered to members and such amounts as are paid by Aetna Better Health of Missouri. In no event (including non-payment by Aetna Better Health of Missouri for covered services rendered to members by provider for whatever reason, including claim submission delays and/or UM sanctions, insolvency of Aetna Better Health of Missouri or breach by Aetna Better Health of Missouri of any term or condition of the agreement under which provider participates) shall provider bill, charge or collect a deposition from, seek compensation, remuneration or reimbursement from, or have any course against any member or a person (other than Aetna Better Health of Missouri) acting on a member's behalf for covered services eligible for payment, nor shall provider bill a member or a person (other than Aetna Better Health of Missouri) acting on a member's behalf for the difference between the covered charge and the negotiated rate or the amount provider has agreed to accept as full payment under the agreement for any amounts Plan may owe provider or for any monies in excess of applicable co-payments, deductibles or coinsurance, except as otherwise noted below. Provider shall in no event seek payment from any member for any service for which Aetna Better Health of Missouri has denied payment on the grounds that provider has failed to comply with the requirements with respect of such service, including, but not limited to, the failure of Provider to obtain required preauthorization. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills the health plan for the service that has been provided, the prior arrangement with the member becomes null and void.

Provider shall collect from the member and may retain only co-payments, deductibles or charges for services which are not covered services under the member's benefit plan as long as the charges are not charges for reimbursable services. In the event a member requests non-covered services, a provider may render non-covered services to a member so long as provider has obtained a detailed, easy to understand, request for such non-covered services stated clearly in writing and the member clearly understands and has been informed and acknowledged in writing that Aetna Better Health of Missouri will not cover such services. This does not prohibit provider from pursuing available legal remedies including, without limitation, collecting from any insurance carrier providing coverage to an individual.

If a member reports that a provider is balance billing for a covered service, the provider will be contacted by an Aetna Better Health of Missouri provider relations who is researching the report. Aetna Better Health of Missouri is obligated to notify MHD when a provider continues the inappropriate practice of balance billing a member. Failure to comply with these provisions may
result in sanctions including, without limitation, loss of reimbursement, payment of any member’s or Aetna Better Health of Missouri’s costs of defense or collection arising out of such failure, up to and including financial penalties and/or termination of participation:

Provider further agrees that this hold harmless requirement:

• shall survive the termination of the provider’s contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of members and Aetna Better Health of Missouri
• supersedes any oral or written contrary agreement now existing or hereafter entered between provider and a member or a person acting on his/her behalf
• shall be included in any subcontracts between provider and any other provider for the provision of covered services to plan members.

2.11.2 Aetna Better Health of Missouri MO HealthNet Fee Schedule

Aetna Better Health of Missouri’s MO HealthNet fee schedule is based upon the methodology, coding and allowable established by MHD for the MO HealthNet fee schedule and Aetna guidelines. Updates to the fee schedule; including but not limited to CPT code additions/deletions are necessary on occasion. All necessary changes to the fee schedule will be updated within thirty (30) days of Aetna Better Health of Missouri’s notification by MO HealthNet. Codes manually priced by MO HealthNet (PI=6) will be reimbursed at 35% of eligible billed charges. Codes listed with PI-9 are non-covered services and are not payable.

2.11.3 MO HealthNet Provider Bulletins

At times, MHD will publish policy changes regarding coverage or reimbursement via MHD provider bulletins, which are available on the MHD website at www.dss.mo.gov/mhd/providers. Aetna Better Health of Missouri strongly encourages providers to frequently visit the MHD website for changes in MHD policies regarding coverage and reimbursement.

2.12 COMMUNICATION WITH MEMBERS

Aetna Better Health of Missouri does not prohibit providers from giving members information regarding treatment options, or from discussing with members how their benefit coverage relates to a member’s medical needs. Providers are not prohibited from advocating on behalf of a member, or informing the member of their right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

2.13 PROVIDER TERMINATION

2.13.1 Provider Notification Requirement

Providers are required to provide at least 90 days advance written notice of termination, after the initial term of the Agreement. Please refer to your Participating Provider Agreement for specifics. All termination notices should be sent to

Aetna Better Health of Missouri
Attn: Provider Relations
10 S. Broadway Ste. 1200
St. Louis, MO 63102

2.13.2 Termination by Aetna Better Health of Missouri

Aetna Better Health of Missouri may reduce, suspend or terminate network participation privileges due to the following circumstances:

• Termination, revocation, or suspension of provider’s license, certification, or accreditation in a final disciplinary action by a state licensing board or other governmental agency.
• Provider’s suspension or termination from participation in Medicare or MO HealthNet.
• Termination of provider’s professional liability insurance.
• Conviction of, or plea of no contest to, a felony or any criminal charge relating to health care delivery.
Aetna Better Health of Missouri determines in good faith that the provider’s performance is inadequate or that continued provision of services to members may result in, or is resulting in, danger to the health, safety or welfare of members. Where the danger results from the actions of provider’s staff, contractors or subcontractors, then provider shall suspend its relationship with such staff, contractors, subcontractors upon immediate notice from Aetna Better Health of Missouri, at least with respect to members, and if providers fails to take such action, Aetna Better Health of Missouri may terminate the provider agreement upon ten (10) days notice.

Aetna Better Health of Missouri will conduct all contract terminations in accordance with Missouri Revised Statutes 354.609.2.

2.13.3 Member Notification of Provider Terminations

Aetna Better Health of Missouri will be solely responsible for notifying members when an in-network primary care provider or other provider seen on a regular basis, (such as a practitioner or practice group in general, family or internal medicine or pediatrics) is no longer participating. Aetna Better Health of Missouri will notify members at least 30 calendar days prior to the effective date of the termination, or upon becoming aware of the termination but no later than 15 calendar days after receipt of the notification, and will help them select a new practitioner.

2.13.4 Continuation of Care after Termination

For members who are disabled, in the second or third trimester of a pregnancy, or have a life threatening illness, or for members who are undergoing active treatment for a chronic or acute medical condition, a terminating provider may be required to continue caring for such members following the termination date, through the current period of active treatment; OR for a period of up to 90 calendar days whichever is less when it is medically necessary and in accordance with the dictates of medical prudence. In the case of a pregnant member, continuation of care shall continue through the postpartum period for members in their second or third trimester.

Such provision for the continuation of care shall guarantee that the member is not liable to the terminating provider for any amounts owed for medical care other than deductibles or co-payments specified in the member’s benefit plan.

2.14 PROVIDER AGREEMENT

The Aetna Better Health of Missouri Participating Provider Agreement is the document which includes the signature page, the General Provisions, all Attachments and all documents attached to or incorporated by reference, sometimes referred to as the provider contract. As stated in the Provider Agreement, the Provider Manual is incorporated into the Agreement and the terms and conditions set forth in the Provider Manual shall control in the event of a conflict with the General Provisions of the Agreement or any Attachment.

This manual is intended to be used as an extension of the Aetna Better Health of Missouri Participating Provider Agreement and as a communication tool and reference guide for providers and their office staff. While the provider manual contains basic information about the MO HealthNet (MHD) Managed Care Program and the Centers for Medicare and Medicaid Services (CMS), providers are required to fully understand and apply MHD and CMS requirements when administering covered services. Please refer to Missouri Department of Social Services website is www.dss.mo.gov/ and the CMS website www.cms.hhs.gov.

For the purpose of this manual, “provider” refers to both practitioners (licensed health care professionals who provide health care services) and providers (institutions or organizations that provide services) that have agreed to provide Covered Services to health plan members pursuant to a Participating Provider Agreement (“contract”).

2.14.1 Subcontracting Services

Providers shall not subcontract any services required to be provided under their Agreement or any portion of their Agreement without prior written consent of Aetna Better Health of Missouri if the subcontract requires a member to receive covered services at locations other than provider locations.

2.15 TELEMEDICINE

Aetna Better Health of Missouri supports the use of Tele-health services and telemedicine as a means of increasing access to specialty and behavioral health care services. Tele-health services provided through advanced telecommunications technology from one location to another benefit Aetna Better Health of Missouri members. The medical information is exchanged in real-time communication from an Originating Site, where the patient is located, to a Distant Site, where the provider is located, allowing them to interact as if they are having a face-to-face session. Telemedicine offers members, particularly those in rural areas of the state, access to health care services without having to travel extensive miles for an appointment.
Aetna Better Health of Missouri is looking to the future to expand the use of non-traditional service delivery methods such as telemedicine in order to improve the quality of care members in rural areas by increasing access to specialty care and improving patient outcomes by decreasing delays in diagnosis and treatment.

Providers utilizing telemedicine services should submit claims according to the billing guidelines outlined by MO HealthNet. Please contact your provider relations representative if you add telemedicine services to your practice.

2.16   HOSPITAL ACQUIRED CONDITIONS/WRONG SITE/PERSON/PROCEDURE POLICY

Providers agree to abide by Aetna Better Health of Missouri’s policies regarding payment for provider preventable conditions (i.e. “never events”, health-care acquired conditions, serious preventable adverse events). Such policies are have been implemented pursuant to applicable Federal law (42 CFR § Parts 434, 438 and 447) and Missouri law (13 CSR 70-25.120; 70-15-200). The policies shall be provided upon written request and may be updated form time to time by Aetna Better Health of Missouri. Reimbursement for services associated with provider preventable conditions shall be determined solely in accordance with these policies.

2.17   PROVIDER SATISFACTION SURVEY

Annually Aetna Better Health of Missouri conducts a provider satisfaction survey. The survey is sent out to randomly selected participating providers. Survey results are compiled and reviewed with our health plan Quality committees and shared with providers via the provider newsletter.
SECTION 3: HEDIS

3.1 HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure that the public has the information it needs to reliably compare performance of managed health care plans. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA).

HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. Although not originally intended for trending, HEDIS results are increasingly used to track year-to-year performance. HEDIS is also one component of NCQA's accreditation process. HEDIS results must be collected and reported separately for populations covered by commercial insurance, Medicaid and Medicare.

HEDIS is used by more than 90 percent of America's health plans to measure performance, care and service. Altogether, HEDIS 2017 consists of 91 measures across 7 domains of care. Health plans use HEDIS results to see where they need to focus their improvement efforts and work collaboratively with providers to achieve their goals. Aetna Better Health of Missouri also has a member reminder system in place to educate members about the importance of receiving services included in the HEDIS measures.

3.2 KEY HEDIS MEASURES

HEDIS measures address a broad range of important health issues. Among them are the following:

- Annual Dental Visits
- Adolescent Well Care Visits
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with URI
- Asthma Medication Ratio
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Antidepressant Medication Management
- Lead Screening in Children
- Childhood and Adolescent Immunization Status
- Follow-up Care for Children prescribed ADHD medication
- Follow-up After Hospitalization for Mental Illness
- Prenatal and Postpartum visits

3.3 CALCULATING HEDIS RESULTS

To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by NCQA. The audit allows comparability across organizations and ensures validity and integrity of HEDIS data. It is required for organizations seeking NCQA accreditation or for reporting to NCQA public reporting products, such as Quality Compass®. Aetna Better Health of Missouri contracts with a NCQA licensed auditor and uses NCQA licensed software to extract the data for HEDIS from our claims system. For information not available in the claims system, Aetna Better Health of Missouri performs medical record reviews to extract the information from providers medical records. This combination of claims data and medical record reviews is called the “hybrid” methodology.

To ensure that HEDIS stays current, NCQA has established a process to evolve the measurement set each year. NCQA's Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans and others, debates and decides collectively on the content of HEDIS. This group determines what HEDIS measures are included and field tests determine how it gets measured.

3.4 HEDIS AND MEMBER SATISFACTION SURVEY

Included in HEDIS is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) which measures members’ satisfaction with their care in areas such as claims processing, customer service, communication with their health care providers and getting needed care quickly. Per our contract with MO HealthNet, Aetna Better Health of Missouri performs the Child Medicaid CAHPS® survey per region (Eastern Missouri, Central Missouri, and Western Missouri) annually. Aetna Better Health of Missouri contracts with a NCQA certified survey company to perform the annual CAHPS® survey.
3.5 HEDIS FREQUENTLY ASKED QUESTIONS (FAQ)

Some frequently asked questions regarding HEDIS data collection are addressed below.

A. Why does Aetna Better Health of Missouri collect HEDIS data?

The collection and reporting of HEDIS data is required by MO HealthNet and by accrediting bodies such as the National Committee for Quality Assurance (NCQA). The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

B. How are HEDIS measures generated?

HEDIS measures can be generated using three different data collection methodologies:
- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of members along with claims and encounter data)
- Survey

C. Why does Aetna Better Health of Missouri need to review medical records when it has claims data for each encounter?

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings and results of tests that may not be available in claims/encounter data. Typically, an Aetna Better Health of Missouri Quality Improvement employee will call the physician's office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the provider to fax or mail the specific information.

D. How accurate is the HEDIS data reported by Aetna Better Health of Missouri?

HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by Aetna Better Health of Missouri, so the Plan may ask for copies of records for audit purposes. Aetna Better Health of Missouri also monitors the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

E. Is patient consent required to share HEDIS related data with Aetna Better Health of Missouri?

The HIPAA Privacy Rule permits a provider to disclose protected health information to Aetna Better Health of Missouri for the quality related health care operations of the health plan, including HEDIS, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506(c)(4). Thus, a provider may disclose protected health information to a health plan for the plan’s HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

F. May the provider bill Aetna Better Health of Missouri for providing copies of records for HEDIS?

According to the terms of their contract, providers may not bill either the plan or the member for copies of medical records related to HEDIS.

G. How can providers reduce the burden of the HEDIS data collection process?

We recognize that it is in the best interest of both the provider and the plan to collect HEDIS data in the most efficient way possible. Options for reducing this burden include
- Provide the health plan remote access to provider electronic medical records (EMRs)
- Set up electronic data exchange from the provider EMR to the health plan
- Enroll in Missouri’s health information exchange
- Enter immunization data into Missouri’s immunization registry (ShowMeVax). (For more information, refer to Missouri Department of Health and Senior Services website at health.mo.gov/living/wellness/immunizations/showmevax.php.)

Please contact the Aetna Better Health of Missouri Quality Improvement department for more information.
H. How can providers obtain the results of medical record reviews?

Aetna Better Health of Missouri’s Quality Improvement department can share the results of the medical record reviews performed at your office and show you how your results compare to that of the plan overall. Please contact the Aetna Better Health of Missouri Quality Improvement department for more information.

3.6 HEDIS GAPS IN CARE REPORTS ON PROVIDER SECURE WEB PORTAL

Aetna Better Health of Missouri makes available HEDIS Gaps in Care Reports via our Secure Web Portal. These reports are a guide providers can use to identify Aetna Better Health of Missouri members who are missing key preventative services. Providers should then contact and educate the member so that the service can be scheduled.
SECTION 4: PREVENTIVE CARE SERVICES

4.1 ADULT HEALTH SCREENING

The adult health screening assesses the health status of a MO HealthNet recipient over age twenty (20). It is to be used to detect and prevent disease, disability, and other health conditions or their progression. Physicians providing this service must be able to provide or coordinate the provisions of all required components. The recommended adult health screening schedule is below. Aetna Better Health of Missouri will cover adult health screening consistent with recommendations of the U.S. Preventive Service Task Force (USPSTF) found online at www.uspreventiveservicestaskforce.org. A copy of these clinical practice guidelines are available by contacting your provider relations representative or the QI department. The recommended adult health screening includes:

4.1.1 Components of Adult Health Screenings

The recommended adult health screening includes:

- Health history:
  - Present - current medicines, allergies, health behaviors, mental status
  - Past - immunizations, illness, transfusions or blood products, IV drug use, etc.
  - Family history
  - Risk factors - alcohol, drug use, tobacco use, sun exposure, radiation, sexual activity, occupational hazards, asbestos exposure, exposure to known carcinogens
  - Nutritional assessment - weight loss or gains, BMI measurement, consumption of meals, dietary habits

- Physical examination includes measurements of height, weight, blood pressure, pulse. Physical inspection includes general appearance, skin, gross eyes, ears, nose, throat, oral, thyroid, heart, lungs, abdomen, breasts, pelvic, testicular, rectal exam, prostate, and extremities.

- Visual acuity (E Chart or Snellen chart)
- Hearing Screen (Weber, Rinne, or Puretone)

- Laboratory procedures include:
  - Urinalysis dipstick for blood, sugar, and acetone
  - Hemoglobin and/or hematocrit
  - Stool for occult blood - as indicated, recommended for adults over forty (40)
  - Tuberculin skin test - as indicated, recommended for adults over forty (40)
  - Collection of cervical Pap smear recommended annually unless advised otherwise by a health care provider
  - Collection of specimens for sexually transmitted diseases, as indicated

- Mammogram screening guidelines:
  - For females: Every 1-2 years - 40 years of age and older

- Diagnostic mammography is performed when medically indicated.
- Referral for treatment can be made when health problems or deficiencies are diagnosed. If abnormal test results are obtained, make a referral from the screening when necessary.
- Conduct a behavioral health screening to determine if the member needs behavioral health services.

4.2 EARLY PERIODIC SCREENING DIAGNOSIS TREATMENT (EPSDT)

Medicaid law was amended in 1967 to include preventive and primary health care services for children under the age of twenty-one (21). This amendment to Title XIX of the Social Security Act requires every state with a Medicaid program to provide Early Periodic Screening Diagnosis Treatment (EPSDT) services to children. PCPs are responsible for educating their members on the schedule and follow up requirements of EPSDT examinations. The provider relations department is available to conduct an EPSDT orientation for any provider who will provide EPSDT services.
4.2.1 What is EPSDT?

EPSDT is an acronym used to describe the federal health care screening program for Medicaid-eligible children. The EPSDT program offers preventative and primary health care for millions of the nation’s children. MO HealthNet has adopted the name Healthy Children and Youth (HCY) Program for the EPSDT federal program in Missouri.

E – Early - as soon as possible after eligibility is determined

P – Periodic - predetermined ages the member should be checked again (see schedule below)

S – Screening - quick, simple procedure used to identify and separate the well-child from those children with problems that require further attention

D – Diagnosis - a determination of the nature and cause of the problem. There are two (2) purposes for diagnosing:
- To confirm or rule out the problem
- To develop a plan for dealing with the problem

T – Treatment - services needed to control or cure the problem. This includes:
- Prevention - immunizations
- Correction - eyeglasses, hearing aids
- Limitation of the effect - counseling or education to better understand the problem

Components of a full HCY/EPSDT screen includes the following:

• A comprehensive unclothed physical examination
• A comprehensive health and developmental history including assessment of both physical and mental health developments
• Health education (including anticipatory guidance)
• Appropriate immunizations according to age
• Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated)
• Lead screening at every EPSDT visit from six (6) months of age to six (6) years of age. A lead level lab test should be completed no less than by one (1) year of age and again by two (2) years of age regardless of the outcome of lead screening. Lead levels should also be completed whenever the lead screening identifies the member as at risk for an elevated lead level.
• Hearing screening
• Vision screening
• Dental screening beginning with the first tooth eruption, but no later than 1 year of age even if a tooth has not erupted.

It is not always possible to complete all components of the full medical HCY screening service. For example, immunizations may be medically contraindicated or refused by the parent/guardian. The parent/guardian may also refuse to allow their child to have a lead blood level test performed. When the parent/guardian refuses immunizations or appropriate lab tests, the provider should attempt to educate the parent/guardian with regard to the importance of these services. If the parent/guardian continues to refuse the service, the child’s medical record must document the reason the service was not provided. Documentation may include a signed statement by the parent/guardian that immunizations, lead blood level tests, or lab work was refused. By fully documenting in the child’s medical record the reason for not providing these services, the provider may bill a full medical HCY screening service even though all components of the full medical HCY screening service was not provided.

It is mandatory that the Healthy Children and Youth Screening guide* be retained in the patient’s medical record as documentation of the service that was provided. The Healthy Children and Youth Screening guide is not all-inclusive; it is to be used as a guide to identify areas of concern for each component of the HCY screen. Other pertinent information can be documented in the comment fields of the guide. The screener must sign and date the guide and retain it in the patient’s medical record.

Aetna Better Health of Missouri requires providers maintain adequate fiscal and medical records that fully disclose services rendered, retain these records for at least seven (7) years, and make them available to appropriate Aetna Better Health of Missouri staff, state and federal officials on request. The Healthy Children and Youth Screening guide may be photocopied or obtained at no charge from the MO HealthNet Division. Providers must have this form in the medical record if billing the screening.

* An electronic medical record is acceptable, if the electronic version contains all of the components listed on the HCY screening guide for the patient’s appropriate age group. See section E for information on how to obtain the HCY Screening Guides.
4.2.2 EPSDT Providers
Health departments, pediatricians, general family practice professionals, federally qualified health centers, rural health clinics, community health agencies, Head Start agencies and school based programs provide EPSDT services.

4.2.3 Abnormalities
- Problem is treated, or
- Patients are referred to providers, programs, or agencies that are qualified to treat the condition. It is the responsibility of the referring agencies/providers to follow-up on this referral to determine if treatment was initiated. Quality audits may also examine if providers are initiating this follow-up.

4.2.4 Member Referrals
- Dentists
- Pediatricians
- Sub-specialty agencies/physicians
- Specialty agencies
- Behavioral Health Providers
- Health department clinics:
  a. TB clinic
  b. WIC program
  c. Maternity clinic
  d. Family planning
  e. Lead clinics

4.2.5 Covered Services
Aetna Better Health of Missouri covers well care visits consistent with the American Academy of Pediatrics recommended well child periodicity schedule:

- newborn
- by 1 month
- by 2 months
- by 4 months
- by 6 months
- by 9 months
- by 12 months
- by 15 months
- by 18 months
- by 24 months
- by 30 months
- from 3 years – 20 years old, annually

NOTE: Aetna Better Health of Missouri will cover an EPSDT visit in addition to a sick visit, sports physical or a visit for another purpose or procedure on the same day. Please use modifier 25 on the E & M code to identify as separately reportable services.

4.2.6 Mandatory HCY/EPSDT Screening Guides
There are 2 mandatory forms related to HCY/EPSDT Services.

- The Missouri HCY Lead Risk Assessment guide for evaluating age specific children six (6) months to seventy-two (72) months of age for lead poisoning.
- The Missouri HCY/EPSDT Screening Guide must be completed at all HCY/EPSDT visits.

The forms are a mandatory part of the medical record. An Electronic Medical Record is acceptable, if the electronic version contains all of the components listed on the HCY screening guide for the patient’s appropriate age group.

Copies of these forms may be obtained free of charge from the following:

- Infocrossing, P.O. Box 5600, Jefferson City, MO 65102
- MO HealthNet Provider Services at 573-635-8908
- DSS website: www.dss.mo.gov/mhd

You may also contact your Aetna Better Health of Missouri provider relations representative to obtain a copy of the HCY Lead Risk Assessment guide and the HCY/EPSDT Screening guide.
4.2.7 Components of a Full HCY/EPSDT Medical Screen

4.2.7A INTERVAL HISTORY/PARENT’S CONCERNS/CHILD’S CONCERNS

The purpose of a health and developmental history is to gather information about diseases and health problems for which no standard screening test has been developed, and to compile historical information about the child and the family. Answers to a standard set of questions can identify those children who may be at a substantial risk of a significant health problem. The health and developmental history should also provide information about siblings, growth history, conditions suffered by blood relatives, previous medications, immunizations, allergies, and a developmental history of the child as well as other family members.

4.2.7B NUTRITIONAL ASSESSMENT

The assessment of children’s nutritional status and eating habits, (and the use of alcohol and tobacco), are taken at the time of the physical examination. Evaluation is also suggested for the following groups:

- Children who demonstrate weight loss or no weight gain over a period of time.
- Children who are considerably overweight in proportion to their height or greater than the 85th percentile according to the CDC BMI for age growth chart. Refer to the document library on Aetna Better Health of Missouri’s website www.aetnabetterhealth.com/mo for a copy of the BMI for age growth chart.
- Other variations from expected growth parameters such as weight for age and height for age below the 5th percentile.
- Disease in which nutrition plays a key role such as cardiovascular disease, hyperlipidemia, gastrointestinal disorders, hypertension, metabolic disorders, physical and mental handicaps affecting feeding, allergies, surgery. If information suggests dietary inadequacy, obesity or other nutritional problems, further assessment is indicated, including:
  - Family, socioeconomic or any community factors
  - Determining quality and quantity of individual diets (i.e., dietary intake, food acceptance, meal patterns, methods of food preparation/preservation, and utilization of food assistance programs)
  - Further physical and laboratory examinations
  - Preventive treatment and follow-up services, including dietary counseling and nutrition education
  - Provide intervention for those children considered to be at risk (85th percentile of BMI)

4.2.7C UNCLOTHED PHYSICAL EXAMINATION

The physical examination includes specific screening elements as appropriate for the child’s age and health history:

- General appearance
- Body measurements
- Skin evaluation
- Blood pressure
- Auscultation of heart and palpation of femoral arteries
- Pulmonary evaluation/auscultation of the lungs, chest configuration, and respiratory movements
- Pulse
- Abdominal evaluation of musculature, organs, masses
- Urogenital evaluation
- Vocalization and speech for appropriate age
- Facial features evaluation
- Neurological evaluation, including gross/fine motor coordination
- Orthopedic evaluation, including muscle tone and scoliosis
- Ears, eyes, nose and throat inspection
4.2.7D ANTICIPATORY GUIDANCE
Health education is a required component of screening services and includes anticipatory guidance. Health education and counseling to parents/guardians as well as children are required and designed to assist in understanding what to expect in terms of the child's development, and to provide information about the benefits of healthy lifestyles, practices, and accident and disease prevention.

4.2.7E LAB/IMMUNIZATIONS
Laboratory procedures appropriate for the individual's age and population groups are required under the EPSDT program. Refer to “Recommendations for Preventive Pediatric Health Care Bright Futures” by the American Academy of Pediatrics for the most current recommendations. A link to the guidelines can be found on the Aetna Better Health of Missouri website under Practice Guidelines.

4.7.7F LEAD SCREENING & TESTING
All children should have a lead test by 1 year of age and again by 2 years of age regardless of the outcome of the lead risk assessment and any time a child is found to be at risk through a lead screening. Aetna Better Health of Missouri has a lead case management program.

The HCY Lead Risk Assessment Guide is designed to allow the same document to follow the child for all visits from six (6) months to six (6) years of age. The HCY Lead Risk Assessment Guide has space on the reverse side to identify the type of blood test, venous or capillary, and also has space to identify the dates and results of blood lead levels. This form must be maintained as part of the medical record. The HCY Lead Risk Assessment Guide should be used at each HCY screening to assess the exposure to lead, and to determine the risk for high dose exposure.

A comprehensive lead risk assessment includes both the verbal lead risk assessment and blood lead level determinations.

The HCY Lead Risk Assessment Guide is available for providers' use on the Aetna Better Health of Missouri website www.aetnabetterhealth.com/mo. The tool contains a list of questions that require a response from the parent/guardian. A positive response to any of the questions requires blood lead level testing by capillary or venous method.

If you have any questions or need additional information related to lead screening and testing, please call Aetna Better Health of Missouri's Lead Case Manager at 1-800-213-7792.

4.2.7G DEVELOPMENT PERSONAL-SOCIAL AND LANGUAGE
The Department of Health and Senior Services (DHSS) and Centers for Medicare and Medicaid (CMS) define a developmental assessment as the range of activities surrounding the examination of the child, adolescent and young adult to determine whether they fall within the normal range of achievement for the child's age group and cultural background.

The developmental assessment is performed at the time of the screening for all ages. Information from the parent or others with knowledge of the individual, direct observation, and talking with the member are utilized to assess the individual's behavior.

It is recommended to include the following elements in the developmental assessment of children of all ages:

- Communication skills, focusing on expression, comprehension and speech articulation
- Self-help and self-care skills
- Social-emotional development, focusing on the ability to engage in social interaction with other children/adolescents, parents and other adults
- Cognitive skills, focusing on problem-solving and reasoning
4.2.7H FINE MOTOR/GROSS MOTOR

It is recommended to include an assessment of fine motor and gross motor development for children of all ages.

4.2.7I HEARING

Children should be tested using an appropriate test such as the Weber, Rinne, or Puretone Audiometric evaluation along with history from the parent/guardian.

4.2.7J VISION

Administration of age-appropriate vision assessment:

- General external examination and evaluation of ocular motility
- Gross visual acuity examination with fixation test
- Testing fight sense with pupillary light reflex test
- Intraocular examinations with ophthalmoscope

Standardized testing methods include:

- Visual acuity test for distance on each eye. The Illiterate E test, the STYCAR-, (Screening Test for Young Children and Retardates) or the Lippman Matching Symbol Chart - HOTV may be utilized. Children four (4) and five (5) years of age should be tested at ten(10) to (15) feet.
- To determine muscle balance, a cover test and the Hirschberg test (corneal light reflex) should be given. Parents should be asked if they have noticed the child’s eyes turn in or out.
- All individuals ages five (5) to twenty (20) years should be evaluated for distance visual acuity utilizing the Illiterate E or the Snellen letters for a linear fashion. The test should be at twenty (20) feet.
- Individuals who wear glasses should be tested while wearing their glasses.

4.2.7K DENTAL

The American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommend that children should see a dentist:

- When the first tooth appears or no later than the first birthday
- Twice a year for preventive services
- If there is evidence of infection, inflammation, discoloration, malformation of the dental arches, malformation or decay of erupted teeth.

4.2.8 Early Periodic Screening Diagnosis and Treatment (EPSDT) Billing and Reporting

Providers must submit Preventative Medicine CPT codes (99381-99395) along with appropriate modifier(s) to indicate performed screenings. According to MO HealthNet Division EPSDT billing guidelines, the primary diagnosis must be submitted as the first diagnosis in field 21 of the CMS claim form. Additionally, this same primary diagnosis must be reflected on the appropriate line item (field 24 E). In most instances, the primary diagnosis will be Z00.121 or Z00.129. Please refer to the MO HealthNet Division’s most current Professional Billing Booklet, Healthy Children and Youth Program Section for specific coding requirements. The link is www.dss.mo.gov/mhd/providers/education/pro/pro08.pdf.

Aetna Better Health of Missouri will provide coverage for an office visit performed at the same time as the HCY/EPSDT screening if the child was seen for a reason other than the EPSDT screening, (i.e., sick child visit). Additionally, Aetna Better Health of Missouri will provide coverage for an HCY/EPSDT screening performed during a prenatal visit for members twenty (20) and under. Providers must document appropriately in the member medical record to support the billing of both EPSDT and separately reportable E&M services.
### 4.2.8A HCY/EPSDT PREVENTATIVE MEDICINE CODING GRID

Full HCY Screening: Provider has completed and documented all ten (10) required components of the HCY/EPSDT screening, use EP modifier; in addition, if a referral for diagnostic or treatment services is made, add the UC modifier.

Partial HCY Screening: Provider has completed and documented segments of the full HCY/EPSDT screening, but not all ten (10) components, use the EP & 52 modifier; in addition, if a referral for diagnostic or treatment services is made, add the UC modifier.

**HCY/EPSDT AND PREVENTATIVE MEDICINE CODING GRID**

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifiers</th>
<th>Ages</th>
<th>Acceptable DX</th>
</tr>
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<tr>
<td>99381</td>
<td>EP</td>
<td>0-1</td>
<td>Members over 28 days old: Z00.121, Z00.129</td>
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<tr>
<td>99391</td>
<td>EP &amp; 52</td>
<td>0-1</td>
<td>Members Newborn through 7 days old: Z00.110</td>
</tr>
<tr>
<td></td>
<td>EP &amp; UC</td>
<td>0-1</td>
<td>Members 8 through 28 days old: Z00.111</td>
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<tr>
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<td>99392</td>
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<td>1-4, 5-11, 12-17, 18-20</td>
<td>Z00.121, Z00.129</td>
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</tbody>
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*UC must always be the last modifier.

**Note:** Aetna Better Health of Missouri will cover an EPSDT visit in addition to a sick visit. Please use modifier 25 on the E&M code to identify these as a separately reportable services.
4.4 CARE MANAGEMENT AND SUPPORT AVAILABLE FROM AETNA BETTER HEALTH OF MISSOURI

Aetna Better Health of Missouri educates members about the importance of HCY/EPSDT screenings. Aetna Better Health of Missouri sends member reminders when members are due for screenings and provides follow up reminders if screenings are not completed. Aetna Better Health of Missouri also provides scheduling assistance and transportation assistance or mileage reimbursement for those members who are eligible for the benefit.

Aetna Better Health of Missouri also provides care management services including case management programs, disease management programs and social work assistance for our members with special needs, complex medical conditions or chronic medical conditions. Please refer to Section VI for additional information about our care management programs.
SECTION 5: MEMBER SERVICES AND BENEFITS

5.1 MEMBER ELIGIBILITY AND VERIFICATION OPTIONS

5.1.1 Member ID Card

The Aetna Better Health of Missouri member ID card should be reviewed prior to rendering services. Any questions regarding benefit coverage should be directed to Aetna Better Health of Missouri Member Services at 1-800-566-6444.

Adult members must present the MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) as well as the health plan membership card, in order to access non-emergency services. The transfer of an identification card or membership card to a person other than the adult member for the purpose of using services constitutes a fraudulent act by the adult member.

5.1.2 Sample of Aetna Better Health of Missouri Member ID Card

![Sample of Aetna Better Health of Missouri Member ID Card]

1. Member Name
2. Member ID (MO Healthnet ID#)
3. Date of Birth
4. PCP Name
5. PCP Phone number
6. Effective Date
7. Claims submission information

5.1.3 Sample of CMPCN ID Card

The following ID card is for members in the Western Region who are members of the Children’s Mercy Pediatric Care Network (CMPCN). For more information, please refer to Section 8 of this provider manual.

![Sample of CMPCN ID Card]

1. Member Name
2. Member ID (MO Healthnet ID#)
3. Date of Birth
4. PCP Name
5. PCP Phone number
6. Effective Date
7. Claims submission information
8. CMPCN Logo
5.1.4  **Sample of State of MO HealthNet ID Card**

The following ID card is an illustration to show a sample ID card issued to MO HealthNet members.

![MO HealthNet ID Card Image]

5.1.5  **Other Eligibility Verification Options**

Members are encouraged to carry their Aetna Better Health of Missouri Member ID card at all times. Should a member present without an ID card, **services should not be denied**. Payment for services is always subject to member eligibility at the time of services. Due to “day specific eligibility” the provider is required to always verify the member’s eligibility by:

- Aetna Better Health of Missouri Provider Secure Web Portal
- Aetna Better Health of Missouri Member Services 1-800-566-6444
- Emdeon: [www.emdeon.com](http://www.emdeon.com); or
- Missouri HealthNet ARU Line: 573-635-8908; or
- Infocrossing website: [www.emomed.com](http://www.emomed.com)

To confirm the Aetna Better Health of Missouri member’s PCP selection, call Member Services at 1-800-566-6444.

5.2  **MEMBER RIGHTS AND RESPONSIBILITIES**

Aetna Better Health of Missouri 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 a 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 of Missouri requires compliance with member rights and responsibilities, especially treating members with respect and dignity. Understanding member’s rights and responsibilities are important because you can help members to better understand their role in and improve their compliance with treatment plans.

It is Aetna Better Health of Missouri 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 of Missouri is made aware of an issue with a member not receiving the rights as identified above, Aetna Better Health of Missouri 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 of Missouri is made aware of an issue when the member is not demonstrating the responsibilities as outlined above, Aetna Better Health of Missouri will make good faith efforts to address the issue with the member and educate the member on their responsibilities.
5.2.1 MO HealthNet Managed Care Health Plan Member Rights

- Be treated with respect and dignity
- Receive needed medical services
- Privacy and confidentiality (including minors) subject to state and federal laws
- Select their own PCP
- Refuse treatment
- Receive information about their health care and treatment options
- Participate in decision-making about their health care
- Have access to their medical records and to request changes, if necessary
- Have someone act on their behalf if they are unable to do so;
- Get information on our Physician Incentive Plan, if any, by calling 1-800-566-6444
- Be free of restraint or seclusion from a provider who wants to:
  - Make them do something they should not do
  - Punish them
  - Get back at them
  - Make things easier for him or her
- Be free to exercise these rights without retaliation
- Receive one copy of their medical records once a year at no cost to them
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of their benefit coverage
- Make recommendations regarding the organization’s member rights and responsibilities policy
- Privacy
- Voice their complaints or appeals about the organization or the care it provides
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities
- Participate with their health care providers in decision-making about their health care

5.2.2 MO HealthNet Managed Care Health Plan Member Responsibilities

- Call Aetna Better Health of Missouri to order a new member ID card if theirs is lost
- Show their Aetna Better Health of Missouri member ID card and their red or white MO HealthNet card when they see a provider. If they have a primary insurance, show that card also.
- Contact their PCP first when needing medical care
  - Only use the emergency room in an emergency
- Follow all instructions given by their health care provider
- Follow appointment scheduling rules
  - Make and keep PCP appointments or call ahead to cancel
  - Make sure their child sees his/her PCP for regular check ups and shots
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care
- Follow plans and instructions for care that they have agreed to with their providers
- Provide all the information (to the extent possible) that the organization and its practitioners and providers need to care for them
- Show their Aetna Better Health of Missouri member ID card at all health care offices
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
5.3 MEMBER ENROLLMENT

5.3.1 Member Enrollment into MO HealthNet

The MO HealthNet program is solely responsible for MO HealthNet member enrollment. Once eligibility is verified through Family Support Division (FSD), the MO HealthNet Managed Care eligible member must work with MO HealthNet’s enrollment broker to select a MO HealthNet Managed Care Plan and select a PCP from that health plan’s PCP listing. MO HealthNet then transmits a daily eligibility file to Aetna Better Health of Missouri to notify of member additions, terminations, and demographic changes. If a new Aetna Better Health of Missouri member has not selected a PCP, Aetna Better Health of Missouri’s Member Services will make a random PCP assignment on their behalf, based on availability and geographic location. For more information about MO HealthNet Managed Care member enrollment process, please visit the MHD website at www.dss.mo.gov/MHD/.

5.3.2 Newborn Enrollment

Family Support Division (FSD) will enroll newborns of eligible Aetna Better Health of Missouri members with Aetna Better Health of Missouri once the parent/guardian has completed the MO HealthNet newborn enrollment process. Unless the parent/guardian selects a different MO HealthNet Managed Care Plan, newborns born during the mother’s Aetna Better Health of Missouri enrollment period under Pregnancy ME codes 18, 43, 44, 45 and 61 are eligible to receive services from Aetna Better Health of Missouri. The state enrollment process must be completed to ensure timely and accurate claims processing of newborn claims. Any service payment issues related to newborn care should be directed to Claims Inquiry Claims Research at 1-800-566-6444.

Hospital social service coordinators usually initiate the process of educating and facilitating the parent/guardian of a Aetna Better Health of Missouri newborn to complete the MO HealthNet enrollment process. FSD enrolls newborns retrospectively enrolled with Aetna Better Health of Missouri to the date of birth when they are born to mothers eligible under Pregnancy ME codes 18, 43, 44, 45 or 61. Delayed newborn enrollment may cause claim reimbursement issues for providers. Contact FSD and/or your regional provider relations representative to facilitate the correction of the delayed enrollment, and to receive instructions on the process to submit your claim(s).

If the parent/guardian does not select a PCP for the newborn, Aetna Better Health of Missouri shall make a random PCP assignment once the newborn has been individually enrolled as a Aetna Better Health of Missouri member. Providers should call Member Services at 1-800-566-6444 or view Member Eligibility section on Provider Secure Web Portal to verify the PCP assignment.

5.3.3 Provider Restrictions Regarding Enrollment Activities

Providers shall not conduct or participate in health plan enrollment, disenrollment, transfer, or opt out activities or attempt to influence a member’s enrollment. Prohibited activities include:

- Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet Managed Care;
- Requiring or encouraging the member and/or guardian to use the opt out as an option in lieu of delivering health plan benefits;
- Mailing or faxing MO HealthNet Managed Care enrollment forms;
- Aiding the member in filling out health plan enrollment forms;
- Aiding the member in completing on-line health plan enrollment;
- Photocopying blank health plan enrollment forms for potential members;
- Distributing blank health plan enrollment forms;
- Participating in three-way calls to the MO HealthNet Managed Care Enrollment helpline;
- Suggesting a member transfer to another health plan; or
- Other activities in which the health plan, its representatives, or in-network providers are engaged in activities to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan (their own or another);
- Aiding the member in completing on line health plan enrollment

5.4 PCP ASSIGNMENT

5.4.1 PCP Assignment Process

Members are given the opportunity to select primary care providers (PCP) when they enroll in the MO HealthNet Managed Care Program. If a member does NOT select a PCP upon enrollment, Aetna Better Health of Missouri assigns one. Aetna Better Health of Missouri shall consider factors, such as language, location and special needs.
The member may request a PCP change if the provider was automatically assigned by Aetna Better Health of Missouri upon notification of the PCP assignment. A list of PCPs is made available to all members. Member services representatives are available to assist members with PCP selection.

Members are given the freedom to select participating PCPs based on age limit restrictions.

Members are encouraged to choose a PCP that is geographically convenient but are not restricted by any geographic locations.

Members may request to change their PCP assignment no more than two (2) times per year. Children in State custody or Foster Care placement are not limited to the number of PCP changes. PCP change requests may be backdated to the newborn's date of birth, if the request is made within 60 days of the birthdate. All other PCP change requests will be made effective the date of the request. Providers can assist members to update their PCP by completing the PCP Change Request fax form found on the Provider Secure Web Portal. The member or parent/guardian must agree to the change and sign the form which can be faxed to Member Services at 844-858-1806.

Members with disabling conditions and/or chronic illnesses may request a specialty care provider to act as a PCP. These requests will be reviewed by Aetna Better Health of Missouri’s Medical Director to ensure the requested specialist agrees to accept the role of PCP and assume all the responsibilities associated with this role.

5.4.2 Procedures for Members to Change PCP

Members may change their PCP, when eligible, by contacting Member Services at 1-800-566-6444.

All requests to change providers, exceeding the two (2) allowed per year after member’s initial PCP selection, shall be reviewed on a case-by-case basis. Aetna Better Health of Missouri may grant a member’s request to change PCPs more than twice per year if the member has concerns about the following:

- **Accessibility** - Appointments, telephone, or wait times
  Members have difficulty obtaining services due to office hours or dissatisfaction with response times, appointment waiting times, or telephone unavailability.

- **Attitude** - Office staff and/or provider
  Members believe the provider or office staff shows a lack of courtesy or lack of cultural sensitivity.

- **Quality** - Care provided by the provider and office staff
  Members are dissatisfied with how care is provided especially when the provider or office staff does not explain the treatment plan or diagnosis.

Members also have the right to request a PCP change through the member grievance process. When the PCP change is ordered as part of a resolution to a formal grievance proceeding, the change shall not be restricted.

5.4.3 Member Disenrollment from PCP Panel

The PCP may request the removal of a member from his/her panel when supporting documentation is presented. Circumstances that may warrant a disenrollment request include, but are not limited to:

- **Documentation of member’s failure to follow a recommended health care treatment plan.** This can occur after one (1) verbal or one (1) written warning of the implication and possible affect of non-compliance.

- **Documented chronic missed appointments.**

- **Documented behavior that is consistently disruptive, unruly, abusive or uncooperative.**

The PCP should follow the following guidelines to remove a member from his/her panel:

- **Provider must notify the member in writing by certified mail advising the reason for termination and to choose another PCP within thirty (30) days.**

- **Provider is required to manage care for urgent and emergent services during this time period.**

- **Provider must fax notification with supporting documentation to the provider relations department.**

Provider relations will review request and supporting documentation and if acceptable will contact Members Services to facilitate the selection of a new PCP and Case Management to address noncompliance issues identified by the PCP.
5.4.4 Member Disenrollment from Aetna Better Health of Missouri
MO HealthNet Division may disenroll members from a health plan for any of the following reasons included but not limited to:

- Selection of another health plan during open enrollment, the first ninety (90) calendar days of enrollment, or for just cause.
- Change of residence that places the member outside of the health plan’s region.
- To implement the decision of a hearing officer in a grievance proceeding by the member against the health plan, or by the health plan against the member.
- Loss of eligibility for either MO HealthNet Fee-For-Service or MO HealthNet Managed Care.
- Member exercises choice to voluntarily disenroll, or opt out, as specified herein under MO HealthNet Managed Care Program eligibility groups. (Example: When a pregnant member chooses to deliver by home birth.)

5.5 MEMBER EDUCATION AND RESOURCES

5.5.1 Member Handbook
Aetna Better Health of Missouri’s Member Handbook is written and designed in a member-friendly format. Major emphasis is placed on readability and understanding of benefits. Upon enrolling in Aetna Better Health of Missouri, a Member Handbook is mailed to each member household. The handbook is also on the Aetna Better Health of Missouri website.

5.5.2 Member Newsletters
Aetna Better Health of Missouri distributes a member newsletter entitled Member Newsletter, that emphasizes wellness and early intervention. Aetna Better Health of Missouri also uses Member Newsletter to communicate benefit updates and changes to members. The member newsletters are mailed directly to the member’s home address on file and are also available in the Member area on our website at www.aetnabetterhealth.com/mo.

5.5.3 New Member Packet
Educational and informational materials are periodically sent to our members, including a New Member Packet upon enrollment. The packet contains the following:

- Welcome letter
- Aetna Better Health of Missouri identification card with the member’s PCP’s contact information
- How to locate a participating provider by using the Locate A Provider function on www.aetnabetterhealth.com/mo
- Where to find a copy of Member Rights and Responsibilities
- How to file Member Grievance or Appeal
- Where to find a list of covered and non-covered benefits

All of this information is also available on our website at www.aetnabetterhealth.com/mo or by calling Member Services at 1-800-566-6444.

5.5.4 Member Outreach Program
Aetna Better Health of Missouri’s member outreach program provides targeted education to members through regular mailings, newsletters, and telephonically. These outreach efforts include:

- Education and information on available benefits
- Reminders for annual well-child visits, EPSDT, lead testing, and immunizations
- Disease management for members with health issues such as asthma and diabetes
- Birthday newsletters highlighting important preventive health information
- Targeted case management outreach and education on applicable health topics for members who qualify

5.6 MO HEALTHNET PROVIDER MARKETING GUIDELINES
Aetna Better Health of Missouri and its participating providers are allowed to educate and conduct outreach campaigns to reach MO HealthNet Managed Care eligible individuals; however, all activities are subject to MHD guidelines.
Participating providers are required to submit all member marketing and education materials to Aetna Better Health of Missouri prior to distribution to members. Aetna Better Health of Missouri will submit all marketing and educational materials to MHD on behalf of the participating providers for written approval.

The following are required marketing guidelines for Aetna Better Health of Missouri, its participating providers and subcontractors. Providers and subcontractors may advise MO HealthNet Managed Care members of the plans in which they participate through the following communications:

- Equally display a list of all plans in which they participate and not favor one health plan over another on displayed information.
- Equally display all contracted health plan logos.
- Provide all contracted health plan phone numbers.
- Provide equal representation for all contracted health plans.
- Displaying MO HealthNet enrollment help line phone number.
- A letter to previous fee-for-service recipients who may be eligible for MO HealthNet Managed Care, informing of all health plans the provider accepts.

Prohibited activities include:

- Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet Managed Care;
- Requiring or encouraging the member and/or guardian to use the SSI “opt out” as an option in lieu of delivering health plan benefits
- Mailing or faxing health plan enrollment forms
- Aiding the member in filling out health plan enrollment forms
- Photocopying blank health plan enrollment forms
- Distributing blank health plan enrollment forms
- Participating in three way calls with the MO HealthNet Managed Care Enrollment Helpline
- Suggesting a member transfer to another health plan
- Other activities in which the health plan, its representatives, or in-network providers are engaged in activities to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan (their own or another)

5.7 MEMBER BENEFITS

5.7.1 Benefit Determinations

The MO HealthNet Division has established a comprehensive standard benefit plan for all MO HealthNet Managed Care health plans. These MO HealthNet Managed Care benefits may differ from those provided through Missouri’s MO HealthNet Fee-For-Service program.

For specific questions or for clarification of covered benefits contact Aetna Better Health of Missouri’s Pre-authorization Department at 1-800-566-6444. The determination as to whether a specific service is covered is based upon, but not limited to, the following reasons:

- Services included in the MO HealthNet Managed Care’s standard comprehensive benefit plan
- Member’s eligibility and category of eligibility
- Identification of the service as a covered benefit in Missouri’s MO HealthNet fee schedule
- Documentation and/or presentation of the medical necessity for the service
- Utilization of participating providers, unless the service is not available in-network or in an emergency
- Aiding the member in completing online health plan enrollment

In the rare instance when an unlisted, unspecified or miscellaneous HCPCS code is used, providers must submit the clinical documentation and/or description of the code with the claim. Unlisted, unspecified or miscellaneous codes that do not include the additional documentation or description will adjudicate as “unlisted procedure code/submit notes or recode.”
Please be aware that a member must be eligible with Aetna Better Health of Missouri on the date the service is provided. Due to this date-specific eligibility the provider is required to verify the member’s eligibility through the State’s ARU line, www.emomed.com or the Provider Secure Web Portal on each and every date of service. Aetna Better Health of Missouri is not responsible for the reimbursement of services when MO HealthNet has retroactively terminated a member’s eligibility, even if authorization has been obtained.

5.7.2 Member Co-payments

MHD assigns each member to a particular category of aid, designated by an ME code. This code will identify members that are responsible for cost sharing (co-pays) on specific services. The co-pay for the service is identified when a member’s eligibility is verified via the MO HealthNet ARU line, www.emomed.com, or www.emdeon.com, and should be requested of the member on the date of service.

Services cannot be denied to any member on the basis of such member’s inability to pay an applicable co-payment, if the member is unable to pay the co-payment at the time of service. At this time, Aetna Better Health of Missouri members do not have any copayments. Please refer to Section 15 for information regarding coordination of benefits, for when members with primary coverage have copayments.

5.7.3 Medical Services

Aetna Better Health of Missouri has a network of contracted providers including hospitals, ancillaries, physicians, and advanced practice nurses available to cover all medically necessary services required by members. Please refer to the Locate A Provider option on Aetna Better Health of Missouri’s website at www.aetnabetterhealth.com/mo for a complete listing of network providers.

5.7.4 Reference Laboratory Services

Outpatient reference laboratory services must be directed to a contracted laboratory provider.

<table>
<thead>
<tr>
<th>PREFERRED PARTICIPATING LABORATORIES</th>
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<tbody>
<tr>
<td>Central</td>
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<tr>
<td>LabCorp of America</td>
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<tr>
<td>Quest Diagnostics</td>
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<td>Heartland Health Laboratories Inc</td>
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<tr>
<th>OTHER CONTRACTED LABORATORIES</th>
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<tbody>
<tr>
<td>Central</td>
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<tr>
<td>Boyce and Bynum Laboratory</td>
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<tr>
<td>MedTox (lead testing only)</td>
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<tr>
<td>Tamarac Medical (lead testing only)</td>
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Please refer to the Provider Search on the Aetna Better Health of Missouri website www.aetnabetterhealth.com/mo for a complete listing of contracted laboratories.

5.7.5 Emergency Services

Emergency medical services are those health care items and services furnished that are required to evaluate or stabilize a sudden and unforeseen situation or occurrence or a sudden onset of a medical, behavioral health or substance abuse condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent lay person, possessing average knowledge of health and medicine, to result in:

- placing the patient’s physical or behavioral health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
• serious impairment of bodily functions; or
• serious dysfunction of any bodily organ or part; or
• serious harm to self or others due to an alcohol or drug abuse emergency; or
• injury to self or bodily harm to others; or
• with respect to a pregnant woman who is having contractions:
• there is inadequate time to effect a safe transfer to another hospital before delivery; or
• transfer may pose a threat to the health or safety of the woman or the unborn.

Note: Emergent services are not subject to prior authorization, however Aetna Better Health of Missouri must be notified within ten (10) days following an emergency admission, service or procedure to request certification and/or continuation of treatment for that condition.

Aetna Better Health of Missouri will reimburse non-participating providers for the evaluation and/or stabilization of emergency conditions according to State guidelines. Aetna Better Health of Missouri shall accept the attending provider’s determination and continue reimbursement as an emergent level since the member’s medical stabilization has not been achieved.

Aetna Better Health of Missouri will contact members that inappropriately seek routine and non-emergent services through emergency department visits to educate the member on visiting their PCP for routine services and/or treatments.

Members that utilize ground ambulance transportation under the prudent lay person’s definition of emergency will not require authorization for the ambulance service.

Aetna Better Health of Missouri will reimburse non-participating providers for emergency services rendered to treat an emergency medical condition according to state guidelines, and in accordance with Section 6085 of the Deficit Reduction Act of 2005.

Emergency department charges incurred for a member who is admitted to hospital during the encounter will be included in the hospital’s per diem payment.

5.7.6 Dental Services

Aetna Better Health of Missouri is contracted with DentaQuest for the provision of dental services. Providers, members, or other responsible parties may verify dental benefits by contacting Aetna Better Health of Missouri’s Member Services at 1-800-566-6444.

Please refer to Section 9: Dental Services for additional information.

5.7.7 Behavioral Health and Substance Abuse

Behavioral health and substance abuse services are covered services for eligible (based on ME Code) Aetna Better Health of Missouri members. Aetna Better Health of Missouri provides a comprehensive range of behavioral health care services for Aetna Better Health of Missouri members with behavioral health coverage. Services include outpatient routine office visits for therapy and medication management, a broad range of hospital based services for both behavioral health and substance dependence disorders, home-based therapy services, and access to many helpful community based resources.

Providers, members or other responsible parties should contact Member Services at 1-800-566-6444 to verify available behavioral health and substance abuse benefits. We can also assist members and PCPs with provider referrals and with making appointments for members in need of therapy and/or psychiatry services.

Aetna Better Health of Missouri members and providers have access to specialty behavioral health Case Managers for assistance in obtaining both routine and higher complexity health care services. Aetna Better Health of Missouri primary care providers can also contact our case managers for assistance in facilitating specialty behavioral health services for our members.

Please refer to Section 7: Behavioral Health Services for more information about this program.

5.7.8 Pharmacy Benefits

Pharmacy services and coverage for Aetna Better Health of Missouri members are carved out and handled directly by MO HealthNet. Please refer to Section 13: Pharmacy of this provider manual for more information regarding pharmacy services.

5.7.9 Vision/Optical

Vision/Optical services are handled by our subcontractor, March Vision. Please refer to Section 12: Vision/Optical Services of this provider manual for more information regarding Vision Services.
5.7.10  Radiology/Imaging and Pain Management
Outpatient radiology/imaging and pain management prior authorization is handled by our subcontractor, eviCore. Please refer to Sections 10 and 11 for more information regarding Pain Management and Radiology/Imaging services.

5.7.11  Transportation Services (Non-Emergent & Emergent)

5.7.11A  NON-EMERGENCY MEDICAL TRANSPORTATION
Transportation service is a covered benefit for eligible members when it is necessary to receive non-emergent medically necessary health services. Aetna Better Health of Missouri is contracted with Medical Transportation Management (MTM) for the provision of these services. Providers, members, or other responsible parties should contact MTM at 1-800-688-3752 or Aetna Better Health of Missouri Member Services at 1-800-566-6444 to verify available transportation benefits.

5.7.11B  CRITERIA FOR NON-EMERGENCY MEDICAL TRANSPORTATION
- At the time of transport, the member must be eligible with Aetna Better Health of Missouri through a medical eligibility code that includes this benefit (ME Codes 02, 08, 52, 55, 57, 59, 64, 65, 73, 74, 75, 80, 82, 89 are excluded from this benefit).
- Member must have an appointment for a covered benefit or be in need of urgent medical care.
- If possible, requests for transportation should be made at least three (3) business days prior to a scheduled appointment.
- Requests for transportation for urgent care services may be made as needed. MTM will determine the mode of transportation at the time the request is made.

Non-emergent ambulance transports require prior authorization and are handled and coordinated through MTM Transportation by calling 1-800-688-3752.

5.7.11C  EMERGENCY TRANSPORTATION
Emergency transportation is provided for all members by phoning 911 or local emergency service number based on Missouri House Bill 335.

5.7.11D  MILEAGE REIMBURSEMENT FOR MEMBERS
Most Aetna Better Health of Missouri members are eligible for mileage reimbursement to and from most medical appointments (members who pay MO HealthNet a premium are not eligible).

Medical Transportation Management, Inc (MTM) requires a Mileage Trip Log be completed and signed by a provider or provider health care professional staff member for Aetna Better Health of Missouri members requesting mileage reimbursement for covered medical visits. MTM will verify the provider visit occurred before reimbursing a member for mileage.

If a member needs a Mileage Trip Log, it is available on the Aetna Better Health of Missouri website at www.aetnabetterhealth.com/mo. Providers cannot charge a Aetna Better Health of Missouri member for requesting a log.

5.7.11E  TRANSPORTATION LEVEL OF NEED ASSESSMENT FORM
The Level of Need (LON) Assessment Form is required when a member requests a mode of transportation that is of a higher level than the most efficient and effective mode available. For instance, if the member’s health plan has public transportation (i.e. bus) as an option for transport and the member refuses, preferring a taxi, MTM will require the provider to complete and return the LON Assessment Form located on our Provider Secure Web Portal. The member’s physical and psychological conditions will be reviewed to determine the most efficient mode of transportation using the LON assessment form.

Responses in the following areas of the LON Assessment Form are utilized to assess the member’s physical, cognitive and sensory abilities:

Patient travels to appointments with:
- Electric Wheelchair or Manual Wheelchair or Scooter or Walker or Cane
- The member is able to transfer into a van independently
- The member is unable to transfer independently but can transfer with assistance
• The member’s ability to communicate their needs
• The member’s ability to remove himself from an unsafe situation
• The member’s current above described needs are described as temporary or permanent

During the period between when the LON Assessment Form is faxed to the provider and it is returned, a temporary certification for the requested mode of transportation is granted for a period of two weeks.

Once the LON Assessment Form is returned via fax to 1-877-406-0568, it is reviewed by our Care Management staff to determine the most appropriate level of transportation service and length of certification. The trip is scheduled and the member is notified via telephone.

If the member is not satisfied with the mode of transportation granted, the MTM customer service representative will advise the member that the granted mode of transportation is based on information provided by their doctor. The member can communicate with their doctor and request they re-submit the LON Assessment Form to MTM with the updated information. If member is still dissatisfied and would to like to file an appeal, the member’s telephone call will be transferred to Quality Management.

5.7.12 Interpreter Services

Language can be one of the biggest barriers to members receiving the best health care Aetna Better Health of Missouri provides interpreter services to non-English speaking, and hearing or visually impaired members at their medical appointments. MHD is responsible for notifying Aetna Better Health of Missouri at the time of the member’s enrollment about this special need. Members may request from Member Services, the member handbook or other educational materials in alternate languages or formats.

To promote the delivery of quality health care services to all non-English speaking members, the provider and/or member may request interpreter services available by contacting Aetna Better Health of Missouri Member Services at 1-800-566-6444.

Aetna Better Health of Missouri offers a TDD/TTY line 1-800-735-2966 for hearing-impaired members.

When a member prefers an available family member or friend to interpret for them or decides not to utilize Aetna Better Health of Missouri’s hearing impaired support service line, this preference must be noted in the member’s medical record.

Standard member literature for the visually impaired may be requested by contacting Member Services at 1-800-566-6444.

5.7.13 Ted E Bear MD Club for Kids

Aetna Better Health of Missouri proudly offers the unique benefits of the Ted E Bear MD Club for Kids. As a value-added benefit, Aetna Better Health of Missouri will pay annual membership fees for our age appropriate members to join one of the following clubs:

• Participating Boys & Girls Clubs (All Regions)
• Girls Inc. (Eastern Region)
• Boy Scouts of America (All Regions)
• Girl Scouts of America (All Regions)
• Caring Communities Out-of-School Time program (Western Region)
• 4-H (All Regions)
• Discovering Options (Eastern Region)
• Girls on the Run (Kansas City)
• Kansas City YMCA

Members must call Member Services at 1-800-566-6444 to receive a club voucher. They must complete the voucher and take it to the club of their choice. The voucher covers one child’s joining fee per year for any of the clubs listed above.

We strongly encourage members to take advantage of the fun, safe activities offered through the club of their choice (age restrictions apply). Clubs feature activities, such as computer labs, game rooms, tutoring, fitness, homework assistance, arts and crafts, personal and educational growth, sports and physical development and after-school care (activities vary according to location).
Aetna Better Health of Missouri partners with and actively educates over 300 leading non-profit organizations and community agencies that positively influence low-income, high-risk youth in our MO HealthNet Managed Care communities. These organizations help promote health and safety, personal well-being, leadership and positive self-image, encourage community and civic involvement.

Aetna Better Health of Missouri also participates in community health fairs and events throughout the three MO HealthNet Managed Care regions in order to educate members and the community on the MO HealthNet Managed Care health program and our unique benefits. For more information on our community participation, please call the Community Relations Department at 1-800-566-6444.

5.7.14 Family Planning

Aetna Better Health of Missouri’s confidentiality policy must extend to minors when the minor member is requesting family planning, other reproductive health services. The parent/guardian of a minor member requesting information must demonstrate the minor member’s consent prior to the release of information regarding family planning and/or other reproductive health services.

Aetna Better Health of Missouri allows for freedom of choice for family planning and/or reproductive health services, which may be accessed in-network or from an out of network provider.

Sterilization procedures follow MO HealthNet guidelines and therefore are not covered for members under the age of 21. Members must sign the sterilization consent form at least 30 days but not more than 180 days prior to the date of the sterilization procedure. Please refer to MO HealthNet’s website at www.dss.mo.gov/mhd/providers/ to access the form along with specific requirements. The Acknowledgement of Receipt of Hysterectomy Information consent form and instructions is also available at this website, or by visiting the Provider area at www.aetnabetterhealth.com/mo.

5.7.15 Women, Infants and Children (WIC) Program

The Women, Infants and Children (WIC) program is a health promotion, nutrition education and supplemental food program administered by Missouri Department of Health and Senior Services (DHSS) to assist women, infants and children who have nutritional needs. As part of the initial assessment of members and as part of the initial evaluation of newly pregnant women, the provider must provide and document the referral of pregnant, breastfeeding or postpartum women, or a parent/guardian of a child under the age of five (5) as indicated.

Participant eligibility is based on 3 things, category, income and nutritional risk. Categories include:

- Women - pregnant women, postpartum breastfeeding women up to one (1) year after delivery while nursing, and postpartum non-breastfeeding women up to six (6) months after delivery or termination of the pregnancy
- Infants from birth up to one (1) year of age
- Children from one (1) year up to their 5th birthday

A physician or health care provider must provide and document a referral of pregnant, breastfeeding, or postpartum women, or a parent/guardian of a child under the age of five (5), as indicated, to the WIC program as part of the initial assessment of members and as part of the initial evaluation of newly pregnant women. Members may call 1-800-392-8209 to find out more information about qualifying for the WIC Program and making an appointment for the WIC assessment and screening. At this appointment members will receive a health and nutritional screening and nutrition information.

5.7.16 Parents as Teachers (PAT)

Aetna Better Health of Missouri supports Parents as Teachers (PAT), a home-school-community partnership which supports parents roles as teachers. This program is administered by the public school districts. Families who are expecting a child or have a child under the age of kindergarten entry is eligible for PAT. Their services include personal visits from certified parent educators, group meetings, developmental screenings, and connections with other community resources. Parents interested in PAT can contact their local school district directly. Although this service is not covered by MO HealthNet, Aetna Better Health of Missouri encourages pediatric providers to make referrals to the PAT program. Additional information on the PAT program is available in the State and Federal Program Requirements Section.

PAT services include:

- Personal visits from certified parent educators
- Group meetings
- Developmental screenings
- Connections with other community resources from the time the child is born until he/she enters kindergarten
PAT programs collaborate with other agencies and programs to meet families’ needs, including Head Start, First Steps, the Women Infants and Children Program (nutrition services), local health departments, the Family Support Division, etc. Independent evaluations of PAT show that children served by this program are significantly more advanced in language development, problem solving, and social development at age three (3) than comparison children, 99.5% of participating families are free of abuse or neglect, and early gains are maintained in elementary school, based on standardized tests.

Additional information about PAT is available at the Department of Elementary and Secondary Education’s website at www.dese.mo.gov/ or the National Center for Parents As Teachers at www.parentsasteachers.org.

5.7.17 First Steps

Aetna Better Health of Missouri can help our members’ family get services from the First Steps Program. First Steps is Missouri’s Early Intervention system for infants and toddlers, birth to age 3, who have delayed development or diagnosed conditions that are associated with developmental disabilities.

Children are eligible for First Steps if they have a significant delay (50% or greater delay in development) in one or more of the following areas:
- cognition (learning);
- communication (speech);
- adaptive (self help);
- physical (walking); or
- social-emotional (behaviors).

Children are referred to First Steps through:
- physicians;
- hospitals, including prenatal and postnatal care facilities;
- parents;
- child-care programs;
- local educational agencies, including school districts and Parents as Teachers;
- public health facilities;
- other social service agencies;
- other health care providers;
- public agencies and staff in the child welfare system, including foster care;
- homeless family shelters; or
- domestic violence shelters

An assessment is done to establish eligibility and determine the needs of the child. The assessment is provided at no charge to the family and is arranged by the regional System Point of Entry (SPOE) office in which the child and family lives. Once a child is determined eligible, the services are determined by an Individualized Family Service Plan (IFSP) team. Aetna Better Health of Missouri can refer members to First Steps. First Steps and Aetna Better Health of Missouri will work together to manage the child’s care.

5.7.18 Individual Education Programs (IEP)

Individual Education Programs (IEP) are developed by public schools for developmental and educational needs. Public school based services included in an IEP include physical therapy, occupational therapy, speech therapy, hearing aid, personal care, private duty nursing, or psychology/counseling services. Aetna Better Health of Missouri does not pay for services included in an IEP, but will not delay medically necessary school based services pending the completion of an IEP. Aetna Better Health of Missouri also collaborates with the school based services in an IEP to ensure appropriate medical information is being transferred to the school and coordinates ongoing care with special education services.
SECTION 6: MEDICAL MANAGEMENT

6.1 UTILIZATION MANAGEMENT (UM) PROGRAM

6.1.1 Purpose

Aetna Better Health of Missouri’s utilization management objective ensures that members receive quality services that are medically necessary, meet professionally recognized standards of care, and are provided in the most effective and medically appropriate setting. The program provides a mechanism for prospective, concurrent, and retrospective review of services and treatments provided. Pre-authorization, concurrent review and retrospective review are components of the UM program.

6.1.2 Program Oversight

The Quality Management Utilization Management Committee comprised of Aetna Better Health of Missouri participating providers, Medical Directors, and management staff, is granted the authority and primary responsibility for continuous oversight of the UM program by the board of managers. The UM program is overseen by a physician, the Medical Director. A behavioral health practitioner is actively involved in implementing the behavioral health aspects of the program.

6.1.3 Utilization Management Staff

The utilization management staff are comprised of integrated physical health and behavioral health experienced licensed personnel such as physicians, registered nurses, licensed practical nurses, licensed professional counselors, licensed clinical social workers and other certified ancillary health care professionals. All staff are supervised by a registered nurse with extensive managed care experience. All clinicians are licensed in the State of Missouri. All non-licensed staff work directly under the supervision of a licensed staff member. All medical necessity determinations that do not meet utilization review criteria are made by physicians.

6.1.4 Holiday Schedule

Aetna Better Health of Missouri is closed for business on the following days or the observed day:

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day
- Veterans Day

The following days may be used for staff training:

- Lincoln's Birthday
- Columbus Day
- Truman's Birthday
- Veterans Day

6.1.5 Clinical Practice Guidelines

Aetna Better Health of Missouri endorses a variety of nationally recognized clinical practice and preventive care guidelines. Clinical practice and preventive care guidelines made available by Aetna Better Health of Missouri are not a substitute for the professional medical judgment of treating physicians or other health care practitioners.

Evidence based clinical practice guidelines are based on information available at a specific point in time and during review and adoption by the Quality Management Utilization Management Committee. The most current guidelines are published and made available through a variety of professional organizations such as the American Academy of Pediatrics, the American Academy of Family Practice, the National Institute for Health and the American College of Obstetrics and Gynecology and the American Psychiatric Association. The guidelines are reviewed at least every two (2) years.

The guidelines most recently reviewed and approved by the Aetna Better Health of Missouri Quality Management Utilization Management Committee are available to providers at the Aetna Better Health of Missouri’s website www.aetnabetterhealth.com/mo. You can also contact your provider relations representative or the Quality Department to request a copy. Disclosure of clinical practice guidelines is not a guarantee of coverage.
6.1.6 Utilization Management Decisions and Incentives

Aetna Better Health of Missouri does not reward providers, practitioners or other individuals for issuing denials of coverage or service. The authorization decisions made are based only on the appropriateness of care and service and existence of coverage. Financial incentives for those making determinations do not encourage decisions that result in underutilization.

6.1.7 Review Criteria

To support prior authorization decisions, Aetna Better Health of Missouri uses nationally recognized, and/or community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of Missouri policies and procedures.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of Missouri uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of Missouri’s population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting providers when appropriate. These are to be consulted in the order listed:

- Criteria required by applicable State or federal regulatory agency
- Applicable nationally recognized medical necessity guidelines. Hertz Corporation, formerly known as Milliman Care Guidelines (MCG) is the primary decision support tool for physical health reviews. And, LOCUS/CASII (formerly known as CALOCUS) guidelines are the primary decision support tool for behavioral health reviews.
- Aetna Better Health of Missouri Clinical Policy Bulletins (CPBs)
- Aetna Better Health of Missouri Policy Council Review

All reference sources used, including Aetna CPB’s, include:

- Peer-reviewed research, or
- A meta-analysis of available research on a particular topic, or
- Evidence-based consensus statements, or
- Expert opinions of health care professionals, or
- Guidelines from nationally recognized health care organizations.

Note that coverage is excluded for procedures, treatments and devices that are determined to be experimental or investigational.

Medical, behavioral health management criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members. To request a copy of criteria and practice guidelines, providers may contact Aetna Better Health of Missouri at 1-800-566-6444.

6.1.8 Communication with Members Regarding Treatment

Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

6.1.9 Definition of Medically Necessary

Medically Necessary services, supplies, procedures, etc., are those that (1) prevent, diagnose, or treat a physical or behavioral health or injury; (2) are necessary for the member to achieve age appropriate growth and development; (3) minimize the progression of disability; (4) are necessary for the member to attain, maintain, or regain functional capacity; or (5) cannot be omitted without adversely affecting the member’s condition or the quality of medical care rendered. In reference to medically necessary care, behavioral health services shall be provided in accordance with a process of behavioral health assessment that accurately determines the clinical condition of the member and the acceptable standards of practice for such clinical conditions. The process of behavioral health assessment shall include distinct criteria for children and adolescents. The health plan shall provide medically necessary services to children from birth through age twenty (20), which are necessary to treat or ameliorate defects, physical or behavioral health, or conditions identified by an HCY/EPSDT screen. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.
6.2 REQUESTING AUTHORIZATION

6.2.1 How To Request Prior Authorization

A prior authorization request may be submitted by:

**Online:** Submit request through the 24/7 Provider Secure Web Portal located on the Aetna Better Health of Missouri’s at www.aetnabetterhealth.com/missouri

**PHONE:** Call 1-800-566-6444

Aetna Better Health of Missouri Prior Authorization Department

8 a.m. to 5 p.m. CST Monday – Friday

**AFTER HOURS:** Call 1-800-566-6444

**FAX:** Fax the request form to 1-866-341-1327 which is available 24/7 (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.

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Provider Secure Web Portal, or call us at 1-800-566-6444. The portal will allow you to check status and view authorization history.

For further information about the Provider Secure Web Portal, please review Section 20 of this manual.

6.2.2 Medical Necessity Decisions

Decisions are made in accordance with MO HealthNet contractual guidelines as outlined in the inpatient/outpatient services section. If a question of medical necessity or appropriateness arises, the case will be reviewed by the Medical Director or plan provider advisor. Providers must understand that MO HealthNet reserves the right to change benefits from time to time. Aetna Better Health of Missouri will notify providers if and when any benefits change. An authorization number will be issued upon approval of the request.

6.2.3 Peer-to-Peer Reviews

The admitting/attending provider has the right to initiate a peer-to-peer by contacting the Health Services Department within three (3) business days of a denial, including the day the determination was given. The peer-to-peer review is usually conducted by the Medical Director who made the original determination.

6.2.4 Prior Authorization Decision Time Frames

Aetna Better Health of Missouri utilizes the following decision time frames:

- Approval or denial of urgent services when determined as such by emergency room staff shall be provided by Aetna Better Health of Missouri within thirty (30) minutes of request.
- Approval or denial shall be provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider.
- Approval or denial shall be provided within 36 hours, inclusive of one (1) business day, of obtaining all necessary information for routine services.
- For termination, suspension, or reduction of previously authorized covered services, the notice of action will be mailed at least ten (10) days before the date of adverse determination.

6.2.5 Time Frame to Report Code Changes for Authorized Services

Aetna Better Health of Missouri currently provides authorization for specifically requested codes (CPT, HCPCS, etc). Providers have seven (7) calendar days to contact the Prior Authorization department to request code adjustments following a completed procedure. This means if the procedure performed is not the exact code that was authorized we will review the request to adjust the authorization to correct the code. The code must be similar to the one authorized and performed on the same area originally requested. For example: a laparoscopic hysterectomy was requested but unable to perform via the method and open abdominal hysterectomy is the procedure completed. The provider would call Prior Authorization to report this change. If the codes are not similar, once the claim denies for needing an authorization, an appeal can be filed.
6.2.6 Notice of Action
Requests that are not approved are communicated to the requesting provider, member and provider of service in writing within required time frames. The notice of action will outline the member’s and provider’s right to additional review.

6.3 PRIOR AUTHORIZATION CONFIRMATION
Upon approval of the requested service, Aetna Better Health of Missouri will supply the provider with the following:

- Authorization number
- Time frames for which the authorization is valid
- Total number of days/visits/items approved

6.3.1 Confirmation via Provider Secure Web Portal
Providers may utilize our Provider Secure Web Portal to review authorization information. Below is a list of features available using this free, internet based tool for Aetna Better Health of Missouri providers.

- Submit new authorization requests
- Look up authorizations (Search by member, status, authorization number)
- View authorization detail
- View authorization history
- Attach files in pdf format

Please refer to Section 20: Provider Secure Web Portal for more information.

6.4 AUTHORIZATIONS AND CLAIM SUBMISSION
If a provider submits a claim that includes services that they failed to obtain authorization for, all claim lines will deny including those that do not routinely require and authorization. It is recommended to include the prior authorization number in the appropriate box on the claim forms for services that require an authorization.

Items to consider when adding the authorization number to the claim form:

- Include the number in box 23 of the CMS claim form or box 63 of the UB form.
- Verify that date of services on the claim fall within the authorized services and date ranges.
- Authorization number should not contain any prefixes or suffixes such as R12345, #7890, 3456 by Mary.
- Authorizations obtained from Emdeon should be included on the claim in the requested field.
- EDI and paper claims should contain the authorization number in the requested field.

MO HealthNet updates eligibility on a daily basis. Members must be eligible on the date of service. Refer to transition of care (Section 6.11) for any exceptions. A prior authorization number does not guarantee payment if the member is not eligible or benefits are not available on the date the service is rendered.

6.5 PRIOR AUTHORIZATION REQUIREMENTS

6.5.1 Pre-Admission Review Requirement
PCP offices or attending provider specialists must contact the Pre-authorization Department for a prior admission review of any elective inpatient admissions, observation stays, outpatient and home care service, treatment or equipment that requires prior authorization.

6.5.2 Prior Authorization Process
The prior authorization process supports:

- Verification of member eligibility based on the current eligibility information from MO HealthNet.
- The review of the service requested based upon the available benefit plan for the member.
- The evaluation of medical necessity of services based on the type of service, level of care and network availability as mandated by Aetna Better Health of Missouri’s state contract.
• Accurate claims adjudication.
• Identification of members that may benefit from a referral to care management.

6.5.3 Required Information
Please provide the following information for each service request when calling for authorization:
• Member name
• Ordering physician
• MO HealthNet ID number
• Date of birth
• Expected date of service
• Diagnosis
• Service Requested – CPT or HCPCS code is recommended
• Significant medical information related to the diagnosis and service requested
• Name of provider/facility rendering service

6.5.4 Services Requiring Prior Authorization
Our Secure Web Portal located on our website, lists the services that require prior authorization, consistent with Aetna Better Health of Missouri’s policies and governing regulations. The list is updated at least annually and updated periodically as appropriate. Unauthorized services will not be reimbursed and authorization is not a guarantee of payment. All out of network services must be authorized.

Annually all new HCPCS and CPT codes will initially default to require prior authorization by Aetna Better Health. The PA requirement for these codes may be updated later in the year after further review by Medical Management. If the PA requirement is subsequently removed, the PA Look Up tool will be updated accordingly, and is available to providers via the Secure Provider Web Portal.

6.5.5 Services Requiring Authorization - Summary
Prior authorization is the process for authorizing the non-emergency use of facilities, diagnostic testing and other health services before care is provided. The following is a summary listing of services that require prior authorization. It is not intended to be considered an all inclusive listing. For a comprehensive listing of authorization requirements, please refer to the Aetna Better Health Provider Secure Web Portal.
• Adult day health care services
• Ambulance services - non-emergent
• Ambulance services - fixed wing, rotary wing - non-emergent
• Behavioral Health
  - Psychological Testing
  - Electroconvulsive Therapy (ECT)
  - Inpatient, Partial Hospital
  - Intensive Outpatient Treatment
• Bili lights/Blankets
• Diapers
• DME/Orthotics and Prosthetics/Supplies when service/item requested exceeds Aetna Better Health of Missouri volume limits
• DME - All rentals
• Facility or Free-Standing Ancillary Site
  - Inpatient
  - Observation
  - Outpatient surgery
CT, MRI’s, PET scans, myelograms - See Section VII: Outpatient Radiology/Imaging Program
- Maternity ultrasounds (beyond first two for obstetrical providers and ultrasounds beyond the first three for Maternal Fetal Medicine providers)
- 3D Halogram
- Echocardiograms, holters, stress tests
- Nerve conduction studies
- Therapy services (PT, OT, ST)
- Anesthesia during dental procedure (actual dental certification goes through DentaQuest)
- Nutritional counseling
- Anesthesia services provided in facility (i.e. pain management)
- Infusion services provided in facility (certification for drug to be infused needs to go through MO HealthNet)
- External version
- TPN/Enteral Infusion Services
- Sedation for diagnostic Outpatient Services

• Home care services
  - Home health (visits, private duty, personal care)
  - Infusion (certification for drug to be infused needs to go through MO HealthNet)
  - Hospice
  - Therapy
  - Implants
  - Lab Services - genetic testing

• Office Level
  - Maternity services: global OB, MFM consults; maternity ultrasounds (beyond the first two) for obstetricians and the first three (3) for maternal fetal medicine specialists
  - Nutritional consult
  - Pain management injections (certification for related drugs needs to go through MO HealthNet) Consult the Provider Secure Web Portal for procedures requiring authorization through Aetna Better Health of Missouri’s pain management administrator. Please refer to Section 10 - Pain Management for more information.
  - Second/third opinions
  - Vision therapy
  - Bariatric consult
  - Chiropractic consults
  - All services rendered by non-participating providers including non par independent reference laboratories

6.5.6 Services Not Requiring Authorization – Summary

The following is a summary list of services which do not require prior authorization. It is not intended to be considered an all inclusive listing. For a comprehensive list of authorization requirements, please refer to the Provider Secure Web Portal.

• Ambulance services, emergent only
• Ambulance services – fixed wing, rotary wing – emergent
• Amniocentesis
• Bath/toilet aids, bedpans, urinals
• Chemotherapy in an outpatient or office setting (certification for chemotherapy drugs needs to go through MO HealthNet)
• Diabetic shoes, fitting, modifications when provided to certified diabetics
• Diagnostic procedures (routine) bone films and chest x-ray, and/or barium studies, Upper GI, IVP, non-maternity ultrasound, thyroid uptake nuclear scan, bone age/bone length studies and fetal echo
• EEG
• EKG
• EMG
• Emergency department services
• Immunizations-adult and child (travel immunizations, are not covered benefits)
• Lab services – with exception of genetic testing
• Labor and Delivery Checks – billed with the revenue code of 720, 721, and 722
• Mammograms
• Manual breast pumps
• Non-stress test
• Non-cardiac dopplers
• Office level services (refer to list requiring authorization for exceptions)
• Ostomy* supplies
• Podiatry* Services (office level)
• Pulmonary function test (except exhaled nitric oxide)
• Radiation therapy
• Specific* A-codes & L-codes (please refer to Aetna Better Health Provider Secure Web Portal)
• Voiding Cystourethrogram (VCUG)

*Service may not be covered for members with certain ME Codes.

6.5.7 Volume Limits – DME, Orthotics and Prosthetics, Supplies

Volume limit is the maximum unit allowable within a specified time frame for services and/or supplies rendered in the course of treatment. When the volume limit has been exceeded for any service or item, prior authorization is required. Services or items within the volume limits do not require prior authorization. Please refer to the Provider Secure Web Portal for volume limits.

6.5.8 Specialty Provider Referrals

Aetna Better Health of Missouri does not require PCPs to obtain authorizations to refer members to participating specialists for office level service with the exception of:

• Maternity services
• Maternal Fetal Medicine Consults
• Gastroplasty evaluation
• Second and third opinions
• Vision therapy
• Nutritional Counseling

The specialist must provide communication to the PCP by fax, email, postal mail or telephone within two (2) weeks of the member visit. This communication promotes continuity of care as well as reduces the risk of duplicating services and/or treatments that could place the member at risk. Failure to provide a report to the PCP violates billing reimbursement guidelines that could result in an audit and/or reimbursement recovery by Aetna Better Health of Missouri.

Referring a member from the specialist office to another participating provider specialist must only occur with the prior approval of the member's PCP, when the services in question are of a non-emergent nature. Once this PCP approval has been obtained, the specialist is responsible for coordinating any support documentation for the referral to the provider specialist and PCP. This documentation must be available at the time of the member's visit to ensure continuity of care, timely implementation of an appropriate treatment plan as well as reduces the risk of duplicating services and/or treatments that could place the member at risk.

Note: Services referred to a non-participating specialist must have Aetna Better Health of Missouri’s prior approval.
6.5.9 Second and Third Opinions

Aetna Better Health of Missouri members and providers have the right to a second opinion any time the member disputes Aetna Better Health of Missouri’s, the plan benefit administrator’s, and/or physician’s opinion on a request for services and/or treatment.

Members have a right to third opinion when the recommendation of the second opinion fails to confirm the primary recommendation and there is a medical need for a specific treatment, and if the member desires the third opinion.

Aetna Better Health of Missouri members will incur no expenses for a second or third opinion provided by a participating or non-participating provider.

Aetna Better Health of Missouri will reimburse any non-participating provider for a second and third opinion at the Aetna Better Health of Missouri MO HealthNet fee schedule in effect at the time of service. Aetna Better Health of Missouri will require any service and treatment approved after the second and third opinion be performed by the participating provider initiating the request.

Aetna Better Health of Missouri may request a second medical opinion when the procedure and treatment does not meet established authorization criteria. The member will incur no expense for a second medical opinion requested by Aetna Better Health of Missouri. The provider will be selected from the Aetna Better Health of Missouri panel of provider advisors (PA).

The PA will review all available medical documentation and may request further medical information and/or diagnostic testing in order to complete a review for a second opinion. The member may decline to participate in a second opinion that involves an examination or diagnostic testing. In this case, the original Aetna Better Health of Missouri determination of the medical necessity or appropriateness will be upheld.

All second and third opinions require prior authorization from Aetna Better Health of Missouri and may be initiated by contacting the Pre-authorization Department.

6.5.10 Non-Participating Provider Referral Request

Aetna Better Health of Missouri allows members to receive medically necessary services and treatment by a non-participating provider when the expertise necessary to support the best outcome is not available within the network.

Requests to refer the member out of network must have prior authorization from Aetna Better Health of Missouri before services are to be rendered, except for the following:

- Emergency services
- Family planning
- HIV screenings
- TB screenings

The non-participating provider must complete a letter of agreement for reimbursement prior to the authorization of services being completed. The letter of agreement includes instructions on the billing guidelines required for claims submission. The referral will be established with a set number of visits and/or treatments with individual time frames for the case to reevaluate the need for continued services. Transition of the member’s care back to a participating Aetna Better Health of Missouri provider will be reviewed collaboratively with the attending provider, the Aetna Better Health of Missouri Provider that can appropriately accept management of the care and the Aetna Better Health of Missouri case manager and/or Medical Director.

6.5.11 Hysterectomy Protocol

MO HealthNet requires all patients eligible for a hysterectomy be fully informed about the procedure and any available alternative treatments. The member’s signature on the DSS/MHD Acknowledgment of Receipt of Hysterectomy Information form is required prior to the procedure. The most recent version of the form must be submitted with the physician’s prior authorization request to avoid a rejection of the claim. The pre-authorization coordinator can assist you with the request for authorization and any questions on the completion of the DSS/MHD Acknowledgement of Receipt of Hysterectomy Information form.

Exceptions to the requirement for a DSS/MHD Acknowledgement of Receipt of Hysterectomy Information form may be made in the following situations:

- The individual was already sterile before the hysterectomy. The physician who performs the hysterectomy must certify in writing that the individual was already sterile at the time of the hysterectomy and state the cause of the sterility. This must be documented by an operative report or admit and discharge summary.
• The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines that prior acknowledgment is not possible. The physician must certify in writing to this effect and include a description of the nature of the emergency.

• The individual was not MO HealthNet-eligible at the time the hysterectomy was performed but eligibility was made retroactive and includes the surgery date. The physician who performed the hysterectomy must certify in writing to one of the following situations:
  ° The individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing.
  ° The individual was already sterile before the hysterectomy.
  ° The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines that prior acknowledgment is not possible.

• In the event of an emergency surgery in which the required form is not completed or the procedure was less than the thirty (30) day minimum, a provider’s statement that prior acknowledgment was not possible is required for reimbursement consideration and should be submitted to our Prior Authorization Department.

Please refer to the MO HealthNet website www.dss.mo.gov/mhd/ for a copy of the Missouri DSS/MHD Acknowledgement of Receipt of Hysterectomy Information form and instructions.

6.5.12 Sterilization Procedures Policy

Aetna Better Health of Missouri is required to comply with the standard state and federal regulations regarding sterilization procedures. The attending professional claim must complete the most recent version of the sterilization consent form. The attending provider must meet the following for payment consideration:

• The patient must be at least twenty-one (21) years of age.
• The patient must be mentally competent at the time the surgery is performed.
• The waiting period from the time the consent form is signed to the day of the surgery must allow for a full thirty (30) day waiting period but not to exceed 180 days from the consent date.
• The member must be eligible with Aetna Better Health of Missouri on the date of service.

Aetna Better Health of Missouri requires providers to notify Aetna Better Health in advance of the sterilization request by submitting the completed sterilization via fax to the prior authorization department. The Pre-Authorization department will then enter an authorization for the service with a date span which starts at least 30 days after signature based on the signed consent form. Pre-authorization of this service is required in order for payment consideration by Aetna Better Health.

In instances where the sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on the consent form because of the following circumstances – premature delivery; individual’s expected date of delivery; emergency abdominal surgery. In these instances, an authorization can be put in place once the Prior Authorization Department receives the completed form. This should be submitted within 60 days of the date of the procedure.

Reimbursement cannot be made to the provider if the state requirements are not met and if an authorization has not been issued.

Please refer to the Mo HealthNet website www.dss.mo.gov/mhd/ for a copy of the Sterilization Consent form.

Providers must verify they are utilizing the most current MO HealthNet Sterilization Consent Form.

6.5.13 Nutritional Counseling

Nutritional counseling requires prior authorization when performed by a dietary professional.

6.5.14 Maternity Care

6.5.14A MATERNITY CARE AND GLOBAL OB AUTHORIZATION

A member may initiate the first visit to a participating maternity provider without obtaining a referral. Upon confirmation of a pregnancy, the OB provider must immediately obtain authorization for obstetrical care by submitting a state of Missouri Risk Appraisal form for Pregnant Women request to the Aetna Better Health of Missouri Fax number 866-341-1327 or through the Provider Secure Web Portal or via Emdeon. Please refer to the Aetna Better Health of Missouri website www.aetnabetterhealth.com/mo for a copy of the State of Missouri Risk Appraisal for Pregnant Women form.
The State of Missouri requires MO HealthNet Managed Care plans to provide coverage for post-discharge care to mothers and their newborns. One (1) of the visits must be provided in the home setting within 24 to 48 hours of discharge as determined by the attending provider. The visit must be in accordance with accepted maternal and neonatal physical assessments and provided by a registered professional nurse with experience in maternal and child health nursing or a provider.

6.5.14B OBSTETRICS OBSERVATION/INPATIENT ADMISSION AUTHORIZATION
During pregnancy, the maternity provider assumes the responsibility of coordinating the patient’s care for OB related conditions. Aetna Better Health of Missouri authorizes forty-eight (48) hour admission stays for routine vaginal deliveries and ninety-six (96) hour admission stays for uncomplicated cesarean deliveries. The attending physician and mother may determine that an earlier discharge is in the best interest of the family. Aetna Better Health of Missouri provides coverage for a post discharge mom and baby home care visit for all maternity discharges.

6.5.14C MATERNITY SUBSPECIALTY AND NON MATERNITY SUBSPECIALTY CONSULTATIONS
A provider directed consultation to a Maternal Fetal Medicine Provider requires additional prior authorization from Aetna Better Health of Missouri. Non maternity specialty providers treating pregnant members for pregnancy related issues also need to obtain authorization.

6.5.14D HOME BIRTH SERVICES
Home births are not a covered benefit under the MO HealthNet Managed Care program. Providers must notify Aetna Better Health of Missouri to initiate the disenrollment process as soon as they are aware that home birth is desired and Aetna Better Health of Missouri will coordinate services through MO HealthNet for the home birth.

6.5.14E NEWBORNS
It is the parent/guardian’s responsibility to contact their local FSD office, the Family Support division (FSD) at 855-FSD-INFO on behalf of the newborn to initiate the eligibility process. The parent/guardian may also log into the MyDSS account at www.mydss.mo.gov and add the child as their dependent. Prior authorizations for newborns will be listed under a temporary newborn identification number within Aetna Better Health of Missouri’s system until the newborn has been enrolled, at which time the authorizations will be moved to the newborn’s file and activated for claims processing.

6.6 CONCURRENT REVIEW
Concurrent Review staff employed by Aetna Better Health of Missouri are Missouri registered nurses, licensed practical nurses, licensed professional counselors, licensed clinical social workers, non-clinical staff and are supervised by a Missouri licensed registered nurse.

Concurrent review staff will perform a medical necessity review for each day of an inpatient admission or observation. When the level of care does not meet the criteria or guideline standards, the case will be referred to a Aetna Better Health of Missouri Medical Director for review and determination.

Concurrent review may be conducted on-site, via remote access or telephonic. Telephonic review facilities are required to call in reviews on each Aetna Better Health of Missouri member daily. Pertinent clinical information needed with each review includes, but is not limited to, the following:

• Current symptoms, complaints, vital signs, etc.
• Attending and/or consulting physician notes
• Diagnostic test results
• Laboratory results
• Current orders/treatment
• Treatment plan
• Discharge needs

Once a review is completed, the authorization number, number of days approved, and level of care approved is issued to the hospital and/or attending physician. The attending provider, the facility and the member are sent written notification of any adverse determination. The written notification includes rationale for the clinical determination and the process to initiate an appeal.
6.7 RETROSPECTIVE REVIEW

Retrospective admission reviews are conducted on all inpatient stays for which there were no prospective or concurrent reviews and the member is not currently an inpatient or observation stay case. Retrospective review will not be done on elective inpatient admissions or observation stays that did not receive prior authorization and the member has been discharged at the time of notification to Aetna Better Health of Missouri. The physician, facility, member or representative of a member, may initiate the appropriate appeal for clinical review and reimbursement determination.

6.8 DISCHARGE PLANNING

The discharge planning process and review for clinical and social work care management needs should begin on admission. Concurrent review staff will coordinate discharge services, treatments and/or equipment with the attending physician and/or social services and/or discharge services staff as needed. The discharge plan is based on, but not limited to, benefit availability, medical necessity, network access, patient age, diagnosis, length of treatment, level of skill, family participation, patient acceptance and understanding of the medical condition. The order and request for home health services comes from the physician who assumes responsibility for medical direction of all services. Continuation of services, treatments and equipment post discharge will be reviewed by the concurrent review staff until the patient is released by the attending provider, or the referral of the case to the care manager due to the chronicity and/or complexity of the case.

6.9 CARE MANAGEMENT

The care managers, care management associates, and social workers work closely with the provider, patient and family to coordinate the delivery of patient focused, cost-effective, high-quality care in the most timely manner to ensure optimal patient outcomes. Specifically, care managers ensure that care plans are developed and implemented, in collaboration with members and providers.

The Integrated Care Management program involves coordination of care and services to help ensure open communication, patient understanding and involvement in the member treatment plan. Care management programs help make certain that the member understands not only the overall treatment plan, but the member’s role in his/her health care.

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual’s health needs using communications and available resources to promote quality, cost-effective outcomes. – Commission for Case Manager Certification (CCMC) The goal of case management is to encourage appropriate use of health care services on a case-by-case basis. Practitioners can access more information about these services on the website or by calling 1-800-566-6444.

Providers shall cooperate with Aetna Better Health of Missouri’s medical management activities and procedures to identify, assess and establish a treatment plan for members with complex or serious medical conditions. This includes returning phone calls, answering correspondence such as faxes and responding to Aetna Better Health of Missouri staff as needed so they can perform their medical management duties. These staff members reach out to provider offices to obtain demographic data for members that we are attempting to case manage or assist in their overall health needs.

6.9.1 Case Management

The focus of case management is to:

- Enhance and coordinate a member’s care across an episode or continuum of care
- Negotiate, procure and coordinate services and resources needed by members/families with complex issues
- Insure and facilitate the achievement of quality, clinical and cost outcomes.
- Intervene at key points for individual members.
- Address and resolve patterns of issues that have a negative quality cost impact.
- Create opportunities and systems to enhance outcomes.

The following case management services are available to:

- Members at risk for or having lead poisoning
- Members with special health care needs
- Members pre and post organ transplant
Aetna Better Health of Missouri provides case management services for members with the following diagnoses or situations:

- Anxiety disorders
- Chronic pain
- High-risk diagnoses: including asthma, autism spectrum disorder, bipolar disorder, cancer, cardiac disease, diabetes, hepatitis C, HIV/AIDS, high risk OB, lead, schizophrenia, sickle cell anemia
- Multiple admissions or ER visits with the same or varying diagnosis
- Multiple disciplines/therapies required for a treatment plan
- Non-compliance with treatment plan
- Pervasive developmental disorder
- Pregnancy
- Special health care needs
- Any requests from providers, members and/or other health care professionals

6.9.2 Disease Management

Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. – Disease Management Association of America (DMAA). The goal of disease case management is to prevent exacerbations and/or complications related to specific diagnoses. Aetna Better Health of Missouri has implemented the following disease case management programs:

- Asthma
- Coronary Artery Disease
- Depression
- Diabetes
- Heart Failure
- Chronic Obstructive Pulmonary Disease

6.9.3 High Risk OB Program

Aetna Better Health of Missouri’s goal is to have healthy mothers and babies. In an effort to meet that goal, Aetna Better Health of Missouri has developed a maternal and child program in conjunction with the members’ obstetrical providers. This program promotes prenatal screenings and interventions in order to identify potential high risk factors, and monitor prenatal visit compliance.

These programs promote prenatal screenings and interventions to identify potential high risk factors and to encourage adherence to prenatal care as directed by the OB provider.

Coverage is available for post-discharge care in the home for mothers and their newborns. One (1) visit must be in accordance with accepted maternal and neonatal physical assessment and provided by a registered professional nurse with experience in maternal and child health nursing.

The obstetrical care provider may request service from a qualified nursing agency. The nursing agency must notify Aetna Better Health of Missouri’s Pre-authorization Department. If you have any questions about this process, please contact the Pre-authorization Department.

6.9.4 Lead Case Management

Aetna Better Health of Missouri recognizes that childhood lead poisoning is the #1 environmental hazard facing children in Missouri. The case manager for lead toxicity coordinates follow-up care for lead screens, and educates the family and community on the issues and treatment of lead toxicity. The case manager evaluates case management requests based on the member’s/caregiver’s ability to remain compliant to provider’s follow up requirements and treatment plan; general understanding of the clinical risks when intervention is not provided and based on the complexity of the clinical case.
6.9.5 Special Needs Risk Management

Members with special health care needs are those members who have ongoing special conditions that require a course of treatment or regular care monitoring. An assessment is offered to all members identified with a special health care need. The assessment consists of identifying issues, such as, but not limited to eligibility status, PCP and/or specialty provider access, coordination of care for durable medical equipment (DME), therapy, home health services, behavioral health and/or dental access. Further evaluation includes the member’s and/or family’s ability to remain compliant with a treatment plan and/or follow up care requirements, general understanding of the clinical and quality of life risks when intervention is not provided, and the complexity of the clinical case. The care management staff educates the parent/guardian/member on MO HealthNet Managed Care benefits.

Children in state custody or foster care are evaluated for case management to ensure that the coordination and documentation of care is consistently performed in a timely manner.

6.9.6 Transplant Management

Transplant services are not part of the MO HealthNet Managed Care benefit with the exception of corneal transplants. MHD retains the financial responsibility for all other transplant services for the MO HealthNet Managed Care member. All MHD transplant requests must be preauthorized by MHD and must be performed at a MHD approved transplant facility.

Aetna Better Health of Missouri is responsible for pre-surgery assessment/evaluation and care and post-transplant discharge follow-up care. MHD remains responsible for the immuno suppressive pharmacy products, bone marrow harvest, the inpatient transplant itself from the day of transplant to the date of discharge (including organ or stem cell procurement charges), and related provider services associated with both the procurement and transplant procedure on a fee-for-service basis.

Potential transplant candidates must be reported to:

MO HealthNet Division
Transplant Coordinator
PO Box 6500
Jefferson City, MO 65102-6500
Telephone 573-751-6963
Fax Number 573-526-4650

Aetna Better Health of Missouri’s concurrent review and case management staff, coordinate care between the member, provider, and facilities before, during, and after the transplant and to ensure all pre-authorization requirements have been met. Aetna Better Health of Missouri will try to establish post-transplant care with a participating, network provider, when possible.

6.9.7 Behavioral Health Services

Behavioral health programs and social work services are also available through Aetna Better Health of Missouri Integrated Care Management program. Noted below are examples of behavioral health diagnoses for which members may receive coordination of services:

- Anxiety
- Autism Spectrum Disorder
- Bipolar Disorder
- Postpartum Depression
- Depression

For additional information about our care management programs or to make a referral call 1-800-566-6444.

6.10 INPATIENT AND OUTPATIENT SERVICES

6.10.1 Elective Admissions, Observation Stays and Outpatient Surgeries

Elective hospital observation stays, admissions and outpatient surgical procedures require prior authorization. Contacting Aetna Better Health of Missouri’s Pre-authorization Department prior to scheduling elective services minimizes any scheduling conflicts if issues related to network access, benefit availability, and/or medical necessity arise during the pre-authorization process. At a minimum, the request for services must be made five (5) working days prior to the date of service to promote a timely determination. Providing the following information at the time of the request will expedite the pre-authorization process:

- Member name
- MO HealthNet ID number

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www.aetnabetterhealth.com/mo
Provider Relations 1-800-566-6444
• Expected date of admission
• Primary diagnosis
• Significant medical history related to the diagnosis and/or treatment plan request
• Previous treatments and procedures initiated for the same diagnosis
• Planned procedure or treatment plan
• Attending provider name
• Facility where services are to be rendered

The pre-authorization coordinator will issue an authorization number for the initial day of the observation stay and admission once the review is approved. Subsequent days will be reviewed daily for medical necessity, appropriateness of level of care and benefit availability.

The concurrent review clinician will review for continued stay and level approval. Notification on the level determination will be given to the appropriate utilization management staff at the hospital, outpatient center, rehab and/or skilled facility within timeframes.

All late notifications of elective observation stays, admissions or outpatient surgical procedures are subject to denial based on lack of timely notification or lack of prior authorization (if applicable). In the event the stay or admission is not denied, each day will be reviewed for medical necessity, appropriateness of level of care and benefit availability. Notification of the level(s) approved during a retrospective review will be provided to the appropriate utilization management staff upon completion of the review process. This process may include a referral to the Medical Director for clinical review determination.

6.10.2 Urgent Admissions and Observation Stays

Urgent admissions, observation stays and outpatient surgical procedures directed by the member’s PCP and/or participating specialist must be presented to the Pre-authorization Department within twenty-four (24) hours of the service being initiated or the next business day.

If a member presents to a provider with commercial insurance information, the provider will be afforded forty-eight (48) hours from the admission date to verify coverage and inform Aetna Better Health of Missouri that the coverage presented was incorrect. At the time Aetna Better Health of Missouri is notified, the supporting clinical information is to be provided for authorization determination. The admitting provider must notify the member’s PCP of the admission and observation stay. This timely notification promotes continuity of care for the member during the admission and stay and with coordination of care after discharge.

Review of the clinical information for the urgent admission and observation stay will be completed at the time of notification. Health Services will provide the determination decision for the initial admission and observation stay date based on medical necessity, appropriateness of level of care and benefit availability as well as network accessibility.

The Aetna Better Health of Missouri concurrent review clinician will review for continued stay and level approval. Notification on the level of approved, reduced or denied days will be given to the appropriate utilization management staff at the hospital, outpatient center, rehab and skilled facility within timeframes.

6.10.3 Emergency Services

Aetna Better Health of Missouri will make provisions for, and advise members on the policies of accessing emergency services based on the following definition:

An emergency medical condition is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

• Serious jeopardy of physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child)
• Serious impairment to bodily functions
• Serious dysfunction of any bodily organ or part
• Serious harm to self or others due to an alcohol or drug abuse emergency
• Injury to self or bodily harm to others
• With respect to a pregnant woman having contractions: (1) inadequate time to effect a safe transfer to another hospital before delivery, or (2) transfer may pose a threat to the health or safety of the woman or the unborn.
Emergency services are not subject to prior authorization. Aetna Better Health of Missouri must be notified within ten (10) days following an emergency admission, service or procedure to request certification and/or continuation of treatment for that condition.

Aetna Better Health of Missouri will reimburse non-participating Providers for the evaluation and/or stabilization of emergency conditions according to state guidelines. Aetna Better Health of Missouri will accept the attending physician’s determination and continue reimbursement as an emergent level if the member’s medical stabilization has not been achieved.

Members that utilize ground ambulance transportation under the prudent lay person’s definition of emergency will not require authorization for the ambulance service.

6.10.4 Experimental and Investigational

A health product or service is experimental/investigational if one or more of the following criteria are met:

- Any drug not approved for use by the FDA; and FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature; or, any drug that is classified as IND (investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing means prescribing prescriptions drugs for treatments other than those stated in the labeling approved by the FDA.
- Any health product or service that is subject to Institutional Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by the FDA regulations;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature.

This policy applies to all Aetna Better Health of Missouri members unless superseded by applicable law.

Footnote:
1. “Peer-reviewed medical literature” is a phrase that is defined by two elements:

A. It refers to the requirement that medical literature on a topic is only considered relevant if it is a scientific study, which has been published in the English language (mostly American) medical literature only after review by academic experts for structure of study and validity of conclusions, prior to acceptance for publication; and

B. Based on a methodology used by certain authoritative bodies (including The National Cancer Institute PDQ Guidelines for Cancer Treatment and the International Consensus Conference on Bone Marrow Transplantation), the medical literature is graded for its quality using a 2-by-2 grid based on two parameters: strength of the evidence and effectiveness. Strength of evidence is graded from the highest level of evidence to the lowest, as follows:

- Level 1: Randomized, controlled trial
- Level 2: Cohort/Case Control Study
- Level 3: Systematic Literature Review
- Level 4: Large consecutive case series
- Level 5: Small consecutive case series
- Level 6: Textbook chapters (opinion of a respected authority)
- Level 7: Case report

6.10.5 Outpatient Hospital Services

Aetna Better Health of Missouri contracts with area hospitals and free standing facilities to provide outpatient services such as but not limited to preventive health screenings, diagnostic testing, therapeutic and/or palliative care and surgical services. Most services rendered in an outpatient setting require prior authorization. Consult the Aetna Better Health Provider Secure Web Portal or contact the Pre-authorization Department if you are unsure if the service and/or treatment requires authorization.

When providing outpatient services, remember to:

- Verify member eligibility prior to rendering non-emergent services and/or treatments
- Provide only the services and/or treatments that were authorized
- Aetna Better Health of Missouri’s pre-authorization coordinators are available if you need clarification on the required prior authorization number, what services and/or treatments have been authorized, and to verify the expiration date of the authorization
6.10.6 Limitations and Exclusions
Limitations and exclusions of inpatient/outpatient services and treatments include but are not limited to:

- Personal convenience items, such as televisions, radios or telephones in the patient’s room.
- Private duty nurses
- Any extra charges for a private room
- Cosmetic surgery except when to restore function or deemed medically necessary
- Experimental/Investigational products or services as defined above
- Care for service related to disabilities for which members are entitled to benefits through military, federal or state programs
- Inpatient stays that are not medically necessary or appropriate as determined by Aetna Better Health of Missouri
- All inpatient days prior to a scheduled surgical procedure unless specifically authorized by Aetna Better Health of Missouri

6.10.7 Home Care Services
Home health care and home infusion services require prior authorization. Home care services should be coordinated with the member’s PCP or the referring provider specialist in accordance with the member’s treatment plan. Coverage determinations will be based on medical necessity, available benefit, appropriateness of setting and network availability.

Authorizations for home care and/or home infusion always include the number of visits and a date span for the services. Requests to extend the date span or add additional visits should be requested in advance by calling Aetna Better Health of Missouri’s Prior Authorization Department. Failure to obtain prior authorization will result in claim denials for these services.

6.10.8 Durable Medical Equipment/Orthotics/Prosthetics/Supplies
DME, orthotics/prosthetic and certain supplies require prior authorization, once the Aetna Better Health of Missouri volume limit has been exceeded. Some services may have prior authorization requirements. Please refer to the Aetna Better Health of Missouri Provider Secure Web Portal for a complete listing and to review the volume limits.

Requests which require prior authorization should be coordinated with the member’s PCP or the referring specialty care provider and be in accordance with the treatment plan. Coverage determinations will be based on medical necessity, available benefit, appropriateness of setting and network availability. Failure to obtain prior authorization will result in claim denials for these services.

Purchased DME and Orthotics and Prosthetics items with a claim line billed amount of $500 or less and medical supplies with a claim line billed amount of $100 or less do not require prior authorization. This applies to place of service 12 and volume limits outlined in the volume limit directory remain in place. All Rental DME items with an RR modifier require authorization. The authorization information are available on the Aetna Better Health of Missouri Provider Secure Web Portal.

For DME claims (i.e., Ankle, Foot, Knee, Eye prosthesis, Arm Orthotics, Upper and Lower Prosthesis, Orthopedic foot wear), anatomic modifiers (RT or LT) are required for codes which are bilateral in nature. RT/LT modifiers are NOT required to be submitted if the code by definition is for a “pair”.

6.10.9 Personal Care Services
Personal care services are medically oriented tasks that are designed to meet a client's physical needs and that if provided would avoid nursing facility or institutional placement. Specific criteria must be met and not exceeded to be eligible for personal and advanced personal care. Additional information may be obtained by contacting the care management department at 1-800-566-6444.

Services must be provided by a personal care provider who is participating in the Aetna Better Health network. Requests for family members to be paid for providing personal care are not covered.

Note: Personal care services that are requested for purposes of convenience or are custodial in nature are not a covered benefit.

6.11 TRANSITION OF CARE
Aetna Better Health of Missouri supports members who are newly enrolled with the health plan from another health plan or fee-for-service and members who are transferring from Aetna Better Health of Missouri to another health plan or fee-for-service. To ensure a smooth transition of care, Aetna Better Health of Missouri provides the relevant member information to another health plan.
Aetna Better Health of Missouri collaborates with out-of-network providers and/or previous health plans to ensure there is a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with a medical health, behavioral health, or substance abuse provider that is not in Aetna Better Health of Missouri’s network. Aetna Better Health of Missouri will facilitate obtaining member records from the out-of-network provider and will also pay rates comparable to fee-for-service for these records, unless otherwise negotiated.

Aetna Better Health of Missouri facilitates continuity of care for medically necessary covered services. If a newly added member is receiving medically necessary covered services, the day before enrollment into Aetna Better Health of Missouri, Aetna Better Health of Missouri is responsible for the costs of continuation of such medically necessary services, without prior approval and without regard to whether such services are being provided by in-network or out-of-network providers. Continuation of such services for the lesser of:

• 60 calendar days or
• Until the member has transferred, without disruption of care, to a participating provider

For members eligible for case management, Aetna Better Health of Missouri provides continuation of services authorized by the prior health plan for up to 60 calendar days after the member’s enrollment in the new health plan and services will not be reduced until assessment is conducted by Aetna Better Health of Missouri.
SECTION 7: BEHAVIORAL HEALTH SERVICES

Aetna Better Health of Missouri provides a comprehensive range of behavioral health care services for members.

7.1 AETNA BETTER HEALTH OF MISSOURI MEMBERS INELIGIBLE FOR BH SERVICES

Some Aetna Better Health of Missouri members may not be eligible for covered services. Aetna Better Health of Missouri members in the following ME codes 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 64, 66, 68, 69, 70 do not have behavioral health covered benefits. The member's ME code can be viewed on the Aetna Better Health of Missouri provider portal as part of the member eligibility verification screen. Due to day specific eligibility, it is important that providers verify eligibility at every date of service prior to rendering services.

7.2 DESCRIPTION OF SERVICES

Covered Services include outpatient routine office visits for therapy and medication management, a broad range of hospital based services for both behavioral health and substance dependence disorders, home-based therapy services, telemedicine services, and access to many helpful community based resources. Aetna Better Health of Missouri will assist members and providers with provider referrals and with making appointments for members in need of therapy and/or psychiatry services, including but not limited to:

- Attention Deficit Disorder
- Depression
- Post Partum Depression
- Anxiety
- Alcohol/Substance Abuse
- Bipolar Disorders
- Behavioral Disorders
- Psychotic Disorders and more
- Adjustment Disorders

7.3 BEHAVIORAL HEALTH NETWORK

Aetna Better Health of Missouri credentials and contracts directly with clinical licensed behavioral health providers, community mental health centers and facilities. To join the network, contact Provider Relations at 800-566-6444. Below is a description of network services which are provided through our participating provider network.

7.3.1 Therapy Services

Behavioral health therapy services are provided by Master and PhD licensed level experienced and credentialed counselors, social workers and psychologist practitioners. Therapy services include a range of treatment modalities to address both behavioral health and substance use disorders. These services are scheduled and typically office based; however many participating providers can also arrange for home-based and telemedicine services.

7.3.2 Medication Management Services

Medication management services are provided by Physician level child, adolescent and adult psychiatrists with a broad range of specialty board certifications. These services are scheduled and office based, usually focused on medication evaluation and management of symptoms.

7.3.3 Structured Program and Hospital-Based services

Structured Program and Hospital-Based services provided by licensed behavioral health and substance abuse facility providers. These programs include acute care hospitalization, partial hospital and intensive outpatient programs. Hospital-based services are generally focused on reducing/eliminating more acute symptoms and stabilizing to the point the member can be safely transitioned to ambulatory/outpatient services.

7.4 CARE MANAGEMENT

Integrated Care Management is available for members with special needs and increased complexity of care issues. Care Management activities includes telephonic outreach to members, identification and facilitation of needed health care and other services, member support and health education activity, and coordination of care with the intent of improving overall member health outcomes. A key area of focus is on identified members with both medical and behavioral health issues which would benefit from a coordinated approach for positive outcomes.
Examples of health issues appropriate for Case Management program services:

- More than one psychiatric admission with risk of readmission
- Use of a lethal weapon to harm self or others
- Life threatening suicide attempt
- High risk pregnancy related to behavioral health/substance abuse disorder.
- Members at risk of adverse clinical outcomes due to psychiatric illness, including children at risk of out of home placement
- Other complicating factors including chronic medical conditions and lack of resources required to meet basic daily needs
- Coordination of care for medical/behavioral conditions
- Coordination of care for members who suffer from a combination of medical and psychiatric conditions is important to Aetna Better Health of Missouri. Focused behavioral health intervention and treatment planning and adherence can lead to enhanced overall health outcomes for members with conditions such as in the following examples:
  - Co-morbid illnesses such as diabetes and health conditions with depression
  - At risk pregnancies with substance abuse involvement
  - Obesity
  - Emotional problems and behavioral problems in children and adolescents impacting adherence to required medication and treatment plans Aetna Better Health of Missouri providers can contact Case Management for assistance with members needing behavioral health services, including requesting assistance in obtaining behavioral health provider referrals and making appointments for members.

7.5 REFERRALS

A PCP referral is not necessary for members to access behavioral health services. Aetna Better Health of Missouri can help the PCP office facilitate an appointment for eligible members as needed.

Members can contact Aetna Better Health of Missouri providers directly for appointments and for assistance in obtaining appointments with providers. The provider is responsible for obtaining continued care authorizations. Aetna Better Health of Missouri can answer providers questions related to authorization, member eligibility, claim inquiries and can assist providers and PCPs with community based referrals for additional support to members in need.

7.6 PRIOR AUTHORIZATION

All behavioral health prior authorization requests should be submitted to Aetna Better Health of Missouri. Please refer to section 6.5 for information regarding prior authorization requirements.

7.7 CLAIMS INFORMATION

All behavioral health claims should be submitted to Aetna Better Health of Missouri. Please refer to Section 15 for Claim submission information.
SECTION 8: CHILDREN’S MERCY PEDIATRIC CARE NETWORK (CMPCN)

Aetna Better Health of Missouri is contracted with the Children’s Mercy Pediatric Care Network (CMPCN) which operates an integrated pediatric network that contracts with health care providers in the Kansas City area to provide delegated medical management services to Aetna Better Health of Missouri members. The CMPCN is responsible for providing care and disease management, utilization management and prior authorization for CMPCN members within the service area noted below.

8.1 CMPCN SERVICE AREA

The CMPCN’s service and enrollment area encompasses 13 counties in Missouri and Kansas. The service area includes Jackson County in Missouri and Johnson and Wyandotte Counties in Kansas, and the 10 contiguous counties in the Kansas City metropolitan area.

8.2 CMPCN MEMBERS

Any Western Missouri Aetna Better Health of Missouri members under age 21 who are assigned to a PCP with a primary office location in the 13 county PCN service area will be medically managed by the CMPCN and is considered a CMPCN Member. Providers can identify a member that is medically managed by the CMPCN by the CMPCN logo on back of the Aetna Better Health of Missouri ID card.

8.2.1 Sample CMPCN member ID Card

1. Member Name
2. Member ID (MO Healthnet ID#)
3. Date of Birth
4. PCP Name
5. PCP Phone number
6. Effective Date
7. Claims submission information
8. CMPCN Logo

8.3 PREAUTHORIZATION REQUIREMENTS FOR CMPCN MEMBERS

All prior authorization requests for CMPCN members must be called in directly to the CMPCN at 1-877-347-9367.

8.4 CLAIM SUBMISSION FOR CMPCN MEMBERS

CMPCN member claims should be submitted to Aetna Better Health of Missouri for processing. Please refer to Section 15: Claims and Reimbursement for information on filing claims.

8.5 CONTACT INFORMATION FOR CMPCN

CMPCN website: ..................................www.cmpcn.org
CMPCN Phone: .................................1-888-670-7261
CMPCN Clinical Services: .................1-888-670-7262
SECTION 9: DENTAL SERVICES

Aetna Better Health of Missouri is contracted with DentaQuest for the administration of dental benefits for our members including network management, claims processing and utilization management services. Aetna Better Health of Missouri members with dental benefits should access services of a DentaQuest network provider.

9.1 PROVIDER PARTICIPATION

Dental providers interested in joining the provider network should contact DentaQuest at 1-888-233-1468 or visit the Dentaquest website www.dentaquestgov.com to obtain information.

Members with dental benefits may self-refer to participating dental providers for routine office level dental services. A listing of participating providers is available on our website, www.aetnabetterhealth.com/mo, by selecting “Locate a Provider” then “Find a Dental Provider” channel. Providers and Members can also contact customer service at 1-800-566-6444 for assistance in locating a provider.

9.2 COVERED BENEFITS & PROGRAMS

9.2.1 For Members Under Age 21 & Pregnant Women ME codes

Dental services are covered for eligible Aetna Better Health of Missouri members under the age of twenty-one (21) and pregnant women with ME codes 18, 43, 44, 61, 95, 96, and 98.

9.2.2 For Non-pregnant adult members (age 21 and over)

Aetna Better Health of Missouri Adult members ages 21 and older who are not under a pregnant women ME code on the date of service are eligible for preventative services available through the DentaQuest Provider Network. On an annual basis, in a rolling calendar year, the adult member is eligible for a dental exam, cleaning and x-rays, as well as some restorative procedures, such as fillings, extractions and some medically necessary sedation with a participating DentaQuest provider.

Dental services related to trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury are a covered benefit and require pre-authorization if the member is age 21 or over, unless the member is covered through a pregnant woman ME code.

Aetna Better Health of Missouri providers, including primary care physicians are encouraged to refer their Aetna Better Health of Missouri adult patients to schedule these preventative services. Aetna Better Health of Missouri members, age 21 and older, generally have select dental benefits. Dental benefits covered through DentaQuest may be verified at 1-888-278-7310.

To obtain the status of an authorization or claim, providers should contact DentaQuest directly.

9.2.3 Smiling Stork Program

The goal of DentaQuest’s Smiling Stork program is to educate pregnant women about the importance of receiving dental care during pregnancy. Through Smiling Stork program, DentaQuest provides informational outreach to Dentists, Physicians and Members. Pregnant Members also receive mailings with information on good oral care habits while pregnant and also for children. Members will also receive a reminder notice to schedule an appointment with the dentist.

9.3 PRIOR AUTHORIZATION REQUIREMENTS

Dental providers should contact DentaQuest at 1-888-307-6547 or visit the DentaQuest website to obtain information regarding complete precertification requirements.

Please note that Aetna Better Health of Missouri requires prior authorization for non-routine dental procedures scheduled as outpatient and/or inpatient cases. Review of these cases must be submitted to the DentaQuest Pre-authorization Department at 1-888-307-6547 for review, prior to rendering services, to determine the medical indication for the level of care requested.

9.4 CLAIM SUBMISSION

All covered dental service claims should be submitted to DentaQuest. Dental providers should contact DentaQuest Provider Services at 1-888-307-6547 or visit the DentaQuest website at www.dentaquestgov.com to obtain information regarding claim submission requirements.
9.5 CONTACT INFORMATION FOR DENTAQUEST

DentaQuest Provider Credentialing: 1-800-233-1468
DentaQuest Provider Services: 1-888-307-6547
DentaQuest website: www.dentaquestgov.com
SECTION 10: PAIN MANAGEMENT PROGRAM

10.1 PRIOR AUTHORIZATION REQUIREMENTS

Aetna Better Health of Missouri has entered into an agreement with eviCore HealthCare to manage the prior authorization of specific codes for pain management services. Aetna Better Health of Missouri is responsible for claims adjudication and network management. EviCore will manage the prior authorization process for specific CPT codes.

The CPT codes which require eviCore review are listed on Provider Secure Web Portal.

All requests for pain management codes that are not handled by eviCore are to be sent to Aetna Better Health of Missouri’s prior authorization department. Requests for coverage of the prescription medication for pain management are handled by MO HealthNet.

NOTE:

- It is the responsibility of the ordering physician to obtain prior authorization.
- Providers rendering the above services should verify the necessary authorization has been obtained. Failure to do so may result in non-payment of your claim.

10.2 REQUESTING AN AUTHORIZATION FOR PAIN MANAGEMENT

10.2.1 eviCore

There are three options to request prior authorizations for Pain Management through eviCore HealthCare. In all cases, providers will be expected to provide pertinent clinical and demographic information, including Aetna Better Health of Missouri member ID, patient date of birth, diagnosis, and treatment information. The three options to request prior authorization are:


Fax: Complete eviCore Request form found on eviCore’s website and fax your request to eviCore’s fax line at 1-844-822-3862.

Phone: Call eviCore’s toll free line at 1-888-693-3211.

EviCore will provide an authorization number for all authorized services. Please be sure to make a note of this authorization number in the member’s medical record for future reference.

10.2.2 Aetna Better Health of Missouri Prior Authorization Department

Request for pain management codes that are NOT handled by eviCore are to be sent to Aetna Better Health of Missouri’s prior authorization department. The two options to send the prior authorization request are:

Fax: Complete Aetna Better Health of Missouri’s Pre-Authorization request form and fax to the 24 hour fax line at 1-866-341-1327.

Phone: Call Aetna Better Health of Missouri’s toll free prior authorization line between 8 a.m. and 5 p.m. at 1-800-566-6444.

Aetna Better Health of Missouri will provide an authorization number for all authorized services. Please be sure to make a note of this authorization number in the member’s medical record for future reference.

10.3 AUTHORIZATION VERIFICATION

There are two options to verify the status of a prior authorization request through eviCore. Providers will be expected to provide pertinent clinical and demographic information in order to verify the status of a request. The two ways to verify the status of a request are:

Web: If you submitted the original authorization request online, you can visit www.eviCore.com to verify the status of a prior authorization.

Phone: Call eviCore’s toll free line at 1-888-693-3211.

Note: If you requested an authorization through Aetna Better Health of Missouri’s preauthorization department, please call the authorization line between 8 a.m. and 5 p.m. at 1-800-566-6444.
10.4 CLAIM SUBMISSION FOR PAIN MANAGEMENT SERVICES

Claims for pain management services should be submitted to Aetna Better Health of Missouri. Please refer to Section 15: Claims and Reimbursement for more information on claims submission.

10.5 PROVIDER PARTICIPATION

Aetna Better Health of Missouri maintains responsibility for contracting and credentialing outpatient pain management providers. If you are not a participating provider and would like to join the Aetna Better Health of Missouri network, please contact Provider Relations at 1-800-566-6444.
SECTION 11: OUTPATIENT RADIOLOGY/IMAGING PROGRAM

11.1 PRIOR AUTHORIZATION REQUIREMENTS

Aetna Better Health of Missouri is contracted with eviCore (formerly known as Med Solutions Inc.) to manage the prior authorization of non-emergent, high tech, outpatient radiology/imaging services. Under the agreement between Aetna Better Health of Missouri and eviCore, Aetna Better Health of Missouri is responsible for claims adjudication, network management and medical protocols; eviCore will manage the prior authorization process.

The Outpatient Radiology/Imaging Program will apply to all Aetna Better Health of Missouri Members. Prior authorization through eviCore is required for all outpatient, non-emergent, diagnostic imaging and advanced imaging services including:

- CT /CTA
- MRI/MRA/MRS
- OB ULTRASOUND
- NON-OB ULTRASOUND
- PET SCAN
- DIAGNOSTIC NUCLEAR MEDICINE
- NUCLEAR CARDIOLOGY

The code specific list of services that require prior authorization thru eviCore can be found on the authorization look up tool on the Aetna Better Health Provider Secure Web Portal which can be accessed via the website www.aetnabetterhealth.com/mo.

NOTE:

- It is the responsibility of the ordering physician to obtain prior authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of your claim.

11.1.1 Obstetrical Ultrasound prior authorization requirement

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Obstetrical Ultrasound Authorization Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrical Provider</td>
<td>The initial two ultrasounds ordered per pregnancy do not require an authorization if the obstetrical provider has secured the global pregnancy notification authorization. The third and subsequent obstetrical ultrasounds require prior authorization by contacting eviCore via phone, fax or web.</td>
</tr>
<tr>
<td>Maternal Fetal Medicine (MFM) Provider</td>
<td>The initial three ultrasounds ordered per pregnancy do not require authorization if the MFM has an office consult authorization. The fourth and subsequent obstetrical ultrasound require prior authorization by contacting eviCore via phone, fax or web.</td>
</tr>
</tbody>
</table>

11.2 REQUESTING AN AUTHORIZATION FOR OUTPATIENT RADIOLOGY/IMAGING SERVICES

There are three options to request prior authorizations for radiological/imaging through eviCore. In all cases, providers will be expected to provide pertinent clinical and demographic information, including Aetna Better Health of Missouri member ID, patient date of birth, diagnosis and treatment information, and results from prior imaging. The three (3) options to request prior authorization are:

Web: Access online auth submission through www.eviCore.com. Ordering physician registration/login is available on the home page.

Fax: Complete eviCore Radiology Fax Request form found on eciCore's website and fax your request to eviCore's 24 hour fax line at 1-888-693-3210.

Phone: Call Aetna Better Health of Missouri's toll-free prior authorization line between 8 a.m. and 5 p.m. at 1-800-566-6444, select the prompt for radiology services.

EviCore will provide a eviCore authorization number for all authorized services. Please be sure to make a note of this authorization number in the member’s medical record or for future reference.
11.3  AUTHORIZATION VERIFICATION OPTIONS

Providers are required to verify all necessary authorizations are in place prior to rendering services.

There are two options to verify the status of a prior authorization request through eviCore. Providers will be expected to provide pertinent clinical and demographic information in order to verify the status of a request. The two (2) ways to verify the status of a request are:

**Web**: Visit [www.eviCore.com](http://www.eviCore.com). Select the Authorization Lookup link and select Aetna Better Health of Missouri from the drop down list provided.

**Phone**: Call Aetna Better Health of Missouri’s toll-free prior authorization line between 8 a.m. and 5 p.m. at **1-800-566-6444**, select the prompt for radiology services.

Please note that all eviCore authorizations are loaded into Aetna Better Health of Missouri’s system within 1 business day. When this information is translated into our system, an Aetna Better Health of Missouri authorization number is generated. If you are using the Aetna Better Health of Missouri Provider Secure Web Portal to verify authorization of radiology/imaging services, please use the member ID to search for the authorization information.

11.4  CLAIM SUBMISSION FOR OUTPATIENT RADIOLOGY/IMAGING SERVICES

Claims for outpatient radiology/imaging services should be submitted to Aetna Better Health of Missouri. Please refer to Section 15: Claims and Reimbursement for more information on claim submission.

11.5  PROVIDER PARTICIPATION

Aetna Better Health of Missouri maintains responsibility for contracting and credentialing outpatient and free-standing radiology/imaging providers. If you are not a participating provider and would like to join the Aetna Better Health of Missouri network, please contact Provider Relations at **1-800-566-6444**.
SECTION 12: ROUTINE VISION SERVICE

12.1 ROUTINE VISION SERVICES

MARCH Vision Care Group is the routine vision care network for Aetna Better Health of Missouri. MARCH Vision Care manages the routine vision care benefit for all Aetna Better Health of Missouri members. Aetna Better Health of Missouri members may obtain routine vision services from any participating MARCH Vision Care provider.

12.2 CLAIM SUBMISSION FOR ROUTINE VISION SERVICES

Claims for routine vision services should be submitted to MARCH Vision at:

MARCH Vision Care Claims Address
6701 Center Drive West. Ste 790
Los Angeles, CA  90045

MARCH Vision Care claim submission and Provider Reference Guide can be located on the MARCH Vision Care website. www.marchvisioncare.com

Claims for medical (non-routine) vision services should be submitted to Aetna Better Health of Missouri. Non participating providers must obtain prior authorization to provide services to Aetna Better Health of Missouri members and receive claim payment.

12.3 PROVIDER PARTICIPATION

MARCH Vision Care has a comprehensive network of vision care providers in Missouri. If you are a participating provider for MARCH Vision Care, please refer to your MARCH Vision Care provider Reference Guide.

If you are not a MARCH Vision Care provider and would like to join the MARCH Vision network, please contact MARCH Vision at 1-888-493-4070 ext 7576.

12.4 MEMBER ELIGIBILITY VERIFICATION

Vision Providers are required to confirm member eligibility and vision benefits prior to rendering services. There are two options to confirm routine vision benefits for Aetna Better Health of Missouri members. In all cases, providers will be expected to provide pertinent demographic information, including Aetna Better Health of Missouri member name, member ID, and member date of birth.

Web: Access online benefit verification through the MARCH Vision Care provider portal, eyeSynergy® at www.marchvisioncare.com. Provider registration/login information is available by calling MARCH Customer Service at 1-888-493-4070.

Phone: Call MARCH Vision Care’s toll-free provider services line between 8 a.m. and 5 p.m. CST at 1-888-493-4070.

12.5 MEMBER BENEFITS FOR ROUTINE VISION

Aetna Better Health of Missouri provides optical services for eligible members with this benefit. Providers should contact MARCH Vision Care at 1-888-493-4070 to verify member benefit information for routine vision services, including optical. For a complete listing of all participating vision providers, please refer to the Provider Search on MARCH Vision Care’s website.

12.6 PRIMARY CARE FAX NOTIFICATION

MARCH Vision will provide fax notification to PCP’s regarding Aetna Better Health of Missouri member eye exam results. This includes notification on potential early disease detection and diabetic retinal eye exam results. This aspect is very helpful for coordinating with primary care practices for Aetna Better Health of Missouri members who may need interventions including but not limited to diabetes.

12.7 VISION SERVICES PROGRAM FACT SHEET

For more information, please refer to the Vision Services Program Fact Sheet which can be found on our website www.aetnabetterhealth.com/mo and Provider Secure Web Portal or contact your provider relations representative.
SECTION 13: PHARMACY

13.1 PHARMACY SERVICES

ALL Pharmacy Services are covered by the MO HealthNet Pharmacy Program.

Pharmacy Services include:

- ALL medications and pharmaceuticals administered on an outpatient basis
- Physician-administered drugs
- Over-the-counter (OTC) products (limited)
- Drugs dispensed by outpatient pharmacies
- Medications administered in the outpatient department of a hospital or other outpatient clinic
- Medications provided in a home health setting including home infusion
- Diabetic medications (oral and injectable): including syringes, diabetic testing equipment and directly-related supplies such as strips, calibration solution, lancets and alcohol pads
- Peak flow meters and aerochambers

Direct any provider questions about the pharmacy benefit to MO HealthNet at 1-800-392-8030.

13.2 PROVIDER PARTICIPATION

Providers must be enrolled in the MO HealthNet program to provide pharmacy services. Those who participate in the MO HealthNet Program agree to accept MO HealthNet payment as reimbursement in full for any pharmacy services provided to Aetna Better Health of Missouri members. A member cannot be billed for the difference between the MO HealthNet payment and the provider’s billed charges.

An application to become a MO HealthNet provider can be found on the MO HealthNet website: www.dss.mo.gov/mhd/providers/index.htm

13.3 OVER-THE-COUNTER (OTC) DRUGS

A complete list of OTC products covered by MO HealthNet can be found at their website: dss.mo.gov/mhd/cs/pharmacy/pdf/otc_coveredproducts.pdf.

13.4 PRIOR AUTHORIZATION

The MO HealthNet Pharmacy Prior Authorization Line is 1-800-392-8030. Forms can be downloaded at: www.dss.mo.gov/mhd/cs/pharmacy

13.5 DOSE OPTIMIZATION LIST

MO HealthNet’s Dose Optimization List is a list of quantity limits. Updates are provided in MO HealthNet Provider NewsFlash. The most updated list of dose optimizations can be found at www.dss.mo.gov/mhd/cs/pharmacy.

13.6 CYBERACCESS℠

CyberAccess℠ is a web-based tool which allows providers to prescribe electronically, view diagnosis data, receive alerts, select appropriate preferred medications and electronically request drug and medical prior authorizations for their MO HealthNet and Aetna Better Health of Missouri members.

To become a CyberAccess℠ user contact the Xerox and Quality Solutions help desk at 1-888-581-9797 or 573-632-9797 or Email to CyberAccessHelpdesk@xerox.com. Xerox Care and Quality Solutions staff will set up individual training sessions with each provider site that requests access to the web tool. More information can be found at dss.mo.gov/mhd/cs/medprecert/pages/cyberaccess.htm.
SECTION 14: QUALITY MANAGEMENT

14.1 OVERVIEW

Aetna Better Health of Missouri has a Quality Improvement (QI) Program that is an ongoing, comprehensive and integrated system designed to set the foundation for its quality organizational structure. The QI program is under the leadership of the Medical Director and actively initiates, monitors and evaluates standards of health care practice, the infrastructure essential to the delivery of clinical quality of care and services to members. Aetna Better Health of Missouri maintains a companywide commitment to quality and industry best practices and/or standards as set forth by state and federal regulators, as well as accrediting organizations. The QI program description serves to coordinate, integrate and oversee the quality improvement program for health care and services provided to all members of Aetna Better Health of Missouri. Physician participation is an integral component of Aetna Better Health of Missouri’s Quality Improvement Program. Requests for committee participation should be directed to the Aetna Better Health of Missouri Chief Medical Director and/or the Aetna Better Health of Missouri Director of Quality Improvement.

Contracted practitioners and providers are required by contract to:
• Cooperate with QI activities
• Maintain the confidentiality of member information and records
• Allow Aetna Better Health of Missouri to use their performance data

14.2 COMMITTEE STRUCTURE

A. Aetna Better Health of Missouri Board of Managers delegated oversight of the Aetna Better Health of Missouri Quality Improvement program to the Quality Management Oversight Committee. The Board of Managers meets annually and reviews and approves the QI program documents, i.e., Program Description/Strategy; Work Plan; and Evaluation.

B. Quality Management Oversight Committee (QMOCC) - This committee is comprised of executives at Aetna Better Health of Missouri responsible for oversight of the QI program. The committee meets at least six times per year to guide improvement strategies.

C. Quality Management/Utilization Management Committee - This committee meets quarterly and includes practitioners from the community and key staff at Aetna Better Health of Missouri. The committee is responsible for providing oversight and physician review of the Health Plan’s clinical Quality (including Clinical Practice Guidelines, criteria and protocols), and Utilization Management Programs.

14.3 GOALS AND OBJECTIVES

Goals

Program goals include the following:
• Continuously improve the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
• Define, demonstrate and communicate the organization-wide commitment to improving the quality of care and patient safety.
• Foster a partnership among members, caregivers, providers, and community, which allows Aetna Better Health of Missouri to promote effective health management, health education and disease prevention, as well as encourages the appropriate use of health care and services by members and providers.
• Measure and enhance member satisfaction with the quality of care and services provided by our network providers.
• Measure and enhance provider satisfaction with the quality of service provided by Aetna Better Health of Missouri.
• Maintain compliance with local, state and federal regulatory requirements, and accreditation standards.
• Identify opportunities and make improvements based on measurement, validation and interpretation of data.
• Incorporate public health goals from the State Medical Assistance QI Program, where applicable.
• Provide oversight of delegated entities to ensure compliance with Aetna Better Health of Missouri standards as well as state and federal regulatory requirements and accreditation standards including the monitoring and improvement of behavioral health care delivery.
• Ensure collaboration with behavioral healthcare networks to improve continuity and coordination of care between behavioral health specialists and primary care practitioners. This includes member and provider education regarding the process for
obtaining behavioral healthcare and/or substance abuse services that are “carved out” of the Managed Care Organization (MCO) contracts and provided by fee-for-service State Medicaid programs, as applicable.

Objectives

Program objectives include the following:

A. To integrate the Quality Improvement Program with other operational functions to facilitate the quality improvement process through development and implementation of policies and procedures, that provide guidance on responding to situations that pose an immediate threat to the health and safety of members.

B. To conduct an annual evaluation of the QI program.

C. To establish and conduct an annual review of quality and performance improvement projects (QIPs/PIPs) related to significant aspects of clinical and non-clinical services, targeting the specified population. The QIPs/PIPs will include the following components:
   - Criteria for the selection and prioritization
   - Measurement of performance
   - System interventions
   - Improving performance
   - Systematic and periodic follow-up on the effect of the interventions to ensure Achievement of demonstrable improvement. Focus on clinical quality.
   - Address consumer safety

QIPs/PIPs will be monitored using quality indicators that are objective, unambiguous, and based on current clinical knowledge, evidence based or health services research. Focus will be on system interventions, as indicated, including the establishment or alteration of practice guidelines. Quality indicators selected will allow the measurement of outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies of these outcomes. The status and results of each QIP/PIP will be reported annually to the designated regulatory agency as required. Details of the specific QIPs/PIPs are contained in the designated Quality Improvement reporting template. Aetna Better Health of Missouri follows the PIP reporting and format requirements as required by the State and the External Quality Review Organization.

D. To ensure members are given their rights and responsibilities, including how to obtain services and how to submit a complaint or appeal. To educate all providers on member rights and responsibilities.

E. To support objectives aimed at the development, monitoring and servicing of members with complex and special health needs through:
   - Annual population assessments to identify needs of populations and sub-populations so that case management processes and resources can be updated to address member needs.
   - Promotion of preventive health services and the management of chronic diseases through disease management programs that encourage the use of services to decrease future morbidity and mortality in Health Plan members.
   - A Complex Case Management (CCM) program that identifies members for whom intensive management will improve the quality of care and assist individuals in reaching the optimum level of wellness. Assuring the CCM program is integrated with the utilization, chronic condition and disease management programs, allowing a comprehensive picture of the member’s medical and behavioral health co-morbidities and other conditions. The complex conditions that Aetna Better Health of Missouri case manages are defined within our CCM Program.

14.4 CLINICAL PRACTICE GUIDELINES

The evidenced-based clinical practice guidelines used by Aetna Better Health of Missouri represent best practices and are based on national standards, reasonable medical evidence, and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the health plan chief medical officer, applicable medical committees and, if necessary, external consultants. Clinical practice guidelines are reviewed at least every two years, or as often as new information is available.

Clinical guidelines are made available to providers on the Aetna Better Health of Missouri website; providers are informed of the availability of new guidelines and updates in the provider newsletter. Providers may request a copy of a guideline at any time by contacting their provider relations representative or the Aetna Better Health of Missouri office of the chief medical officer.
14.5 MEDICAL RECORD MANAGEMENT AND REQUIREMENTS

Aetna Better Health of Missouri providers are responsible for maintaining medical record systems that ensure the following:

• Confidentiality of Protected Health Information (PHI).
• Records are kept current in a detailed, organized, and comprehensive manner that permits effective member care and quality review.
• Records are available and accessible for quality review in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Aetna Better Health of Missouri providers are responsible for maintaining records according to federal and state requirements.

In accordance with Missouri law (RSMO Section 334.097), physicians shall maintain an adequate and complete medical record for each member and may maintain electronic records provided the record keeping format is capable of being printed for review. Aetna Better Health of Missouri providers are responsible for maintaining records according to federal and state regulations and applicable accreditation standards, such as NCQA.

Furthermore, Missouri law imposes obligations on individual providers and health care facilities and entities relating to the maintenance, retention and disposal of medical records including:

• maintain a patient record for each individual to whom medical services were provided;
• maintain the records for a minimum of 7 years from the date of service unless federal or state law or medical practice standards require a longer retention period; and
• maintain the records in a way that protects their integrity, ensures their confidentiality, proper use and their accessibility and availability to each patient as required by law.

Each health care provider should ensure that patient health information is available to meet the needs of continued patient care, legal requirements, research, education, and other legitimate uses.

The American Health Information Management Association (AHIMA) recommends that medical records for adults be maintained for ten years after the most recent encounter and that medical records for children be maintained until the age of majority plus the statute of limitations.

Aetna Better Health of Missouri requires that medical records be maintained in compliance with federal and state regulations and that appointment logs be maintained for a minimum of 1 year for the state agency to verify compliance to appointment standards.

Aetna Better Health of Missouri contracts with providers require that providers cooperate with QI activities including:

• Providing access to practitioner medical records to the extent permitted by state and federal laws. Medical records may be reviewed on-site or requested for review to meet state requests, for the collection and submission of HEDIS data as required by State law, MO HealthNet requirements and to meet other accreditation requirements.
• Providers maintain the confidentiality of member information and records.

NOTE: When members enroll in MO HealthNet, they sign a waiver to release medical records and other requested participant protected health information to the State of Missouri and to agents of the State, such as Aetna Better Health of Missouri.

14.5.1 Copy or access to Member Medical Records

The medical record is the property of the provider who generates the record. All member records must be made available to authorized representatives of the State of Missouri MO HealthNet Agency, Department of Health and Human Services within thirty (30) days of request.

Upon written request of a member, guardian or legally authorized representative of a member, the provider shall furnish a copy of the medical records of the member’s health plan history and treatment rendered within 30 days of the initial request. Members are entitled to one (1) copy of their medical record per year at no cost to the member. The fee for additional copies shall not exceed the actual cost of the time and materials used to compile, copy, and furnish such records.

It is important that medical record information be provided in a timely manner when a member requests a PCP and/or specialty provider change to assure adequate coordination and a safe transfer of member care and services. Aetna Better Health of Missouri requests that medical record(s) be transferred to a new provider within ten (10) business days of receipt of the request, or prior to the next scheduled appointment to the new primary care provider, whichever is earlier.
14.5.2 Confidentiality
Confidential information is any information that is revealed during the course of a confidential relationship. It includes communication between the member, the provider or other clinical persons involved in the member’s medical, psychiatric, and/or substance abuse care.

14.5.3 Release of Information
Valid authorization must be obtained from the member or member’s personal representative to use or disclose PHI for purposes other than treatment, payment or health care operations.

14.5.4 Storage
Medical records should be stored by providers in an area that does not allow for unauthorized retrieval. Member records located at Aetna Better Health of Missouri are maintained in a locked file cabinet.

14.5.5 Transfer of Medical Records
It is important that medical records are transferred in a timely manner when a member requests a PCP and/or specialty Provider change. Aetna Better Health of Missouri requests that medical records be transferred to a new provider within ten (10) business days of receipt of the request.

Primary Care Providers are notified monthly of new members added to their panels via their PCP Panel List. Aetna Better Health of Missouri encourages providers to use this list to contact new members for appointments and request copies of their medical records.

14.5.6 Medical Records Retention
Medical records must be maintained and preserved for a minimum of seven (7) years from termination of the Aetna Better Health of Missouri contract.

Appointment log books or sign-in sheets must be maintained for a minimum of one (1) year in order for the state agency to verify compliance to appointment standards.

14.6 PROVIDER ON-GOING MONITORING PROCESS

14.6.1 Continuous Monitoring for Quality of Care and Service by Providers
In support of our mission to provide quality health care to our members, Aetna Better Health of Missouri has established formal processes for reviewing adverse events, quality of care issues, reporting to NPDB/HIPDB and a formal peer review program. The Quality Improvement Department, under the direction of the Medical Director is responsible for continuously monitoring quality of care and services provided by our provider network and to monitor compliance with applicable Federal and State regulations as required by Aetna Better Health of Missouri’s contract with the MO HealthNet. Processes in place to continuously monitor quality of care and services include credentialing, a peer review process, medical record reviews as applicable and reviews of all reported adverse events and quality of care issues, such as:

• Any unexpected death or physical/psychological injury resulting from treatment.
• Other member issues relating to care and/or service, i.e. medical mismanagement or delay in treatment.

14.6.2 Dispute Resolution and Corrective Action (CAP) Process
To govern any disputes between the provider and Aetna Better Health of Missouri that could ultimately result in a change in the network status of the practitioner, a provider dispute resolution process has been established. Aetna Better Health of Missouri will notify providers of any issues regarding noncompliance, professional competency and/or conduct. For noncompliance, at a minimum, the following steps take place:

• At least two (2) written notification letters are sent to the provider notifying him/her of the issue, Aetna Better Health of Missouri’s policy, including the potential for corrective action.
• Upon determination that the provider has not complied with Aetna Better Health of Missouri’s participation requirements, the Medical Director may initiate corrective actions. Corrective actions may include, but are not limited to, counseling, practice restrictions, financial penalties, termination of provider’s participation, imposing summary suspension if such action is necessary to protect member’s health and welfare, notifying the medical group of which the provider is a member, that corrective actions have been imposed.
• The Medical Director may refer the issue to an appropriate committee for review and recommendations. If the recommendation is contract termination, the provider will be notified immediately by certified mail.

• The Medical Director or designee or the Credentialing Committee may recommend termination of the Aetna Better Health of Missouri provider for substandard performance, failure to comply with administrative requirements or any other reason.

14.6.3 Immediate Suspension
The Medical Director or designee may immediately suspend or restrict any practitioner if the Medical Director determines that the health of Aetna Better Health of Missouri members or any individual referred by Aetna Better Health of Missouri to practitioner for care is in imminent danger or jeopardy because of the actions or inactions of a participating provider or that, in his or her sole discretion, an Aetna Better Health of Missouri practitioner may be subject to disciplinary action, including termination. Pursuant to the credentialing policy, the Medical Director or designee may immediately suspend or restrict the provider’s participation status, during which time Aetna Better Health of Missouri will investigate to determine if further action is required.

14.6.4 Appeal of Corrective Action
An opportunity to appeal any corrective action is available to all providers. A hearing to appeal the imposition of action is available to a provider against whom a final adverse action is recommended if the practitioner submits a written request within thirty (30) days after the date of the notice letter. The Appeals Committee hears all requested provider hearing appeals. The Appeals Committee may uphold, modify or reject corrective actions.

For specific details or additional information, a copy of the following policies is available upon request.
1) Quality Improvement Medical Record Review
2) Quality of Care Issue Review and Adverse Event Monitoring
3) NPDB/HIPDB Reporting Process
4) Peer Review Program
5) Provider Dispute Resolution

For additional information or copies of policies related to provider on-going monitoring and the provider dispute resolution process, please contact your provider relations representative.

14.7 CULTURAL COMPETENCE
Delivering culturally competent health services requires the understanding of culturally-defined health related needs of individuals, families, and communities, as well as the understanding of culturally based belief systems regarding etiology of illness, disease, health and healing. Aetna Better Health of Missouri supports the education of providers and their employees regarding cultural competence principles and in complying with Title VI and Title VII of the Civil Rights Act and the Americans with Disabilities Act.

There are five (5) essential elements that contribute to a provider’s ability to become culturally competent.

The provider should:
• Value diversity.
• Have the capacity for cultural self-assessment.
• Be conscious of the dynamics inherent when cultures interact.
• Institutionalize cultural knowledge.
• Develop adaptations to service delivery reflecting an understanding of diversity between and within cultures.

14.7.1 Meeting Member’s Cultural and Linguistic Needs
Aetna Better Health of Missouri’s membership is comprised of individuals, who upon enrollment, may declare languages other than English and individuals with visual or hearing impairment. The principal languages as defined by the State contract are English and Spanish. In 2014 the top five languages requested for interpretation remain (1) Spanish (2) Arabic (3) Nepali (4) Burmese and (5) Somali. The request for Bosnian interpretation also increased.

This diverse membership requires both translation of written materials, telephonic and face-to-face interpreter services. Aetna Better Health of Missouri employs Spanish speaking staff in the Member Services department. Aetna Better Health of Missouri provides telephonic interpretation services through Language Line and face-to-face interpretation services throughout all
three regions by contracting with the following agencies: Language Access Metro Project (LAMP), Jewish Vocational Services, International Institute, A-Z Translating Services, and AAA Translation. Interpreter services for hearing impaired members are provided through Deaf Inter-Link, Deaf Expression, Inc. and DEAF Way. An interpreter may accompany a member to their provider visit. A member may request this by calling Member Services.

Aetna Better Health of Missouri contracts with Language Line for member telephonic interpretation. Voiance Voice Translation tracks the languages requested and reports this data to Aetna Better Health of Missouri.

Aetna Better Health of Missouri’s 24-hour nurse line employs bilingual staff, supplemented as needed, by a third party interpretation service vendor. The nurse line also supports members needing TDD/TTY services via a local TTY access number.

In accordance with our contract with the state of Missouri, a language block has been added to all member literature. This block reads: "To receive a translated copy of this document, call Member Services at 1-800-566.6444. Para recibir una copia traducida de este documento, llame al servicio para miembros al 1-800-566.6444."

To meet the needs of our speech, hearing and visually impaired members the member handbook is also offered in Braille and audio upon request. Aetna Better Health of Missouri tracks any requests received for any of these alternative versions. Aetna Better Health of Missouri also monitors for any grievances related to language services.

14.7.2 Title VI of the Civil Rights Act of 1964
No person in the United States shall, on the grounds of race, color or national origin be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination under any program or activity receiving federal assistance. The Title VI regulation prohibits retaliation for filing an unlawful discrimination complaint or for advocacy for a right protected by Title VI.

14.7.3 Title VII of the Civil Rights Act of 1964
Prohibits discrimination on the basis of race, color, national origin, sex, or religion in all employment activities (i.e., interviews, promotions, disciplinary actions, terminations, etc.).

14.7.4 The Americans with Disabilities Act of 1990
42 U.S.C. 12101 et seq (ADA)
The purpose of the Act is to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life; to provide enforceable standards addressing discrimination against individuals with disabilities and to ensure that the federal government plays a central role in enforcing these standards on behalf of individuals with disabilities.

Steps providers must take to be in compliance:

1. Designate a ‘Civil Rights Coordinator’ or contact person for your facility.
2. Public notification of a non-discrimination policy.
3. Display a “Non-Discrimination in the provision of services” poster in a location easily accessible and visible to clients.
4. Conduct civil rights training for employees.
5. Develop a particular complaint procedure for clients wanting to file a complaint of discrimination
6. Collect and maintain information regarding racial/ethnic makeup of workforce (if over 50 employees) and information on client or service complaints.

Source: peu.momed.com/momed/presentation/providerenrollmentgui/CivilRightsFormsWindow.jsp

14.8 ADVANCE DIRECTIVE REQUIREMENTS
Aetna Better Health of Missouri is required to provide education about advance directives to providers, staff and members. Advance directives provide for the right for any member to participate in and direct their own health care decisions, to accept or refuse medical or surgical treatment and to prepare an advance directive which is documented in writing.

All Aetna Better Health of Missouri providers are required to inform members of their individual rights under state laws governing advance directives. Providers need to document patient advance directive information in the patient medical record. As part of the medical record review process, Aetna Better Health of Missouri audits applicable medical records to determine compliance with advance directives policies and procedures.
Providers are required to notify members to what extent he/she will honor a patient's advance directive. Providers may not discriminate against a patient who does not have an advance directive. Providers are required to document patient advance directive information in the medical record. Providers should also provide ongoing community education on advance directives.

Advanced Directive Health Care

Since December of 1991, federal law directs that most health care providers give adults information about their rights under state laws about advance directives. The laws include:

- The right to participate in and direct your own health care decisions
- The right to accept or refuse medical treatment
- The right to prepare an advance directive
- The right to information about whether a health care provider will honor your advance directives.

The law:

- Prohibits institutions from discriminating against people without an advance directive
- Requires institutions to document individuals information regarding advance directives
- Requires institutions to provide on-going community education regarding advance directives

An advance health care directive is a tool for health care decisions when a person cannot speak for themselves. It tells health care providers what future health care wishes your patient has if they are too sick to tell you them self. This is the only time an advance directive is used.

Providers should talk to their patients who are 18 years of age or older about their wishes, fears and medical options.

14.8.1 Types of Advance Health Care Directives

There are two types of advance health care directives:

- a living will and
- a durable power of attorney for health care

A living will is a legal document with written instructions spelling out any treatments a patient wants or does not want if unable to speak for them self and they are terminally ill or permanently unconscious. A Durable Power of Attorney for Health Care is a document that allows a patient to name a person to make medical decisions for them if they cannot. This person will act as the patient's “agent” when treatment decisions need to be made and the patient cannot make them. Agents can only make decisions about the specific treatment areas described in the power of attorney.

14.8.2 Who Needs an Advance Directive?

Because illness and injury can happen at any time, all adults should consider having an advance directive, even if they are in good health now.

It is every patient’s choice and right to sign an advance directive. No insurance company or health care provider can force a person to sign an advance directive.

Patient’s can change or stop an advance directive at any time.

An Advance Directive does not change insurance coverage.

14.8.3 Where Can I Get an Advance Health Care Directive?

A durable power of attorney for health care and advance health care directive forms may be available through a health care provider, a local public library or the Missouri Bar at:

326 Monroe
Jefferson City, MO 65101
573-635-4128
The following resources may also be helpful:

- Missouri Office of the Attorney General:
  - www.ago.mo.gov
  - www.putitinwriting.org/putitinwriting_app/content/piiwbrochure.pdf
- American Bar Association:
  - www.abanet.org/aging/toolkit/home.html
- Aging with Dignity:
  - www.agingwithdignity.org
- Missouri Bar Association:
  - www.mobar.org
- National Hospice and Palliative Care Organization:
  - www.caringinfo.org
- Children's Hospice International:
  - www.chionline.org

14.9 PATIENT SAFETY

In November 1999, the Institute of Medicine’s (IOM) Committee on Quality Health Care in America released a comprehensive report regarding medical errors in the health care system. "To Err is Human: Building a Safer Health System." The report cited startling statistics including that 44,000 Americans die annually due to medical errors. It presented recommendations that call for action to reduce these errors at a number of different levels. Specifically, it suggested that health care organizations and accrediting bodies do the following:

- Require health care organizations to implement meaningful patient safety programs;
- Focus greater attention on performance measures and standards for both health care organizations and health care professionals on patient safety.

Aetna Better Health of Missouri has responded to these developments by including an emphasis on patient safety in the Quality Improvement Program. A number of activities are in place to monitor aspects of patient safety. The National Quality Forum’s recommended adverse event list has been combined with the CMS list of hospital-acquired conditions and other events identified by Aetna Better Health of Missouri to be used for quality of care adverse event monitoring and reporting. Physicians’ credentials are verified in accordance with NCQA standards plus monitoring of disciplinary action against physicians occurs on an ongoing basis.

14.10 PROVIDER PROFILES

In an effort to promote the provision of quality care, Aetna Better Health of Missouri may profile 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 of Missouri’s profiling program is intended to support clinical decision-making and patient engagement as providers 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 of Missouri 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

Aetna Better Health of Missouri 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 of Missouri’s Medical Directors regularly visit individual network providers to interpret profile results, review quality data, and discuss any new medical guidelines. Our Medical Directors investigate potential utilization or quality of care issues that may be identified through profiles. Aetna Better Health of Missouri’s medical leadership is committed to collaborating with providers to find ways to improve patient care.
SECTION 15: CLAIMS AND REIMBURSEMENT

15.1 CLAIM PAYMENTS AND PROCESSING TIME FRAMES

Payment is always subject to member eligibility at the time of services. Please be aware that members must be eligible with Aetna Better Health of Missouri on the date the service is provided. Due to day specific eligibility the provider is required to verify the member's eligibility through the State ARU line, Emdeon office, www.aetnabetterhealth.com/mo or Infocrossing website on each and every date of service. Aetna Better Health of Missouri is not responsible for the reimbursement of services when MO HealthNet has retroactively terminated a member’s eligibility, even if authorization has been obtained. See Section 6.11: Medical Management, Transition of Care for exceptions.

In accordance with Missouri statutes, within 48 hours of receipt of an electronically filed claim, Aetna Better Health of Missouri will send electronic acknowledgement of the date of receipt of the claim. Aetna Better Health of Missouri has thirty processing days after receiving a claim to (a) pay or deny the claim if it is a Clean Claim, or (b) send an electronic or facsimile notice of the status of the claim indicating what additional information Aetna Better Health of Missouri needs in order for the claim to be processed as a Clean Claim. Within 10 processing days of receiving such additional information from the provider, Aetna Better Health of Missouri will pay or deny any undisputed part of the claim, or send another electronic or facsimile notice to the provider indicating what additional information is necessary in order to process the claim. This will be Aetna Better Health of Missouri’s final request for additional information. Once Aetna Better Health of Missouri receives the information from the provider in response to the final request, Aetna Better Health of Missouri must, within 5 processing days, either pay or deny the claim.

Electronic Claims that are not processed within 45 processing days of receipt by Aetna Better Health of Missouri will be subject to interest in the amount of 1% per month on the unpaid balance and penalties in the amount of 1% per day on the unpaid balance of the claim in accordance with Missouri statutes.

15.2 ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICES

Electronic funds transfer (EFT) is Aetna Better Health of Missouri’s standard payment method for provider reimbursement. EFT is a secure, direct deposit into your bank account. EFT is similar to direct deposit of paychecks or tax refunds. It’s a proven method for providers to securely get their payments up to one week faster than paper checks and is at no cost to providers. Enroll by completing the EFT Enrollment Form found on our provider website and submitting to the Aetna Better Health Finance Department for handling.

To sign up for ERA, complete the ERA enrollment form found on our website and submit it to Provider Relations for handling.

15.3 NATIONAL PROVIDER IDENTIFIER NUMBER & TAXONOMY CODES

The National Provider Identifier Number (NPI) is a ten (10) digit provider number specifically assigned by CMS. All providers must use their NPI number on all claims submitted to Aetna Better Health of Missouri. To apply for this free NPI number visit the National Plan/Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov/. Aetna Better Health of Missouri does not have any special requirements that differ from the national instructions for each field on the CMS and the UB claim forms.

The CMS and UB claim forms contain fields specifically for the NPI information. On the CMS Form the rendering provider’s (box 31) NPI number is placed in the bottom half of the 24J field. The NPI for the billing provider in box 33 is placed in the 33A field. Additionally, providers may send a NPI number for the facility where services were rendered in box 32A. On the UB form the billing provider listed in box 1 on this form places their NPI number in field 56.

Pathology, Emergency, Anesthesia, Radiology and Laboratory (PEARL) providers will be required to bill their taxonomy codes in addition to their NPI for correct claims processing. Other Aetna Better Health of Missouri providers may be required to also bill their taxonomy codes in order for our system to adjudicate claims. The health care provider taxonomy code is a ten-character, unique alphanumeric code, that represents provider specialties. If a provider is required to submit claims to Aetna Better Health of Missouri providing this information, place the code in box 33-B on the top line on the CMS form and in block 33-B on the UB claim form.

15.4 ELECTRONIC CLAIM SUBMISSION

Electronic claim submission offers providers the fastest and most efficient claims adjudication, reduces office paperwork and mailing costs. Contact your regional provider relations representative for additional information.

Aetna Better Health of Missouri encourages all participating providers to submit electronic claims whenever possible. Aetna Better Health of Missouri can receive initial and corrected claim submissions for both professional and facility claims. EDI Claims are
NOT considered received until claims have passed clearinghouse edits and are accepted into the Aetna Better Health of Missouri system. Providers must review all reject reports from the clearinghouse to verify acceptance, and payments are always subject to member eligibility on the date of service.

Aetna Better Health of Missouri has partnered with Emdeon to provide electronic services to our providers. Aetna Better Health of Missouri has implemented electronic claim filing in order to meet the Health Insurance Portability and Accountability Act (HIPAA) compliance standards. Additional electronic claim submission information is available on our website at www.aetnabetterhealth.com/mo. Please verify with your practice management vendor regarding file formatting and information on how to submit claims.

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Real Time Transaction ID#</th>
<th>Payor ID#</th>
<th>Claim Type</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emdeon</td>
<td>ABHMO</td>
<td>128MO</td>
<td>UB and CMS</td>
<td>877-GO-WEBMD</td>
</tr>
</tbody>
</table>

15.4.1 **Electronic Submission of Corrected Claims**
Corrected or replacement claims may be submitted electronically. Use the Claim Frequency Type Code (CLM05-3) in the 837 5010 EDI format. A value in this field equal to “7” indicates a replacement claim. Additionally, Aetna Better Health of Missouri accepts the following:

<table>
<thead>
<tr>
<th>Claim Type Frequency Code (code set 235)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>5</td>
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<tr>
<td>7</td>
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<tr>
<td>8</td>
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</tbody>
</table>

Any other code (including 1) submitted in the claim type frequency code will not be flagged in our system as a resubmission and will be adjudicated as original submission. The above field code values are for 5010 professional claims. Institutional claims submission use the same code values submitted in the last position of the type of bill field.

Corrected claims must include all original claim lines.

15.4.2 **Corrected Claims with Attachments**
Providers should send the resubmitted claims noting “corrected” or “resubmission” and any attachments via mail to:

Aetna Better Health of Missouri  
P.O. Box 65855  
Phoenix, AZ 85082-5855

Note: Aetna Better Health of Missouri cannot accept a claim via EDI and the attachments mailed separately.

15.4.3 **Initial Claims with Attachments**
Provider should submit all initial claims with attachments via paper to claims address:

Aetna Better Health of Missouri  
P.O. Box 65855  
Phoenix, AZ 85082-5855

15.5 **CLAIM SUBMISSION ADDRESS FOR PAPER CLAIMS**
All paper claims must be submitted directly to Aetna Better Health of Missouri at the following address:

**INITIAL AND CORRECTED SUBMISSIONS**
Aetna Better Health of Missouri  
P.O. Box 65855  
Phoenix, AZ 85082-5855
Each corrected claim must clearly indicate “corrected” or “resubmission”. Corrected claims must include all original claim lines.

### 15.6 TIMELY FILING REQUIREMENTS

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Timely Filing Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Claims (Outpatient/Professional/Ancillary Svcs.)</td>
<td>Ninety (90) calendar days from date of service (DOS)</td>
</tr>
<tr>
<td>Initial Claims (Inpatient Services)</td>
<td>Ninety (90) calendar days from date of discharge (DOD)</td>
</tr>
<tr>
<td>Newborn Claims</td>
<td>Ninety (90) days from the date of enrollment into Aetna Better Health of Missouri’s eligibility files</td>
</tr>
<tr>
<td>Coordination of Benefits (All provider types)</td>
<td>Ninety (90) calendar days from date of primary carrier remittance advice</td>
</tr>
<tr>
<td>Adjusted/Corrected Claims</td>
<td>Providers have 180 days from the date of the first EOB to contact Aetna Better Health of Missouri to request an adjustment or for Aetna Better Health of Missouri to receive a corrected claim.</td>
</tr>
</tbody>
</table>

### 15.7 PROOF OF TIMELY FILING

Aetna Better Health of Missouri considers the following acceptable proof of timely filing:

**Electronic Claims (EDI)**  
The only acceptable documentation is a copy of a Second Level Acceptance report from the Emdeon clearinghouse, which confirms the claim was accepted by Aetna Better Health of Missouri. Documentation must support the claim was submitted within the timely filing policy for initial and corrected claims.  

*Note:* Level 1 or R022 reports are not considered proof of timely filing. These reports do not confirm Aetna Better Health of Missouri has accepted the claim for processing.

**Paper Claims**  
Report, printout or print-screen from the provider’s practice management system which clearly shows the claim was sent to Aetna Better Health of Missouri within the established timely filing limits is considered acceptable proof of timely filing.

For providers without a practice management system, a copy of the original CMS 1500 with the original date billed is considered acceptable proof of timely filing.

The proof of timely filing must be received by Aetna Better Health of Missouri within one (1) year of the date of service (DOS)

*Note:* Tracer claim submissions, MO HealthNet EOBS, and other MO HealthNet plan remittance advices are not considered acceptable proof of timely filing.

Acceptable proof of timely filing should be submitted to following address within the claims adjustment period. Be sure to note the claim as “Corrected” and attached a copy of the acceptable proof of timely filing.

Aetna Better Health of Missouri  
P.O. Box 65855  
Phoenix, AZ 85082-5855

Provider inquiries regarding claims processing should be directed to Claims Inquiry Claims Research at **1-800-566-6444**.

Paper claim submission to the claims P.O. box with the claim noted as “corrected - see attached proof of timely filing” with the acceptable proof of timely filing attached.

For claims not meeting the above acceptable proof of timely filing criteria, providers may initiate a request through the complaint and appeal process to have a specific claim and supporting documentation reviewed.

Note: A copy of a MO HealthNet remittance advice or other MO HealthNet Managed Care plan remittance advice are not considered acceptable documentation to override untimely filing. Member eligibility is date specific and should be confirmed at every visit or encounter.
15.8 ENCOUNTER DATA SUBMISSION REQUIREMENTS

Aetna Better Health of Missouri is mandated by our contract with MO HealthNet to report all provider encounters. Aetna Better Health of Missouri requires claims and encounter data to be submitted using a UB or CMS form. Claims must be received within ninety (90) days from the date of service for office level/outpatient services or from the date of discharge for inpatient services. Line items billed with a zero ($0.00) charge are not accepted by MO HealthNet. Corrected claims must be received within 180 days from the initial remittance advice date and include all original claim lines, including those previously paid correctly.

15.9 ACCEPTABLE CLAIM FORMS (UB AND CMS)

• Facility claims must be submitted on current UB form, with valid revenue codes, CPT, HCPCS codes and the correct type of bill.
• Professional and ancillary claim(s) (non-facility) must be submitted on the current CMS form.
• List all other health insurance coverage when applicable (Block 9A-D of CMS form and Block 58-62 of the UB form). Aetna Better Health of Missouri, as an agency of the state, is the payer of last resort in most instances. For details, refer to COB Section.
• Providers must submit their NPI number in 24J and Block 33A of the CMS form and Block 56 of the UB form.
• All providers, including FQHCs and RHCs, must submit their claims listing out their usual and customary charges as the billed amounts on the applicable claim form.
• Handwritten claims will not be accepted.

All claims must be submitted on a standard claim form and contain the basic data elements necessary for processing. For additional information on the standard CMS form visit [www.nucc.org](http://www.nucc.org) and for the UB form visit [www.nubc.org](http://www.nubc.org).

15.10 COMPONENTS OF A “CLEAN” CLAIM

A Clean Claim is a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment. Here are some tips about submitting Clean Claims:

• Payment is subject to the member’s eligibility at the time the service is rendered.
• Aetna Better Health of Missouri requires standard coding on all claims submitted.
• Initialing your corrections ensures the integrity of the claim being submitted. Altered or corrected claims that are not initialed at the correction site are not considered a clean claim and will be processed with a rejection status.
• Claims submitted for assistant surgeon services which are on the MHD assistant surgeon list (available on the MHD website) will not require authorization. Standard modifier billing guidelines apply when submitting claims.
• Authorizations obtained should be included on the claim in the required field.
• If the revenue code requires a HCPCS or CPT, then it must be submitted.

15.11 VERIFICATION OF CLAIMS PROCESSING OPTIONS

15.11.1 Remittance Advice

Aetna Better Health of Missouri generates weekly checks and remittance advices to all providers for all paid, pended or processed claims. 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. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A copy of the Aetna Better Health of Missouri Remittance Advice is shown in Section 15.11.1b.

For Electronic Remittance Advice (ERA), providers should complete an ERA Enrolment form found on our website, [www.aetnabetterhealth.com/mo](http://www.aetnabetterhealth.com/mo), and submit to provider relations for processing.

NOTE: Aetna Better Health of Missouri will provide an explanation of benefits (EOB) to members upon request. In addition, on a quarterly basis, Aetna Better Health of Missouri will issue EOB’s to a sampling of members receiving services.
15.11.1A CLAIM DISPOSITION CODES

Claim disposition codes are listed on the remittance advice, including a summary of the disposition or reason codes that explain the outcome of claim processing including but not limited to claim adjustments, ineligible amounts, denials, or payments. If you have any questions regarding the claim disposition codes listed in your remittance advice, please contact Claims Inquiry Claims Research at 1-800-566-6444.

15.11.1B. SAMPLE REMITTANCE ADVICE & INFORMATION

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 of Missouri 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 of Missouri 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 of Missouri 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 Electronic Funds Transfer (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.
• Tax Identification Number (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 complaint/appeal rights information.

15.11.2 Provider Secure Web Portal
Aetna Better Health of Missouri encourages providers to take advantage of using our online Provider Secure Web Portal as it is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic.

The Provider Secure Web Portal can be accessed via our website, [www.aetnabetterhealth.com/mo](http://www.aetnabetterhealth.com/mo). Provider must register to use our portal, by completing the portal registration form found on the website and submitting to provider relations for processing.

Please see Chapter 20 for additional details surrounding the Provider Secure Web Portal.

15.11.3 Claims Inquiry Claims Research (CICR) 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 National Provider Identification (NPI) number with applicable suffix if appropriate
  - Member name and member identification number
  - Date of service
  - Claim number from the remittance advice on which you have received payment or denial of the claim

CICR representatives are available five (5) days a week, Monday–Friday from 8:00 a.m. – 5:00 p.m. CST to answer questions related to the processing of claims by calling 1-800-566-6444.
Aetna Better Health of Missouri is closed for business on the following days or the observed day:

- New Year’s Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day

The following holidays may be utilized for Claims Customer Service and Member Services Departmental Staff training:

- Lincoln’s Birthday
- Columbus Day
- Truman’s Birthday
- Veterans Day

15.12 AUTHORIZATION AND CLAIM SUBMISSION

- Claims for services requiring an authorization must include the authorization number in block 23 on the CMS form and block 63 on UB form and in the appropriate field on EDI claims.
- Facilities performing multiple services should confirm if an authorization is needed by reviewing each procedure code for an authorization requirement. Facility claims that include services that the provider failed to obtain authorization for, will result in a denial on all claim lines including those that do not routinely require an authorization.
- Dates of service on the claim should fall within the prior authorized service date range if authorization is required.

15.13 AUTHORIZATION AND BILLING OF MATERNITY SERVICES

15.13.1 Eligibility Verification

Verification of member eligibility should be completed at every visit or encounter through the MO HealthNet’s ARU line at 573-635-8908, Infocrossing www.emomed.com, or via our Provider Secure Web Portal, or calling Member Services.

15.13.2 Authorization Requirement

- Office visits for all maternity services require global authorization for payment. The global authorization number must be listed in box 23 of the CMS form.
- Two (2) ob ultrasounds are included in the global ob authorization for obstetrical providers.
- Additional authorization is required for ultrasounds beyond the first two included with the Global Authorization for obstetrical providers. These requests should be made to eviCore. Refer to Section 11 for more information.
- Additional authorization is NOT required for non-stress tests performed in the provider’s office.
- A provider directed consultation to a maternity subspecialty provider requires additional prior authorization from Aetna Better Health of Missouri. If approved, the maternity subspecialty provider can provide up to three (3) ob ultrasounds without prior authorization.
- Maternal Fetal Medicine Providers must authorize the fourth (4th) and subsequent ultrasound they order. These requests should be made to eviCore. Refer to Section 11 for more information.

15.13.3 Maternity Visit Claim Submission and Encounter Reporting Requirements

- Prenatal office visit encounter data is required to be submitted within ninety (90) days from date of delivery or last prenatal visit to support the MHD encounter reporting requirement. Maternity care providers must submit every antepartum visit as a claim to Aetna Better Health to support submission of encounters to MO HealthNet and documentation for HEDIS reporting. When billing antepartum visits, providers should list their billed charges, submit these services with a penny ($0.01), or if your system allows submit as a $.00 charge but, you will need to confirm the $.00 charge reaches our system. Our system will accept an E/M such as 99201-99205, 99211-99215, or 0501F or 0502F.
- Providers not performing the delivery must submit a claim indicating “Fee-For-Service” to allow for payment of the antepartum visit(s) and to meet timely filing requirements.
- Postpartum care included in the global maternity care payment should be reported for HEDIS measurement purposes. Please refer to the HEDIS quick reference billing guide located at www.aetnabetterhealth.com/mo.
• Aetna Better Health of Missouri will allow both types of delivery (vaginal and caesarean) in instances of multiple gestations, but only one global delivery code is allowed. A caesarean delivery is considered to include the delivery of all fetuses since only one incision is made.

• Last menstrual period (LMP) - In addition to the gestational age/delivery indicator, the last menstrual period is still required on all claims for global and/or prenatal/delivery services. Providers must enter the date of the last menstrual period (LMP) on the professional claim. The date of service is the delivery date. A delivery diagnosis code must be submitted.

• Services with zero payment - Services equating to a zero payment that are considered paid, including antepartum prenatal encounters collected for claims encounter reporting appear on the remittance advice without a disposition description/remark code. Please note this when posting claims that are paid at a zero rate.

• The application of these guidelines does not guarantee payment. Issues related to billing errors and member eligibility may cause a claim and/or claim line to adjudicate with a non-payment status.

• Please review the following Maternity Services Claim/Encounter Report Matrix:

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Number of Visits</th>
<th>CPT Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Maternity Care (Antepartum care, delivery and postpartum care), Vaginal Delivery</td>
<td>3 or more Antepartum</td>
<td>59400, 59610</td>
</tr>
<tr>
<td>Global Maternity Care (Antepartum care, delivery and postpartum care), Cesarean Delivery</td>
<td>3 or more Antepartum</td>
<td>59510, 59618</td>
</tr>
<tr>
<td>Antepartum Care Only</td>
<td>1-3 visits</td>
<td>Bill with E&amp;M Codes</td>
</tr>
<tr>
<td>Antepartum Care Only</td>
<td>4-6 visits</td>
<td>59425</td>
</tr>
<tr>
<td>Antepartum Care Only</td>
<td>7 or more visits</td>
<td>59426</td>
</tr>
<tr>
<td>Delivery Only</td>
<td>N/A</td>
<td>59409, 59514, 59612, 59620</td>
</tr>
<tr>
<td>Delivery and Postpartum Care</td>
<td>N/A</td>
<td>59410, 59614, 59515, 59622</td>
</tr>
<tr>
<td>Postpartum Care Only</td>
<td>1</td>
<td>Bill with E&amp;M Codes or 59430 (separate procedure)</td>
</tr>
<tr>
<td>Postpartum Care provided as part of Global delivery only</td>
<td>1</td>
<td>Refer to HEDIS Billing Guide on website</td>
</tr>
<tr>
<td>Multiple Births</td>
<td></td>
<td>See “Note regarding multiple births” below. The 59 modifier is required for the “delivery only” code for each additional vaginal birth.</td>
</tr>
</tbody>
</table>

*The CPT code list is not intended to represent all available maternity CPT codes.

Claims for delivery services must include a delivery diagnosis code.

The application of these guidelines does not guarantee payment. Issues related to billing errors and member eligibility may cause a claim and/or claim line to adjudicate with a non-payment status.

15.14 COORDINATION OF BENEFITS (COB)

By law, MO HealthNet is the payer of last resort. As an agent of the MO HealthNet, Aetna Better Health of Missouri will be considered the payer of last resort when other coverage for a member is identified. Aetna Better Health of Missouri shall be used as a source of payment for covered services only after all other sources of payment have been exhausted.

15.14.1 COB Exceptions

The only exceptions to this policy are claims for:

• Services that are provided to a member on whose behalf child support enforcement is being carried out by the Missouri Department of Social Services, Division of Child Support Enforcement

• EPSDT

• Labor and delivery (excludes inpatient services)
• Post partum care (excludes inpatient services)
• Prenatal care for women
• Preventative pediatric services

Questions related to subrogation claims should be directed to Claims Inquiry Claims Research (CICR) at 1-800-566-6444.

15.14.2 COB Filing Limits and Requirements

COB claims must be received by Aetna Better Health of Missouri within ninety (90) days from the member’s primary carrier remittance advice date. A copy of the primary carrier remittance advice must accompany the claim. One claim form should be submitted per primary carrier remittance advice if the billed amount of the claim is totaled.

Aetna Better Health of Missouri is responsible for all deductibles, coinsurances, co-pays, and patient responsibility up to 100 percent of the MO HealthNet fee schedule for non-participating providers and 100 percent of the contracted rate for participating providers, taking into consideration the payment by the primary. The provider will be paid up to our allowable when considering both the primary and secondary insurance. This is known as Benefit Less Benefit. If the primary payment is greater than the Aetna Better Health of Missouri payment, no additional payment is due. If the primary payment is less than the Aetna Better Health of Missouri payment, the difference will be issued to cover deductibles, coinsurance, co-pays and patient responsibility.

In keeping with the BLB methodology, claims processed as secondary by Aetna Better Health of Missouri are paid at the “header” level - not the “line” level. This means that Aetna Better Health of Missouri takes into consideration the total billed amount, the total primary carrier payment, the total primary carrier member responsibility, and the total Aetna Better Health of Missouri allowed amount. Claims are not coordinated line by line, meaning the overall methodology does not change if the primary carrier allows more than Aetna Better Health of Missouri on one claim line or when the primary carrier allows less than Aetna Better Health of Missouri on another claim line.

Note: The primary carrier’s payment amount is used in the equation when determining the amount Aetna Better Health of Missouri will pay as the secondary carrier. The primary carrier’s allowed amount is NOT used in the BLB equation. The standard equation is as follows:

Aetna Better Health of Missouri Allowed Amount
less Primary Carrier Payment
Aetna Better Health of Missouri secondary payment (up to the primary carrier’s member responsibility.)

15.14.3 COB Claim Processing Policy

To meet COB requirements in our state contract, Aetna Better Health of Missouri has a process in place with a vendor, HMS, to obtain refunds for members with primary insurance coverage when Aetna Better Health of Missouri paid as primary and HMS identified a primary carrier. Aetna Better Health of Missouri providers will receive a remit with an account reflecting a negative dollar amount indicating “a refund was received from vendor.” This type of refund will not recoup money unless the primary insurance allowable is less than Aetna Better Health of Missouri’s allowable. The total refund amount is reflected in the check amount on the first page of the remittance advice.

Third Party Liability (TPL) claims will be pursued by Aetna Better Health of Missouri based on requirements and/or limitations under Aetna Better Health of Missouri’s contract with MO HealthNet.

Providers who identify a member with primary insurance that has been terminated should call CICR or Member Services at 1-800-566-6444. Aetna Better Health will conduct a re-verification and then reprocess claims if necessary.

Participating and non-participating providers are required to follow Aetna Better Health of Missouri’s policy on prior authorization requirements even when Aetna Better Health of Missouri is not the primary payor.

15.15 CLAIM AND BILLING POLICIES & GUIDELINES

Aetna Better Health of Missouri has enhanced our Claims and Reimbursement section of this manual to clarify claims policies and procedures and help Providers decrease administrative costs by knowing what to expect regarding Aetna Better Health of Missouri’s claim determinations. Your Provider Agreement with Aetna Better Health of Missouri requires, among other things, that you keep all contract terms confidential, including payment information. Aetna Better Health of Missouri expects that the information discussed in this section and throughout the Provider Manual will be kept confidential. This document does not replace the terms stated in your Aetna Better Health of Missouri Agreement. In the event of any conflict between the terms stated in this document and your Agreement, the terms of your Agreement will control.
Aetna Better Health of Missouri uses standard claim guidelines that are current as of the date of service and will use best efforts to publish material changes in claims and billing policies and guidelines via the quarterly provider newsletter, or more frequently at Aetna Better Health of Missouri’s discretion.

Aetna Better Health of Missouri strives to process claims in a timely and accurate manner. To achieve that goal, a number of internal departments regularly review claim determinations. The claims department performs random audits to verify that internal controls are functioning appropriately and that the claims processing personnel are performing their work correctly. In this section, providers will find many of the key claims and billing policies and guidelines.

15.15.1 Access to Records for Audits

All records, books, and papers of provider pertaining to members, including without limitation, records, books and papers relating to professional and facility based care provided to members and financial, accounting and administrative records, books and papers, shall be open for inspection and copying by Aetna Better Health of Missouri, its designee and/or authorized state or federal authorities during provider’s normal business hours. Provider further agrees that it shall release a member’s medical records to Aetna Better Health of Missouri to other entities as otherwise required by law. In addition, providers shall allow Aetna Better Health of Missouri to audit provider’s records for payment and claims review purposes. In most instances, Aetna Better Health of Missouri will provide at least forty-eight (48) hours notice prior to requesting access.

15.15.2 Altered Claims

An altered claim is defined as one that has changes, such as whiteout, strike-overs, handwritten information, etc. All alterations on paper claims must be initialed by the provider or provider’s designated representative at the correction site to ensure the integrity of the claim being submitted.

15.15.3 Anesthesia Coding

American Society of Anesthesia codes must be submitted with the appropriate times in minutes, clearly noted on the claim. This information should be provided in Section 24D of the CMS form. Anesthesia minutes handwritten on a typed claim form should be initialed. Aetna Better Health of Missouri authorized dental anesthesia services performed by an anesthesiologist, AA or CRNA and reported using CPT codes are billable to Aetna Better Health of Missouri.

15.15.4 Assistant Surgeon

Assistant surgeon charges are indicated on a provider’s claim (CMS 1500 form, block 24D) with an 80, 81 or 82 modifier. Services provided by an assistant surgeon require prior authorization, with the exception of those procedures with a specific allowable on the MO HealthNet fee schedule.

15.15.5 Ambulance

Destination modifiers are required on all ambulance claim lines. Ambulance claims should be submitted to Aetna Better Health of Missouri.

15.15.6 Authorized Services

Claims for services requiring an authorization should be submitted to Aetna Better Health of Missouri with the authorization code/number listed in the field designated. Services requiring an authorization that are submitted on a claim form without an authorization code/number will be reviewed to determine if an authorization for the service(s) is on file. If an authorization is found it will be matched up and processed with the authorization.

15.15.7 Balance Billing/Hold Harmless

Providers shall accept payment in full for covered services rendered to members and such amounts as are paid by Aetna Better Health of Missouri. In no event (including non-payment by Aetna Better Health of Missouri for covered services rendered to members by provider for whatever reason, including claim submission delays and/or UM sanctions, insolvency of Aetna Better Health of Missouri or breach by Aetna Better Health of Missouri of any term or condition of the agreement under which provider participates) shall provider bill, charge or collect a deposition from, seek compensation, remuneration or reimbursement from, or have any course against any member or a person (other than Aetna Better Health of Missouri) acting on a member’s behalf for covered services eligible for payment, nor shall provider bill a member or a person (other than Aetna Better Health of Missouri) acting on a member’s behalf for the difference between the covered charge and the negotiated rate or the amount provider has agreed to accept as full payment under the agreement for any amounts Plan may owe provider or for any monies in excess of
applicable co-payments, deductibles or coinsurance, except as otherwise noted below. Provider shall in no event seek payment from any member for any service for which Aetna Better Health of Missouri has denied payment on the grounds that provider has failed to comply with the requirements with respect of such service, including, but not limited to, the failure of Provider to obtain required preauthorization. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills and the health plan for the service that has been provided, the prior arrangement with the member becomes null and void.

Provider shall collect from the member and may retain only co-payments, deductibles or charges for services which are not covered services under the member’s benefit plan as long as the charges are not charges for reimbursable services. In the event a member requests non-covered services, a provider may render non-covered services to a member so long as provider has obtained a detailed, easy to understand, request for such non-covered services stated clearly in writing and the member clearly understands and has been informed and acknowledged in writing that Aetna Better Health of Missouri will not cover such services. This does not prohibit provider from pursuing available legal remedies including, without limitation, collecting from any insurance carrier providing coverage to an individual.

If a member reports that a provider is balance billing for a covered service, the provider will be contacted by a Aetna Better Health of Missouri provider relations representative who is researching the report. Aetna Better Health of Missouri is obligated to notify MHD when a provider continues the inappropriate practice of balance billing a member. Failure to comply with these provisions may result in sanctions including, without limitation, loss of reimbursement, payment of any member’s or Aetna Better Health of Missouri’s costs of defense or collection arising out of such failure, up to and including financial penalties and/or termination of participation.

Provider further agrees that this hold harmless requirement:
• shall survive the termination of the provider’s contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of members and Aetna Better Health of Missouri
• supersedes any oral or written contrary agreement now existing or hereafter entered between provider and a member or a person acting on his/her behalf
• shall be included in any subcontracts between provider and any other provider for the provision of covered services to plan members.

15.15.8 Bilateral Procedures

Bilateral procedures are defined as those performed on two (2) sides of the same surgical area. Bilateral procedures should be submitted with one unit and include a 50 modifier. Claims for bilateral procedures noted with a 50 modifier and containing more than one unit, will be split onto two (2) lines for correct processing.

15.15.9 Claim Adjustment process

Adjustments to claims processed by Aetna Better Health of Missouri are performed when a modification to the original claim needs to be completed. All claim adjustments require a two-step process that is outlined below:

• A back-out claim is created. This is the negative version of the original claim and cannot be altered.
• A replacement claim is created. This is the exact copy of the original claim, which allows edits to information within the claim.

15.15.10 Claim Coding

Claims must be submitted with valid CPT, HCPCS, revenue codes and modifiers, if necessary. Claims must be submitted with valid ICD-10 CM diagnosis codes, coded to the highest degree of specificity (fifth digit) to be considered valid. Claims submitted with nonstandard CPT, HCPCS and revenue codes or modifier(s) will be processed with a denial disposition code. Each CPT or HCPCS code line must have a valid place of service (POS) code to avoid rejection of the claim.

15.15.10A DIAGNOSIS CODES

All providers must submit HIPAA compliant diagnoses codes, ICD-10-CM or its successor, CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) or their successors and current Revenue Codes and UB bill types. Aetna Better Health of Missouri will follow all CMS mandates for any future ICD, CPT, HCPCS, Revenue Code or Bill Type changes.

NOTE: Please refer to Section 4.2.8 for diagnosis code requirements for billing EPSDT Services and Section 15.13 for diagnosis code requirement for billing Maternity Care Services.
15.15.10B MODIFIERS

A modifier can be added to a HCPCS or CPT code to describe a unique service or procedure that was performed in the medical setting. The modifier can be reported by adding a two-digit number (or alphabetic characters) after the appropriate HCPCS or CPT code. Below are some key billing requirements to keep in mind when submitting claims:

- **Anatomical modifiers** - Providers must submit anatomical modifiers for any and all services that refer to an anatomical site.
- **EP modifier** - Modifier EP must be used with evaluation/management codes when the member is under age twenty-one (21) on the date of service.
- **25 or 59** - Claims submitted with a 25 or 59 modifier may be subject to requiring medical record notes in order to determine appropriate coding.
- **Behavioral health services** billed by Psychologists, Counselors and Social Workers must be billed using the appropriate provider type modifiers (UD - Licensed Professional Counselor (LPC), AJ = Licensed Clinical Social Worker (LCSW), AH = Psychologist (PhD, PsyD, EdD)).

**Modifier Payment Rates/Reductions**

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. It may also provide more information about a service such as it was performed more than once, unusual events occurred, or it was performed by more than one physician and/or in more than one location. This grid is a reference tool to modifier reimbursement and may not be an all-inclusive list of CPT and HCPCS modifiers.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Payment rate based on allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>150% of reimbursement rate</td>
</tr>
<tr>
<td>51%</td>
<td>50% of reimbursement rate</td>
</tr>
<tr>
<td>51%</td>
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<td>QY</td>
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Please refer to the AMA HCPCS Level I and II coding guides for a complete list of available modifiers and ensure appropriate use of modifiers when submitting claims to Aetna Better Health of Missouri.

15.15.10C UNITS

Providers should bill services in whole unit increments. We are unable to process half units or partial units.
15.15.10D REVENUE CODE/HCPCS CODE BILLING
Facilities submitting on a UB-04 claim should follow the billing requirements listed in the grid below for dates of service beginning 8/1/16.

The following Revenue Codes REQUIRE a HCPCS code. If the HCPCS code is non-covered (PI=9), the claim line will be denied for non-covered service.

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<td>970-979</td>
<td>980-989</td>
<td>990-999</td>
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*Revenue code 762 requires a HCPCS code and G0378 is the only acceptable HCPCS code.

The following Revenue Codes DO NOT require a HCPCS code. The billing of a HCPCS code is optional; however, if a HCPCS code is billed and it's a non-covered (PI=9) code, the claim line will deny for non-covered service.

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<tr>
<th>20-269</th>
<th>270-279</th>
<th>390-399</th>
<th>510-519</th>
<th>710-719</th>
<th>720-729</th>
<th>761</th>
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The following Revenue codes should be submitted as Revenue Code only, when billed with Observation services. The billing of a HCPCS code is optional; however, if a HCPCS code is billed and it’s a non-covered (PI=9) code, the claim line will deny for non-covered service. Please note: All other outpatient pharmacy services fall under the Pharmacy Carve-out and must be billed to MO HealthNet.

| 250-259 | 630-639 |

15.15.11 Claim Disposition Codes
A summary of the disposition or reason codes that explain the outcome of claim processing including but not limited to claim adjustments, ineligible amounts, denials, or payments are listed at the end of every remittance advice summary sent to providers. Claim disposition codes are listed on each claim and a summary of the codes including definitions is found at the end of the remittance advice. If you have any questions regarding the claim disposition codes listed in your remittance advice, please contact Claims Inquiry Claims Research at 1-800-566-6444.

15.15.12 Claims Editing Policy
Aetna Better Health of Missouri utilizes claim editing software to review facility and professional claims submissions in order to identify the coding of services with a higher probability of being incorrect or medically unnecessary. Our editing applications follow NCCI, AMA, NCD, MUE, CMS, US Department of Health and Human Services US Preventative Services Task Force and plan policy guidelines, including but not limited to Aetna Better Health of Missouri Medical Director determinations. Edits are generally reviewed and revised on a quarterly basis or more frequently as determined by Aetna Better Health of Missouri.

Aetna Better Health of Missouri claim editing applications review both facility and professional claims submitted with CPT-4 HCPCS level 1 and 2 codes to analyze the appropriate set of procedures for reimbursement based on industry standard coding guidelines.
Common areas reviewed as part of claim editing include:

- Assistant surgeon: Determination of reimbursement and coverage and multiple procedure reduction.
- Duplicate procedures: Procedures that are billed more than once on a date of service.
- Evaluation and management service billing: Review the billing for services in conjunction with procedures performed.
- Frequency to time: To determine if same procedure codes for the same dates of service are billed by the same provider or same Tax Identification Number.
- Incidental procedures – Procedures that are performed at the same time as a more complex procedure, however, the procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure.
- Mutually-exclusive procedures – Two (2) or more procedures that are billed, by medical practice standards, should not be performed or billed for the same patient on the same date of service.
- Multiple surgical procedures – To ensure when multiple surgical procedures are billed, they are processed based on industry standard rankings of clinical intensity
- Procedure to diagnosis (diagnosis edits): Compare procedure codes to diagnosis codes submitted for appropriateness.
- Procedure to provider: Claims may be reviewed to compare procedure codes billed against provider specialty for appropriateness.
- Procedure to gender: Compare procedure codes to the gender of member for appropriateness.
- Site of Service: Compare procedure codes to the site where the service was rendered for appropriateness.
- Unbundling: Billing two (2) or more individual CPT codes to report a procedure when a single more comprehensive code exists that accurately describes the procedure. In those cases Aetna Better Health of Missouri may process the claim based on the most appropriate code.

Please note that claim edits may select codes having a higher probability of being incorrect but cannot identify all circumstances that may warrant legitimate use of the code. Appropriate documentation in the medical record is essential to support the coding submitted on all claims.

All procedure codes that have been changed or denied due to claims editing will be noted by the appropriate disposition code on the Aetna Better Health of Missouri remittance advice. A claim inquiry that includes medical notes, medical record documentation and specific details related to supporting the provider’s position and should be submitted to CICR as noted below.

Providers should submit a corrected paper claim submission along with notes, medical record documentation and specific details related to supporting the provider’s position regarding the edit applied to the claim. The claim should be clearly marked as “corrected” or “resubmission” and mailed to Aetna Better Health of Missouri. As a cover sheet, providers can utilize the Claim Reconsideration Form. See 15.15.13 for more information.

The provider’s submission will be reviewed by a claim quality management nurse consultant (QMNC) and the disposition of that review will be returned to the provider via the remittance advice within 30 days. Providers checking the status of their Inquiry/Reconsideration should contact Claims Inquiry Claims Research at 1-800-566-6444. If the provider’s Inquiry/Reconsideration is upheld, the provider should refer to the Claims and Appeal options outlined in Section 16 Complaint Process for Providers and Members.

15.15.13 Claim Reconsideration Form

Aetna Better Health of Missouri’s Provider Reconsideration Form is located on the public website and Secure Web Portal. This form is not mandatory, but is available for use as a cover sheet for the provider’s corrected claim. The form should always be submitted with an attachment, including but not limited to itemized billing, primary EOB, proof of timely filing, notes to support the provider’s position on a claims edit. It’s always in the provider’s best interest to have a claim reviewed through the reconsideration process when it’s applicable to avoid prematurely using your appeal rights. Page 2 of the document provides a guide as to if the provider’s claim should be submitted for review as a Reconsideration or an Appeal. For information on filing an Appeal, please refer to Section 16: Complaint Process for Providers and Members.

15.15.14 Claim Review/Reconsideration Process

A claim review or reconsideration is a verbal or written request to research a denial, a claim paid incorrectly, claim bundling issues or a decision made by Aetna Better Health of Missouri. It is not “considered” a complaint or an appeal. All telephonic claim review or reconsideration requests should be directed to Claims Inquiry Claims Research at 1-800-566-6444.
If you are requesting a claim review/reconsideration in writing, a copy of the claim form is always required to be included. Please be sure to mark the paper claim as “corrected” or “reconsideration” and include all supporting documentation and mail to:

Aetna Better Health of Missouri
P.O. Box 65855
Phoenix, AZ 85082-5855

To assist providers with claim reconsideration requests, Aetna Better Health has posted a copy of a Claim Reconsideration Form on our website. This form is not required to be submitted with claim reconsideration requests, however it can be helpful in clarifying the claim issue. Please be sure to submit a claim form with all reconsideration requests. The result of the claim review will be communicated to you via the remittance advice. To avoid delay in processing claim reviews/reconsiderations, do not label the reconsideration as an appeal or complaint.

Before filing a complaint or appeal on a claim issue, we suggest you try to resolve the claim issue using the claim review/reconsideration process. If you feel that the claim review/reconsideration was not satisfactory, then submit all your supporting documentation, including any information that was given to the claims department and file a complaint or appeal as outlined in Section 16: Complaint and Appeal Process.

Some key examples of claims issues that should go through claim review/reconsideration include but are not limited to:

- Denials for timely filing when you have acceptable proof of timely filing
- Denials for no authorization when you have an authorization
- Coding issues such as bundling, mutually exclusive, etc.
- Duplicate denials when there was an additional service
- Claim not paid according to your contract
- Coordination of benefits issues

If you receive a request for additional supporting information (i.e, invoice, itemized billing, medical records, etc.) on your claim remittance advice, please forward this documentation, along with a copy of the claim form, noted “corrected claim” or “resubmission” to the claims department.

15.15.15 Clinic Charges

Outpatient clinic charges/fees, such as Revenue Code 510 are not considered reimbursable services.

15.15.16 Completion of Special Reports or Forms for Members

Preparation of special reports and form, including but not limited to return to work/school forms, annual physicals etc., are not considered reimbursable by Aetna Better Health of Missouri and are not billable to the member.

15.15.17 Collection Advice/Remittance

When a claim has been adjusted, putting your practice in a negative balance, you will receive a collection advice (formerly referred to as a negative remittance advice) once weekly. Each time there is claim activity on your account, the balance of the account may still result in a negative amount. Each of the negative remits will repeat all of the claims that have been reversed plus any new claims that are being held against the negative amount. Since these claims may be received on remits several times, you may want to only note their status when paid.

If your office does not have enough claim volume to clear this negative balance within a month, please refund the overpayments. It is best to remit the sum of the negative claims only. The collection advice summary indicates the amount of refund requested. Once the refund has been processed, a check will be issued for any positive claims being held. Please make all refund checks payable the Aetna Better Health of Missouri and mail to the following address:

Aetna Better Health of Missouri–FINANCE
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

If you have questions about the reversed claims, please contact Claims Inquire Claims Research at 1-800-566-6444.

15.15.18 Diapers

When submitting claims for diapers, providers can choose Aetna Better Health of Missouri to be the primary or secondary insurance billed. Claims for services exceeding the volume limits and authorization requirements will be subject to denial.
15.15.19 Durable Medical Equipment & Orthotics and Prosthetics

Corresponding Modifiers indicating rental (RR), repair (RB) or purchase (NU) are required on each line item. When a date range is billed for a rental, timely filing is based off of the final date of service.

DME Equipment and Orthotics and Prosthetics with a line item billed amount of greater than $500.00 and/or the volume limit was exceeded, it will deny for no authorization if an authorization was not obtained. Medical supplies with a line item billed amount of greater than $100.00 and or the volume limit was exceeded, it will deny for no authorization if an authorization was not obtained.

When a claim for a custom DME or Orthot and Prosthetic item is denied indicating the member was not effective on the date of service, please refer to the Transition of Care section and contact Claims Inquiry Claims Research at 1-800-566-6444.

15.15.20 Encounter Data Submission Requirements

Aetna Better Health of Missouri is mandated by our contract with MO HealthNet to report all provider encounters. Aetna Better Health of Missouri requires claims and encounter data to be submitted using a UB or CMS form. Claims must be received within ninety (90) days from the date of service for office level/outpatient services or from the date of discharge for inpatient services.

Line items billed with a zero ($.00) charge are not accepted by MO HealthNet. Corrected claims must be received within 180 days from the initial remittance advice date and include all original claim lines, including those previously paid correctly.

15.15.21 Hearing Aids

Applicable modifiers, including anatomical must be submitted on each claim line.

15.15.22 Home Health

Providers must submit with applicable modifiers based on the MO HealthNet Fee Schedule.

15.15.23 Hospital Acquired Condition/Wrong Site/Person/Procedure Policy

Providers agree to abide by Aetna Better Health of Missouri’s policies regarding payment for provider preventable conditions (i.e. “never events”, health-care acquired conditions, serious preventable adverse events). Such policies are have been implemented pursuant to applicable Federal law (42 CFR § Parts 434, 438 and 447) and Missouri law (13 CSR 70-25.150; 70-15-200). The policies shall be provided upon written request and may be updated form time to time by Aetna Better Health of Missouri.

Reimbursement for services associated with provider preventable conditions shall be determined solely in accordance with these policies.

15.15.24 Hysterectomy

Providers must submit the most current version of MO Health Net’s “Acknowledgement of Receipt of Hysterectomy Information” form, with their prior authorization request. The form must be completed in its entirety. A copy of the form is available on the MO HealthNet website. It is no longer necessary to attach a copy of the Acknowledgement of hysterectomy form with the claim form.

15.15.25 ICD-10

On October 1, 2015 Aetna Better Health of Missouri will no longer accept ICD-10 codes due to the CMS ICD-10 mandate. Aetna Better Health of Missouri will only accept ICD-10 codes on all claims submitted with dates of service on or after October 1, 2015. Any claim submitted with both ICD-10 and ICD-10 diagnosis codes will be rejected.

Please refer to CMS website for more information about ICD-10 and split claim guidance at www.cms.gov and refer to NUCC and NUCB guides for billing details to verify 837 Implementation Guides (IG) for EDI for correct qualifier to use with the ICD-10 codes.

All providers must submit HIPAA compliant diagnoses codes, ICD-10-CM or its successor, CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) or their successors and current Revenue Codes and UB bill types. Aetna Better Health of Missouri will follow all CMS mandates for any future ICD, CPT, HCPCS, Revenue Code or Bill Type changes. Additional information concerning ICD-10 can be found on our website at www.aetnabetterhealth.com/mo.

15.15.26 Infusion

With the exception of an enteral or parenteral pump, Enteral and Parenteral Therapy HCPCS procedure codes are listed in the Missouri Medicaid Fee Schedule under DME Purchase, indicating an NU modifier must be used with the procedure code. In addition to the NU modifier, the EP modifier must be used for members under the age of 21. Lastly, either the BA or the BO modifier must be billed as the third modifier.
15.15.27 Inpatient Services/POA Requirement
Services are subject to prior authorization requirements. Dates billed for services rendered without an authorization are subject to a denial. The Present on Admission (POA) diagnosis code is required on all claim lines, with the exception of diagnosis codes that are exempt. Charges associated with date of discharge are not payable.

15.15.28 Inpatient Professional Services
Inpatient services are subject to prior authorization requirements. If an inpatient stay is not approved, the professional charges will deny as well.

15.15.29 Itemized Statements
Aetna Better Health of Missouri may require providers to submit an itemized billing statement in addition to the original claim. If an itemized billing statement is required and not supplied, the claim will be denied until one is received.

When submitting by paper, providers should send the requested itemized billing statement to the claims P.O. Box with the claim clearly marked as “corrected” or “resubmission”.

If the charges on the itemized bill are less than billed charges on the original claim, the portion of the claim that does not match will be denied for additional information. All itemized charges must be billed with corresponding revenue codes, CPT and HCPCS codes. Itemized bills may be further subject to a review prior to payment. This review will examine the claim for eligible charges prior to payment.

15.15.30 Legal Owner of Federal Tax Identification Number (FTIN)

Each provider’s legal name and billing address are loaded in Aetna Better Health of Missouri’s provider database from the information on your submitted W-9 Form. If there is a change to the provider’s name, address, TIN, or legal owner of the TIN, you must submit an updated W-9 form to your provider relations representative, including the effective date of the change. Providers are required to provide at least sixty (60) days written notice prior to the effective date of the change, to avoid claim processing issues.

It is important for Aetna Better Health of Missouri to comply with the IRS requirements to assure all claims are processed under the legal name. This will also allow for accurate processing of 1099 forms and avoid mandatory IRS tax withholding on claim payments. The legal owner of the TIN as listed on line 1 of the W-9 should be listed in Box 33, Line 1 of the CMS Form or Block 2 of the UB04 Form. If a claim is submitted with conflicting information in Field 33, Line 1 of the CMS Form or Block 2 of the UB04, the claim will be denied by Aetna Better Health of Missouri. If you have questions regarding your legal name and address information in our system, please contact Claims Customer Service or your provider relations representative.

Using Social Security Number (SSN) as the Tax-Id may present unnecessary risks to providers. Please request new identification numbers if you are currently using your personal SSN. This will ensure your SSN is not exposed over the course of standard business practices and protect yourself from unnecessary harm. Please visit www.irs.gov for more information or to contact your local IRS office.

15.15.31 Maternity Labor and Delivery Evaluation
Claims for Maternity Labor and Delivery evaluation services should be submitted with Revenue Code 720, 721 or 722 and represent the labor room services when the stay was less than six hours.

15.15.32 Maternity Services Billing Requirements
Please refer to Section 15.13 for maternity services billing requirements.

15.15.33 MO HealthNet Fee Schedule & Provider Bulletins

Codes manually priced by MO HealthNet (Pl=6) will be reimbursed at 35% eligible billed charges. Codes designated by MO HealthNet as not covered (Pl=9) are considered non-covered and are not payable by Aetna Better Health of Missouri.

Aetna Better Health of Missouri utilizes the published MO HealthNet fee schedules, bulletins and provider manuals to determine the proper set-up of codes and services. Aetna Better Health of Missouri providers should register with MO HealthNet to receive their periodic provider bulletins, which contain changes in covered services, coding and reimbursement. Each bulletin will identify if the information contained within applies to MO HealthNet Managed Care, which would include Aetna Better Health of Missouri.
15.15.34 Multiple Surgical and Procedure Discounts
Aetna Better Health of Missouri will apply standard multiple procedure reductions when a provider performs and bills two or more surgical procedures for the same date of service.

The first procedure is paid at 100%, the second procedure is reimbursed at 50% and then, according to Aetna Better Health of Missouri contracts, the third and all subsequent procedures are reimbursed at 25%. Surgical procedures are ranked by RVU; the highest RVU procedure will be paid at 100%. A bilateral procedure is reimbursed (for both sides with a unit of 1 and a -50 modifier) at 150%.

There are some procedures identified by CMS that are not subject to multiple procedure reduction edits. Our editing software will remove the 51 modifier when it is billed on these procedures so that the provider can obtain the correct reimbursement at 100%.

Aetna Better Health of Missouri follows the CMS guidelines for reimbursement of procedures when a provider bills for multiple endoscopy procedures for the same member on the same date of service. The lesser valued endoscopy codes will be paid at the difference between its allowed value and the base endoscopy allowed value. Multiple families of endoscopy procedures will be first calculated at their family reduction rate, and then receive the secondary reduction of 100-50-25.

Multiple radiology procedures billed for the same member and same date of service will also follow CMS guidelines for reimbursement. The imaging procedure with the highest technical component will be reimbursed at 100% and the technical component for all secondary procedures is reduced by 50%. This reduction applies only to the radiology procedures with the TC modifier.

Multiple procedure reduction edits are particularly sensitive if the episode of care for the member is billed on more than one claim. Out of sequence claims can cause adjustments and incorrect payments as the entire episode cannot be correctly evaluated.

15.15.35 Newborns
Claims for newborn services should be submitted to Aetna Better Health of Missouri when the newborn has been enrolled with Aetna Better Health of Missouri. Aetna Better Health of Missouri is unable to accept newborn claims prior to the newborn’s enrollment with Aetna Better Health of Missouri. Newborn claims are subject to a timely filing period of ninety (90) calendar days from the date the newborn is added to Aetna Better Health of Missouri’s eligibility system for timely filing. The claims processing system will deny the provider’s claim when it was received beyond the 90 days from date of service. To have your claim reviewed, please contact Claims Customer Service or request a claims adjustment through the Provider Secure Web Portal. Provider claims received within 90 days of the date of enrollment in Aetna Better Health of Missouri’s eligibility system will be reviewed for reprocessing.

15.15.36 Obstetrical - Early Elective Deliveries
According to 13 CSR 70-3.250 Payment Policy for Early Elective Delivery, Aetna Better Health®of Missouri excludes payment for delivering physicians/provider and the delivering institution of early elective deliveries, or deliveries prior to 39 weeks gestational age that are not medically indicated. Payment for such services will be denied or recouped.

Early elective delivery is defined as a delivery by induction of labor without medical necessity followed by vaginal or caesarean section delivery before 39 weeks gestation. Vaginal or caesarean delivery following non-induced labor is not considered an early elective delivery regardless of gestational weeks.

15.15.36A SERVICES RELATED TO EARLY ELECTIVE DELIVERY
(I) All services provided during the delivery-related stay at the delivering institution for maternal care related to an early elective delivery shall not be reimbursed by Aetna Better Health®of Missouri. Nonpayment or recoupment includes obstetric and institutional or facility charges; and

(II) Non-routine newborn services provided for newborns during the initial delivery-related stay at the delivering institution for conditions resulting from an early elective delivery and that are identified within seventy-two (72) hours of delivery may be subject to review and recoupment. Non-payment or recoupment includes facility or institutional charges.

15.15.36B GESTATIONAL AGE/Delivery INDICATOR REQUIREMENT
To identify early elective delivery services, there’s a data requirement on the CMS 1500 claim form and its electronic equivalents including the X12 5010 837P. Claims submitted by the delivering physician are edited to determine if the service is for an early elective delivery. Field 19 of the CMS 1500 paper claim, Loop 2300, or 2400, NTE, 02 of the 837P format MUST contain a “gestational age/delivery” indicator. This field is required for all claims that report a delivery or global prenatal/delivery procedure code. The field requires one of the following four (4) digit alphanumeric values and is
utilized to determine the early elective delivery payment policy. If the value entered in the field contains a character that is not indicated below or is not in the format indicated, the value will be considered invalid and the claim will be denied.

- 1st and 2nd digits represent the gestational age, based on the best obstetrical estimate.
- They must be numeric characters and values from 20 through 42.
- 3rd and 4th digits represent the method of delivery. They must be one of the following alpha characters:
  - LV – Labor non-induced followed by vaginal delivery
  - LC – Labor non-induced followed by caesarean delivery
  - IV – Induced labor followed by vaginal delivery
  - IC – Induced labor followed by caesarean delivery
  - CN – Caesarean delivery without labor, non-scheduled (i.e. add-ons)
  - CS – Caesarean delivery, scheduled

If the gestational age/delivery indicator contains an LV or LC value or contains a gestational age of 39 or greater, the claim will be exempt from this editing and will continue processing through the system.

If the gestational age/delivery indicator contains IV, IC, CN, or CS, and the gestational age is less than 39, the claim will be subject to editing for early elective delivery. If one of the diagnoses on the claim indicates that there is a medical indication for an early delivery, the claim will be exempt from this editing and continue to process. Aetna Better Health® of Missouri utilizes the American Congress of Obstetricians and Gynecologists (ACOG) list of conditions that may be indications for early induction of labor and delivery to determine diagnosis codes that are appropriate to justify an early delivery.

Claims that have the IV, IC, CN, or CS indicator with a gestational age less than 39 weeks and do not have a qualifying diagnosis for early induction of labor and delivery will be denied.

If an inpatient claim for the member’s delivery was paid, the claim will be recouped, unless it contains one of the qualifying diagnosis codes referenced above.

15.15.37 Physical, Occupational & Speech Therapy

Therapy services should be submitted with the appropriate modifier(s) including GN, GO, or GP. Services submitted without an authorization on file will deny for lack of an authorization. Aetna Better Health of Missouri authorizes therapy services separately when a member is receiving services for more than one type of therapy within the same time-period. Providers should submit a separate claim for each authorization.

15.15.38 Rural Health Clinic Billing and Non-RHC Clinic Billing

Services provided by Independent Rural Health Clinics (IRHC) and Provider Based Rural Health Clinics (PBRHC) must comply with MO HealthNet billing guidelines.

For DOS beginning 7/1/15, PROVIDER BASED RURAL HEALTH CLINICS must comply with the following:

- Submit RHC claims on a UB-04 form
- Submit your PBRHC NPI in field 56
- Submit RHC services with Type of Bill 711 series in field # 4
- Submit Type of Bill 717 for corrected claim
- Revenue code in field 42 must be 0521
- Current acceptable 5-digit CPT or HCPCS codes with applicable modifiers must be in field 44.
For DOS beginning 7/1/15, INDEPENDENT RURAL HEALTH CLINICS must comply with the following:

- Submit claims on a UB-04 form
- Submit IRHC NPI in field 56
- Submit claims with the Revenue code 0521 in field #42
- Submit Type of Bill 711 series in field #4
- Submit Type of Bill 717 for corrected claim
- HCPCS procedure code T1015 is required in field #44.

**EPSDT / HCY EXAM**

- HCPCS procedure code T1015 EP is required in field #44.
- The five digit EPSDT / HCY screening code is required in field #74.
  
- Corresponding acceptable ICD-10 diagnosis code must be used as the primary diagnosis in field #67. Refer to the HCY/EPSDT Quick Reference Guide for more information.

Please refer to the MO HealthNet Provider manuals for PBRHC and IRHC for any additional billing guidelines at [http://dss.mo.gov/mhd/providers](http://dss.mo.gov/mhd/providers). VFC vaccine administration is not a reimbursable service.

**Non-RHC Services**

- Claims are submitted on CMS-1500 Claim Form
- Submit the rendering provider in field #24J and the Non-RHC group NPI in field #33A

15.15.39 Recovery of Overpayments

Aetna Better Health of Missouri reserves the right to recover over-paid claims from providers up to 12 months after the date the claim was paid, or longer in cases of fraud or misrepresentation.

Providers have several options for reporting an overpayment:

- Contact Claims Inquiry Claims Research at 1-800-566-6444 to request a claim adjustment be made to remove the money from future claim payments
- Send a check in the amount of the overpayment with a copy of the remittance advice identifying the claim that was overpaid to:
  
  Aetna Better Health of Missouri–FINANCE
  4500 E. Cotton Center Blvd.
  Phoenix, AZ 85040

If Aetna Better Health of Missouri identifies an overpayment, we will adjust the claim. Recovered monies are negatively remitted and will be adjusted off future claim payments.

Providers with negative balances that are greater than 90 days may be subject to collections if there is not enough claim activity to satisfy the negative status.

15.15.40 Service Categories Billable to Other Contracted Entities

Please review to determine the correct claim processing entity for claim submission purposes and the section of this provider manual to reference for additional information:

<table>
<thead>
<tr>
<th>SERVICE CATEGORY</th>
<th>CLAIM PROCESSING ENTITY</th>
<th>PROVIDER MANUAL SECTION REFERENCE</th>
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<td>Dental Services</td>
<td>DentaQuest</td>
<td>Section 9</td>
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<tr>
<td>Medical Services</td>
<td>Aetna Better Health of Missouri</td>
<td>Section 15</td>
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<tr>
<td>Routine Vision</td>
<td>MARCH Vision</td>
<td>Section 12</td>
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</table>
15.15.41 Services Billable to MO HealthNet

Below is a listing of services that when rendered to Aetna Better Health of Missouri, the billing must be submitted to MO HealthNet

- Safe Care Examinations
- Pharmacy, refer to Section 13 for details.
- Abortion Services
- Autism waiver, including home and community based waiver services, behavioral analysis services, personal assistant, in-home respite, out-of-home respite, environmental accessibility adaptations, specialized medical equipment and supplies (adaptive equipment), support broker, and transportation for persons in the Autism waiver.
- Developmental Disability waiver, including home and community-based services.
- Non-emergency medical transportation including members with ME codes 08, 52, 57, 64, 73, 74, 75 who do not have the ability to provide their own transportation to and from health care services including ancillary services.

15.15.42 Sterilization

Providers are to follow the specific requirements outlined in MO HealthNet's Sterilization Consent Form, including utilizing the most current version of the form. The completed form must be submitted by fax to the Pre-Authorization department to obtain an authorization for the service as noted in Section 6.5.12. Providers do not need to submit a copy of the completed sterilization consent form with the claim. Providers can access the form on MO HealthNet's website.

15.15.43 Use of Unlisted, Unspecified or Miscellaneous Procedure Codes

In the rare instance when an unlisted, unspecified or miscellaneous HCPCS code is used, providers must submit the clinical documentation and/or description of the code with the claim. Unlisted, unspecified or miscellaneous codes that do not include the additional documentation or description will adjudicate indicating the procedure is unlisted. The provider should submit notes or recode.
SECTION 16: COMPLAINT PROCESS FOR PROVIDERS AND MEMBERS

16.1 PROVIDER COMPLAINT AND APPEAL PROCESS

Aetna Better Health of Missouri has a Complaint and Appeal process for providers to dispute a claim, authorization, policy, or a Aetna Better Health of Missouri decision.

A Complaint is defined as a verbal or written expression that indicates dissatisfaction or dispute with Aetna Better Health of Missouri’s policies, procedure, claims, denials, or any aspect of health plan functions.

An Appeal is the mechanism which allows the provider the right to have actions taken by the health plan reviewed when the provider (a) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (b) is aggrieved by any rule or policy or procedure or decision by the health plan.

Complaints and Appeals may be Clinical or Administrative in nature. Clinical Complaints and Appeals result from health plan actions that were based, in whole or in part, on medical judgment (i.e. medical necessity determination; experimental or investigational determinations; cosmetic determinations). Administrative Complaints and Appeals result from health plan actions that are not clinical. Issues for review as Administrative Complaint or Appeals can include, but are not limited to, health plan policy, procedure, claims payment, or any non-clinical aspect of health plan functions.

A provider has one (1) year from the date of the incident, such as the original remit date or date of an adverse determination to file a Complaint. Appeals must be filed within 180 calendar days of the action taken by Aetna Better Health of Missouri that gave rise to the Appeal. Complaints and Appeals may be filed verbally, in writing, or in person. A provider may choose to file an Appeal without first filing a Complaint. In addition, a provider may file a Complaint and if the provider is unhappy with the outcome, the provider can then request an Appeal of the matter.

Providers have the right to submit documentation with their Complaint or Appeal. When filing an appeal or complaint, you must state in writing that you are filing an appeal or complaint or your request will be treated as a reconsideration. It is advantageous for the provider to clearly outline the Complaint or Appeal and provide supporting information. The provider should indicate why a decision should be made in the provider’s favor.

Providers also have the right to request and receive a written copy of Aetna Better Health of Missouri’s utilization management criteria, in cases where the Complaint or Appeal is related to a clinical decision/denial, or other applicable health plan policies or procedures relevant to the decision or action that is the subject of the Complaint or Appeal.

Administrative Complaints and Appeals will be reviewed by appropriate health plan personnel based on the matter at issue. For example, Complaints and Appeals regarding the coding of claims will be reviewed by a Quality Management Nurse Consultant who is a Certified Professional Coder. Your resolution letter will include the credentials of the professional who reviewed your Complaint or Appeal.

Clinical Complaints and Appeals are reviewed by health professionals who:

- Hold an active, unrestricted license to practice medicine or a health profession,
- Are board certified (if applicable),
- Are in the same profession or in a similar specialty as typically manages the medical condition, procedure, or treatment at issue, and
- Are neither the individual who made the original decision, nor the subordinate of such individual.

The resolution letter will indicate the specialty of the reviewer and the criteria that was used in the review. A copy of the specialist’s comments or report and the criteria used in the decision are available upon request.

Complaint and Appeal resolution letters will be sent to the provider upon Aetna Better Health of Missouri’s review of the Complaint or Appeal. For Reconsideration requests, a provider can use the Aetna Better Health of Missouri Reconsideration form located on the website, www.aetnabetterhealth.com/mo. Completing the form will provide Aetna Better Health of Missouri with the appropriate information to process a reconsideration request. In addition, it serves as a guide to determine if correspondence should be sent as a reconsideration or as an appeal.
Appeals should be sent using either of the two methods listed below:
Aetna Better Health of Missouri – Appeals
10 S. Broadway, Suite 1200
St. Louis, MO 63102
OR: Fax # 844-692-5109

16.1.1 Expedited Requests
Expedited requests are available for circumstances when waiting the usual time frames for a decision would seriously jeopardize (a) the life or health of a member or in the case of a pregnant member, the member’s unborn child; or (b) a member’s ability to attain, maintain, or regain maximum function. A verbal request indicating the need for an expedited review, should be made directly to Member Services at 1-800-566-6444. Those requests for an expedited review that meet the above criteria will have determinations made within seventy-two (72) hours or earlier as the member’s physical or mental health requires. All after-hour expedited requests can be initiated through the 24-Hour Nurse Hotline 1-800-475-1142.

16.1.2 Claims Review/Reconsideration
Refer to section 15.15.14 for more information regarding Claim review/reconsideration process.

16.1.3 Complaint Process
Complaints may be called in to the Claims Inquiry Claims Research number at 1-800-566-6444 (be sure to indicate you are filing a complaint). When calling in a Complaint, keep in mind that in order to review your Complaint you may be required to provide us with additional information such as medical records to support your position.

Or you may file a Complaint in writing:
Aetna Better Health Of Missouri – Complaint
10 S. Broadway, Suite 1200
St. Louis, MO 63102

Written Complaints will also be accepted via fax at 1-844-692-5109.

16.1.4 Appeal Process
Appeals should be submitted in writing and be clearly noted the provider is filing an appeal. All appeals including relevant supporting documentation should be sent to:
Aetna Better Health Of Missouri – Appeal
10 S. Broadway, Suite 1200
St. Louis, MO 63102

Administrative Appeals may also be submitted via telephone contacting Claims Inquiry Claims Research at 1-800-566-6444 (be sure to indicate you are filing an Appeal).

When submitting a written Appeal please include a statement or letter as to the substance of the Appeal. Documentation that supports your Appeal should also be included.

Appeals must be received within one hundred eighty (180) days of the incident, remit date or date of notice of action that caused the Appeal.

Pre-Service Appeals will be responded to in writing within thirty (30) calendar days of Aetna Better Health of Missouri’s receipt. Appeals related to post-service or any other non pre-service issues will be resolved within sixty (60) calendar days. Responses will be sent via fax if a fax number is provided.

16.1.5 Inquires Regarding Complaints or Appeals
For any inquiries regarding any provider or member complaints please refer to this issue number when contacting Claims Customer Service for status or any other questions regarding your appeal.

When submitting a written Complaint please include a statement or letter as to the substance of the Complaint. Documentation that supports your Complaint should also be included.
Complaints must be received within one (1) year of the incident, remit date or date of notice of action that caused the complaint. Complaints will be responded to in writing within thirty (30) calendar days of receipt of the Complaint for pre-service issues. For Complaints on post-service or any other non pre-service issue, Aetna Better Health of Missouri will respond within sixty (60) calendar days. Responses will be sent via fax if a fax number is provided.

16.2 MEMBER GRIEVANCE AND APPEAL PROCESS

The member is encouraged to discuss his/her concerns with those directly involved such as the provider, medical assistant, receptionist, office or administrative manager or Aetna Better Health of Missouri member advocate. If the question or concern is unresolved, the member is instructed to call or write to Aetna Better Health of Missouri.

Aetna Better Health of Missouri has established a member grievance process that shall guarantee any member the right for a review when they are dissatisfied with a service/benefit. The member is informed that they may request a State Fair Hearing for appeals, which may be filed simultaneously as Aetna Better Health of Missouri’s appeal. MO HealthNet may encourage Aetna Better Health of Missouri and the member to resolve the case before MO HealthNet takes action.

Aetna Better Health of Missouri members will receive assistance, if required, to file either a grievance or an appeal. Aetna Better Health of Missouri also provides a toll-free number 1-800-566-6444, a TDD number 1-800-735-2966 and interpretive services.

16.2.1 Expedited Appeal

Expedited requests are available for circumstances when waiting would seriously jeopardize the well being of the member. A verbal request indicating the need for an expedited review should be made directly to Aetna Better Health of Missouri at 1-800-566-6444. Those requests for an expedited review that meet the above criteria will have the determinations made within seventy-two (72) hours.

16.2.2 State Fair Hearing

Aetna Better Health of Missouri members have ninety (90) days from the date of Aetna Better Health of Missouri’s notice of action or appeal decision letter to initiate a State Fair Hearing. To arrange for a State Fair Hearing, members may call 1-800-392-2161 or write to the MO HealthNet Division, Recipient Services Unit, P.O. Box 6500, Jefferson City, MO 65102.

The member may request continuation of benefits during the appeal review or a State Fair Hearing. If the health plan’s action is upheld in a hearing, the member may be liable for the cost of any disputed services furnished while the appeal was pending determination.

Standard Resolution: The State of Missouri will normally determine a resolution within ninety (90) days of the date the member filed the appeal initially with Aetna Better Health of Missouri (excluding the days the member took to subsequently file for a State Fair Hearing) or the date the member filed for direct access to a State Fair Hearing.

Expedited resolution: If the appeal was first heard through the Aetna Better Health of Missouri appeal process, an expedited resolution will be provided within three (3) working days from the state agency’s receipt of a hearing request for a denial of service that:

- Meets the criteria for an expedited appeal process but was not resolved using Aetna Better Health of Missouri’s expedited appeal time frames, or
- Was resolved whole or partial adverse outcome for the member using the Aetna Better Health of Missouri expedited appeal time frame.

In cases where the State Fair Hearing process is initiated by members, without accessing the Aetna Better Health of Missouri appeal process, an expedited resolution will be provided to the member within seventy-two (72) hours from the State agency’s receipt of a hearing request for a denial of a service. These requests must meet the criteria listed above for an expedited appeal process.

16.2.3 Member Inquiry

An inquiry is a request from a member for information to clarify health plan policy, benefits, procedures or any aspect of the health plan’s function where there is no expression of dissatisfaction. All member inquiries are handled by Aetna Better Health of Missouri Member Services at 1-800-566-6444.
16.2.4 Process Definitions and Time Frames

Members have two (2) distinct processes to indicate dissatisfaction. These processes are a member appeal or a member grievance. Within the appeal process there is an opportunity for a member or their appointed representative to request an expedited appeal/grievance when the standard time frame for a resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function.

For both levels, members have the right to submit written comments with their appeal. Members also have the right to request and receive a written copy of Aetna Better Health of Missouri’s utilization management criteria, in cases where the appeal is related to a clinical decision/denial.

Process Definitions

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<thead>
<tr>
<th>Process</th>
<th>Definition</th>
<th>Determination Timeframes</th>
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<tbody>
<tr>
<td>Grievance</td>
<td>A member grievance is an expression of dissatisfaction about but not limited to issues related to quality of care or services provided and aspects of inter-personal relationships such as rudeness of a provider or employee or failure to respect the Member’s rights.</td>
<td>Member grievance will be resolved within 30 calendar days.</td>
</tr>
<tr>
<td>Appeal</td>
<td>Member appeal is a request for a review of any matter about an action which is defined as a 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; or the failure of the health plan to act within timeframes for the health plan’s prior authorization review process. When the health plan determines the request for an expedited appeal does not meet the State’s definition of expedited appeal, Aetna Better Health of Missouri will transfer the appeal request to the time frame for standard appeal resolution. Aetna Better Health of Missouri will make reasonable efforts to give the member prompt oral notice of the decision to review the request based on standard appeal timeframes and follow up with written notice of that decision. Members must acknowledge in writing the request of a verbal appeal to the health plan before the health plan can initiate a review of the request.</td>
<td>Member appeal will be resolved within thirty (30) calendar days, but not to exceed forty-five (45) calendar days.</td>
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With the member’s permission, providers can act on the member’s behalf by requesting an appeal as the member’s representative.
SECTION 17: FRAUD AND ABUSE GUIDELINES

Aetna Better Health of Missouri is a MO HealthNet managed care company and as such is bound by all federal and state anti-fraud and abuse programs. Aetna Better Health of Missouri must report any potential fraud or abuse by our providers and members. We are bound contractually by the State to report these occurrences and must investigate any fraudulent or abusive behavior meeting the following definitions:

17.1 MO HEALTHNET MANAGED CARE FRAUD DEFINITION

Any type of intentional deception or misrepresentation made by an entity or person in a capitated managed care organization (MCO), primary care case management (PCCM) program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.

17.2 MO HEALTHNET MANAGED CARE ABUSE DEFINITION

Practices in a capitated MCO, PCCM program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the MO HealthNet program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care. The abuse can be committed by an MCO, contractor, subcontractor, provider, State employee, MO HealthNet beneficiary, or MO HealthNet managed care enrollee, among others. It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary cost to the MO HealthNet program or MCO, contractor, subcontractor, or provider. It should be noted that MO HealthNet funds paid to an MCO, then passing to subcontractors, are still MO HealthNet funds from a fraud and abuse perspective.

17.3 PROGRAM DESCRIPTION

Aetna Better Health of Missouri has a comprehensive fraud and abuse program for both providers and members. Within our program, fraud and abuse prevention, detection, reporting, reviewing and corrective actions are our main goals. Much of the detection process comes from providers because they are in the best position to see characteristics of fraud, which leads to the minimization of fraud loss. Organizations suffer tremendous costs as a result of fraud and abuse. With the basic understanding of fraud and abuse along with some common examples, it will be easier to detect any fraudulent activity routine.

Some common examples of member fraud are:

• Letting someone else use their insurance card.
• Using multiple physicians to acquire abusive drugs.

Some common examples of provider fraud are:

• Billing for services not provided.
• Billing for more expensive services than actually provided.

By understanding the common acts of fraud and abuse, we can all work together to try and eliminate the effects of fraudulent and abusive behaviors.

17.4 FEDERAL DEFICIT REDUCTION ACT OF 2005 (DRA)

As you may be aware, in December of 2005, Congress passed the Federal Deficit Reduction Act of 2005 (“the DRA”). Aetna Better Health of Missouri, LLC (“Aetna Better Health of Missouri”), as an entity which receives or makes payments under a State plan approved under Title XIX, or under any waiver of such plan, totaling at least $5,000,000 annually, is required by Section 6032 of the DRA to establish and disseminate written policies to employees and contractors. These policies must include detailed information about the Federal False Claims Act, administrative remedies for false claims and statements established under 31 U.S.C. §§ 3801 et seq., and applicable State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (collectively, “False Claims Acts”).

Center for Medicare and Medicaid Services (“CMS”) has defined “contractors” as “any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of MO HealthNet health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.” CMS clarified that participating network providers are to be considered “contractors” for the purpose of the DRA.

Therefore, we are required to inform you of Aetna Better Health of Missouri’s Employee and Contractor False Claims Act Education materials. These materials can be easily accessed at www.aetnabetterhealth.com/mo, or upon request to your provider relations representative. In addition, more information about the DRA and these requirements are available for your review on CMS’s website www.cms.hhs.gov.

www.aetnabetterhealth.com/mo
Provider Relations 1-800-566-6444
17.5 HOW TO REPORT FRAUD AND/OR ABUSE

If you believe you have information relating to health care fraud, abuse or waste, please contact the Aetna Special Investigation Unit (SIU). The SIU will review the information provided and will maintain the highest level of confidentiality as permitted by law. You may contact our SIU by calling 1-800-566-6444.

17.6 MEDICAID FRAUD CONTROL UNIT

The Medicaid Fraud Control Unit ("MFCU") prosecutes cases involving fraud of the Missouri Department of Social Services’ Medicaid program by health professionals, or abuse or neglect of Medicaid recipients by caregivers. You may direct complaints of suspected Medicaid fraud to Missouri’s MFCU at 1-800-286-3932.

17.7 FRAUDULENT BILLING AND RECOVERY

If a network provider submits fraudulent billings to a MO HealthNet Managed Care health plan, any recoveries associated with the fraudulent billing will be recovered by the State and not the health plan if the health plan previously reported those costs in a cost report used to establish rates. If, however, the fraudulent billing and recovery is done in a period where cost reports have not been submitted by the MO HealthNet Managed Care health plan for that service period, then the recovery shall go to the health plan and the health plan shall not report any of the medical costs associated with the fraudulent billings in the cost report.

Aetna Better Health of Missouri reserves the right to conduct recovery and recoupment on any claims identified to be fraudulent billing.
SECTION 18: HIPAA

18.1 PRIVACY RULE

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in 1996. It was created to assure health insurance protections and portability for individuals changing jobs. In addition, it enforces standards for electronic submission of health information and provides security and privacy of health information to protect the confidentiality and integrity of individually identifiable health information, commonly called Protected Health Information (PHI). Under the Rule, PHI may be communicated for treatment, payment, and health care operations. HIPAA also mandates the use of standard codes and the appropriate use of those codes.

Aetna Better Health of Missouri has a functional privacy program in place. Providers must identify themselves by their tax identification number and/or NPI Number in all telephone conversations with the health plan. Aetna Better Health of Missouri adheres to the minimum necessary requirement of the rule and the de-identification of PHI when appropriate.

18.2 PROTECTED HEALTH INFORMATION (PHI)

To remain compliant with HIPAA, Aetna Better Health of Missouri utilizes some business practices which may affect our provider communities with regard to Privacy and transactions and code sets. These modifications are outlined in this document.

18.3 DELEGATED CREDENTIALING, UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT ACTIVITIES AND PHI

In the event that Aetna Better Health of Missouri delegates credentialing, utilization management or Quality Improvement functions to a provider (the “Delegate”) and such delegation arrangement includes the use of protected health information (“PHI”) by the Delegate, the following shall apply:

Delegate may use and disclose protected health information and non-public personal information (collectively PHI) in its possession for its proper management and administration and/or to fulfill any present or future legal responsibilities of the Delegate, provided that such uses are permitted under state and federal laws and would be permissible if performed by Aetna Better Health of Missouri. Delegate represents and warrants to Aetna Better Health of Missouri that (i) any such disclosures it makes will be required by law and (ii) the Delegate will obtain a written agreement from any such person or entity to whom the PHI will be disclosed that the PHI will be held confidentially and will not be further used or disclosed except as required by laws or for the purpose for which it was lawfully disclosed to such person or entity, and that such person or entity will notify the Delegate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

Delegate agrees to the following:

- Delegate shall not use or further disclose the PHI other than as permitted under this Agreement, HIPAA, GLBA, ARRA and their respective implementing regulations, each as amended from time to time.
- Delegate shall (i) use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for in this Agreement, and (ii) have administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits on behalf of Aetna Better Health of Missouri. Such safeguards shall include, without limitation, conducting a security risk assessment, and training employees who will have access to PHI with respect to the policies and procedures reaquired by HIPAA and ARRA. Upon request from Aetna Better Health of Missouri, Delegate shall provide Aetna Better Health of Missouri with a copy of its written information privacy and security programs.
- Delegate shall adopt and comply with policies and procedures that are in accordance with the HIPAA, ARRA, and GLBA requirements that apply to Delegate’s operations and the Services provided under the Agreement, including without limitations, maintaining the confidentiality and integrity of any information received, maintained or transmitted by or on behalf of Aetna Better Health of Missouri. Upon Aetna Better Health of Missouri’s request, Delegate shall provide a copy of Delegate’s policies and procedures.
- Delegate shall report to Aetna Better Health of Missouri any security incident involving or use or disclosure of PHI not permitted by this Agreement of which it becomes aware. Delegate shall report to Aetna Better Health of Missouri within five (5) days of the Delegate becoming aware of such use, disclosure or incident.
- Delegate shall report to Aetna Better Health of Missouri within five (5) days any Breach of Unsecured PHI. “Breach” shall mean the unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of such information. “Unsecured PHI” shall mean PHI that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary from time to time. Notice of Breach...
shall include, at minimum: (i) the identification of each individual whose PHI has been, or is reasonably believed to have been breached, accessed, acquired, or disclosed during the Breach; (ii) the date of the Breach, if known; (iii) the scope of the Breach; and (iv) a description of the Delegate’s response to the Breach. Upon reasonable request, Delegate shall provide Aetna Better Health of Missouri with information related to the Breach and will cooperate with Aetna Better Health of Missouri in any required notifications.

• To the extent that Delegate provides services to Aetna Better Health of Missouri relating to individuals enrolled in state or federal programs (e.g., Medicare, Medicaid), Delegate shall comply with any additional restrictions or requirements related to the use, disclosure, Medicaid maintenance, and protection of PHI of individuals enrolled in such programs through Aetna Better Health of Missouri.

• Delegate shall require any agent or subcontractor to whom Delegate provides PHI to agree in writing to (i) implement reasonable and appropriate safeguards to protect the PHI, and (ii) comply with the same restrictions and conditions on PHI as required by this Agreement. Upon request from Aetna Better Health of Missouri, Delegate shall provide a copy of any such agreement.

• Delegate shall require, use and/or disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure.

• Delegate shall not directly or indirectly receive remuneration in exchange for any PHI as prohibited by 42 U.S.C. 17935(d) and any regulations promulgated there under.

• Delegate shall not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. 17936(a) and any regulations promulgated there under.

• Delegate shall not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. 17936(b) and any regulations promulgated there under.

• Delegate shall mitigate, to the extent reasonably practicable, any harmful effect that is known to Delegate as the result of a use or disclosure of PHI by Delegate that is not permitted by this Agreement.

• Delegate shall not use, transfer, transmit, or otherwise send or make available, any PHI outside the territory of the United States of America without Aetna Better Health of Missouri’s prior written consent.

18.4 CONTACTING AETNA BETTER HEALTH OF MISSOURI BY PHONE

Your staff will be asked to provide your TIN and/or NPI Number, in addition to identifying member demographic information, as part of our caller authentication process.

18.5 E-MAILING PROTECTED HEALTH INFORMATION

Due to privacy and security considerations, Aetna Better Health of Missouri utilizes a policy to not transmit PHI by unencrypted e-mail over an open network (i.e., standard e-mail). If PHI must be transmitted by email due to certain circumstances, Aetna Better Health of Missouri has a secure message system allowing EPHI, electronic personal health information, to be transmitted. When EPHI is transmitted to an outside party from Aetna Better Health of Missouri, the outside party must open the link to the email and create a password to open the message containing personal health information.

18.6 PERSONAL REPRESENTATIVE

Aetna Better Health of Missouri will allow personal representatives, those individuals that have been granted legal authority under state law, to assist members by acting on their behalf and accessing their personal health information.

18.7 MEMBER DESIGNATED INDIVIDUALS

Members may also provide written permission to have one (1) or more member designated individuals to assist in the handling or resolving questions regarding health care benefits or payments. Aetna Better Health of Missouri’s systems will maintain this information and all member designated individual calls will be subject to the caller authentication processes.

18.8 CLAIMS INQUIRIES

Aetna Better Health of Missouri representatives will not divulge the diagnosis billed on a claim to either the member or provider. Any member questions related to diagnosis will be re-directed to their provider. In addition, any provider’s office requesting diagnosis or procedure code information from the submitted claim will be asked to contact their billing office.
18.9 PROVIDER COMPLAINTS AND APPEALS

Regardless of the type of appeal (written, expedited, or peer-to-peer reviews), both our organization and the provider office should exchange the minimum amount of individually identifiable health information necessary to process the review or appeal.

18.10 AUDITS OF MEMBER’S MEDICAL RECORDS

On an ongoing basis, we conduct quality improvement (QI) activities as required for licensure and reporting requirements. We also conduct utilization management (UM) activities to provide the best quality service to our members. As part of our QI and UM processes, Aetna Better Health of Missouri performs periodic quality reviews and requests medical information.

These requests include the review of randomly selected medical records for patients that are, or have been Members of our health plan.

The disclosure of PHI by physicians to Aetna Better Health of Missouri, or Aetna Better Health of Missouri’s quality review of medical information maintained by physicians, is permissible under the HIPAA Privacy Rule. Aetna Better Health of Missouri will only make requests as allowable under the Privacy Rule of HIPAA. We will also only request the minimum amount of information necessary to accomplish the task at hand.

18.11 EDI TRANSACTIONS

Aetna Better Health of Missouri continually strives to meet the transaction and code set provisions of HIPAA’s Administrative Simplification. Aetna Better Health of Missouri has implemented the x12N v5010 mandated transactions and code sets. Aetna Better Health of Missouri has certified the transactions are HIPAA compliant using SeeBeyond (an enterprise integration system) and Claredi (a third party certification service).

18.12 CODE SETS

Updates are made regularly to comply with standard code sets. HIPAA requires that payers and clearinghouses reject electronic claims with non-standard codes. Any paper claim submitted with non-standard coding will be processed with a denial disposition description and returned to the provider. These claims should be worked by the provider within the timely adjusted period, and resubmitted in the same manner, either electronically or via paper.

18.13 ACCESS TO PHI

Within five (5) days of a request by Aetna Better Health of Missouri for access to PHI about an individual contained in a Designated Record Set (as such Set is then defined by HIPAA regulation), the Delegate shall make available to Aetna Better Health of Missouri, or the individual to whom such PHI relates or his or her authorized representative, such PHI for so long as such information is maintained in the Designated Record Set as set forth in 45 C.F.R. § 164.524. In the event any individual requests access to PHI directly from the Delegate, the Delegate shall, within five (5) days, forward such request to Aetna Better Health of Missouri. Aetna Better Health of Missouri shall be responsible for determining whether to deny access to the PHI and Delegate shall comply with such determinations.

18.14 DISPOSITION OF PHI AT TERMINATION

Within thirty (30) days of the termination of the Delegate, the Delegate and its subcontractors, will return or destroy all PHI received from, or created or received by the Delegate on behalf of Aetna Better Health of Missouri, which the Delegate and/or its subcontractors or agents still maintain in any form, and will not retain any copies of such information. If such return or destruction is not feasible, the Delegate will notify Aetna Better Health of Missouri of the reasons for such in writing. Delegate shall extend the protections, limitations and restrictions of the PHI retained after the termination and shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
SECTION 19: STATE AND FEDERAL PROGRAMS REQUIREMENTS AND SERVICES

19.1 COMMUNICABLE DISEASE REPORTING

Communicable disease surveillance data is used to assess the health status of a community, identify occurrences of selected communicable diseases, apply appropriate interventions, and evaluate health programs and services. To that end, the Missouri Department of Health Rule mandates reporting of certain diseases. Providers must adhere to Missouri regulations 19 CSR 20-20.010 - 19 CSR 20-20.100, and to any relevant city or county ordinances governing disease reporting and communicable or zoonotic disease control measures.

Communicable disease follow-up and contact tracking remains the responsibility of public health agencies but can only be accomplished with the complete cooperation of providers. Control of communicable disease is a cooperative effort of private providers and public health agencies. The benefit of the close functional relationship and the free exchange of information will reduce morbidity and reduce costs.

To accomplish the objective of the DHSS and Aetna Better Health of Missouri, reporting needs to be timely, accurate and complete. In an effort to simplify and improve the current system, the DHSS has adopted a uniform reporting form, which must be utilized to report communicable disease information to the appropriate public health unit.

The local health departments can provide information regarding standard recommended protocols for diagnosis and treatment of a variety of communicable diseases (TB, STD, HIV and other diseases).

- Educational materials for patient or provider use are available from DHSS.
- Disease incidence data collected through the surveillance system is available through DHSS.

19.2 PHYSICIAN INCENTIVE PROGRAM (PIP) REGULATIONS

The Federal Physician Incentive Plan (PIP) regulations are designed to protect beneficiaries enrolled in Medicare and MO HealthNet managed care organizations by placing certain limitations on physician incentive plans that could influence a physician’s care decisions.

On an annual basis and in compliance with this federal regulation, Aetna Better Health of Missouri must disclose physician incentive plans to the CMS, and the state agency. The information to be disclosed shall include the following:

- Effective date of the physician incentive plan
- Type of incentive arrangement
- Amount and type of stop-loss protection
- Patient panel size
- Description of the method, if pooled
- For capitation arrangements, provide the amount of capitation payment broken down by percentage for primary care, referral and other services
- Computations of significant financial risk
- Whether the health plan does not have a physician incentive plan
- Name, address, phone number, and other contact information for a person from the health plan who may be contacted with questions regarding the physician incentive plan.

19.2.1 Overview of the Provider Incentive Plan (PIP) Regulation

Physician Incentive Plans (“PIPs”) are compensation arrangements that may exist between Managed Care Organizations (“MCOs”) and provider or provider groups, or between provider groups and individual providers. PIPs may directly or indirectly have the effect of reducing or limiting services furnished to MO HealthNet recipients enrolled in an MCO. Federal regulations protect beneficiaries enrolled in MO HealthNet MCOs by placing certain limitations on PIPs that could influence a provider’s care decisions. If you are a provider or a provider group, however, you should be informed of the following regarding your own relationships with other providers and provider groups.
19.2.2 PIP Frequently Asked Questions

To Whom Does This Section Apply?

If you are a provider, a provider in a provider group, or a provider who is part of an IPA or other network arrangement (such as a behavioral health provider contracted through Aetna Better Health of Missouri’s behavioral health network), this section will apply to you.

What Information is Required to be Disclosed/Reported?

On an annual basis, and in compliance with federal regulations, Aetna Better Health of Missouri must disclose to the Centers for Medicare and Medicaid Services (“CMS”) and the Missouri Department of Social Services any PIPs that it has established, or that its contracted providers have in place.

- Whether any risk is transferred (i) to the provider or provider group by Aetna Better Health of Missouri, or (ii) to a provider or provider group by an IPA or another intermediate entity. If yes, by what method?
- Whether any risk is transferred (i) to the provider or provider group by Aetna Better Health of Missouri, or (ii) to a provider or provider group by an IPA or another intermediate entity for Referral Services.
- What percent of total potential payment to the provider/provider group is at risk for referrals.
- What is the number of patients included in the same risk arrangement if the number of patients is 25,000 or fewer; what is the type and amount of stop-loss protection insurance.
- Whether the PIP puts providers/provider groups at “substantial financial risk.”
- If there is “substantial financial risk,” what is the amount of stop-loss protection required and how are the survey requirements met?

How Can Providers and Subcontractors Cooperate with Aetna Better Health of Missouri?

Providers shall cooperate with Aetna Better Health of Missouri with respect to, and shall comply with, the PIP requirements, including but not limited to the following:

- Upon request, providers/provider groups will submit to Aetna Better Health of Missouri all data necessary for Aetna Better Health of Missouri to meet its PIP disclosure and reporting obligations in accordance with federal law and the MO HealthNet contract. Providers/provider groups shall certify, in writing, the completeness, truthfulness, and accuracy of all such data.
- If any providers/provider groups are at “substantial financial risk” such providers/provider groups agree to obtain stop-loss protection as required by the federal regulations.
- Providers/provider groups shall cooperate with Aetna Better Health of Missouri regarding Aetna Better Health of Missouri’s obligation to conduct surveys of members in instances where a provider/provider group has indicated that it is at “substantial financial risk.”

What Payments are Prohibited?

PIPs may not include any direct or indirect payments to providers/provider groups as an inducement to limit or reduce necessary services furnished to a Aetna Better Health of Missouri Member. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. It should be understood that this prohibition does not preclude Aetna Better Health of Missouri from encouraging its contracted provider to authorize only those services that are medically necessary. In addition, PIPs that place providers/provider groups at “substantial financial risk” cannot legitimately operate unless stop-loss protections, enrollee survey, and disclosure requirements of the PIP regulation are satisfied, as discussed in greater detail below.

What Information Must be Reported to CMS and the MO HealthNet Agency by Aetna Better Health of Missouri?

The disclosure requirements apply not only to Aetna Better Health of Missouri’s direct contracting arrangements with providers, but to its subcontracting arrangements as well. In general, MCOs must provide to CMS information concerning their PIPs as may be requested by CMS. In addition, MCOs that contract with a provider group that places the individual provider members at SFR for services they do not furnish must disclose any incentive plan between the provider group and its individual providers that bases compensation to the provider on the use or cost of services furnished to Medicare beneficiaries or MO HealthNet recipients. Finally, when an MCO contracts with an “intermediate entity” such as an individual practice association (“IPA”) that, in turn, contracts with one or more provider groups and a provider hospital organization (“PHO”), the MCO must disclose to CMS any incentive plans between the intermediate entity and a provider or provider group that bases compensation on the use or cost of services furnished to Medicare beneficiaries or MO HealthNet recipients.
What Information Must be Reported to Aetna Better Health of Missouri Members?

For Medicare or MO HealthNet beneficiaries who request it, contracting MCOs must provide information indicating (i) whether the MCO or any of its contractors or subcontractors uses a PIP that affects the use of referral services, (ii) the type of incentive arrangement(s) used, and (iii) whether stop-loss protection is provided. If the MCO is required to conduct a survey, it must also provide beneficiary requestors with a summary of survey results.

What is Substantial Financial Risk?

SFR occurs when the incentive arrangement places the provider or provider group at risk for amounts beyond the risk threshold, which is the maximum risk, if the risk is based on the use or costs of referral services. Risk threshold is set at 25% and does not include amounts based solely on factors other than a provider’s or group’s referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

What Happens When Substantial Financial Risk Exists?

In sum, if a PIP puts a provider or provider group at SFR for referral services, Aetna Better Health of Missouri must survey current and previously enrolled members to assess member access to and satisfaction with the quality of services. In addition, adequate and appropriate stop-loss protections must be in place to protect providers and/or provider groups to whom SFR has been transferred.

What Happens if an MCO or a Provider Does Not Comply with the PIP Requirements?

Failure to comply with the PIP rule may result in application of intermediate sanctions, or imposition of civil money penalties, as described in 42 CFR §417.500 and 42 CFR § 434.67. CMS may also withhold Federal Financial Participation from the state if the state or an MCO fails to fulfill State plan or contract requirements, respectively.
SECTION 20: PROVIDER SECURE WEB PORTAL

Aetna Better Health of Missouri provides a web based Provider Secure Web Portal via the website www.aetnabetterhealth.com/mo. This Provider Secure Web Portal provides an alternative method of Customer Service – a self-service way to get your questions answered at your convenience without placing a single telephone call. The portal is available 24/7 for all providers.

20.1 PROVIDER SECURE WEB PORTAL

The Secure Web Portal is a web-based platform that allows us to communicate member healthcare information directly with providers. Providers can perform many functions within this web-based platform. The following information can be attained from the Secure Web Portal:

• Member Eligibility Search – Verify current eligibility of one or more members.
• Panel Roster – View the list of members currently assigned to the provider as the PCP.
• Provider List – Search for a specific provider by name, specialty, or location.
• Claims Status Search – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user’s account provider ID will be displayed.
• Remittance Advice Search – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user’s account provider ID will be displayed.
• Provider Prior Authorization Look up Tool (PROPAT) – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user’s account provider ID will be displayed. The tool will also allow providers to:
  • Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes simultaneously
  • Review Prior Authorization requirement by specific procedures or service groups
  • Receive immediate details as to whether the codes(s) are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
  • Export CPT/HCPS code results and information to Excel
  • Ensure staff works from the most up-to-date information on current prior authorization requirements
• Submit Authorizations – Submit an authorization request on-line. Three types of authorization types are available:
  • Medical Inpatient
  • Outpatient
  • Durable Medical Equipment – Rental
• Healthcare Effectiveness Data and Information Set (HEDIS) – Check the status of the member’s compliance with any of the HEDIS measures. A “Yes” means the member has measures that they are not compliant with; a “No” means that the member has met the requirements.

For additional information regarding the Provider Secure Web Portal, please access the Provider Secure Web Portal Navigation Guide located on our website.

20.2 MEMBER CARE WEB PORTAL

The Member Care Web Portal is another web-based platform offered by Aetna Better Health of Missouri.

Providers are able to do the following via the Member Care Web Portal:

For their Practice:
• Providers can view their own demographics, addresses, and phone and fax numbers for accuracy.
• Providers can update their own fax number and email addresses.
• View a member’s profile which contains:
  • Member’s contact information
  • Member’s demographic information
• Member’s Gaps in Care (individual member)
• Detailed member clinical profile: Detailed member information (claims-based data) for conditions, medications, and utilization data with the ability to drill-down to the claim level*
• High-risk indicator* (based on existing information, past utilization, and member rank)
• Conditions and Medications reported through claims
• Member reported conditions and medications* (including Over the Counter (OTC), herbals, and supplements)

• View and provide updates and feedback on “HEDIS Gaps in Care” and “Care Consideration” alerts for their member panel*
• Provider can look up members not on their panel (provider required to certify treatment purpose as justification for accessing records)

* Any member can limit provider access to clinical data except for: Members flagged for 42 C.F.R. Part 2 (substance abuse) must sign a disclosure form and list specific providers who can access their clinical data.

For additional information regarding the Member Care Web Portal, please access the Member Care Web Portal Navigation Guide located on our website.

20.3 HOW TO REGISTER FOR PROVIDER SECURE WEB PORTAL

To register for the Provider Secure Web Portal, complete the Portal Registration form found on the website or contact Provider Relations at 1-800-566-6444.

Each practice can request registration under their Tax-Identification number and designate one (1) administrator for your account. The designated administrator can then grant other access to users within the same practice.

For the self registration option, please contact Provider Relations so we can provide the pertinent information providers need to utilize this option.

20.4 SUPPORT ASSISTANCE

If you experience any problems accessing any function of the Provider Secure Web Portal, contact Provider Relations at 1-800-566-6444.
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