Aetna Better Health Kids is a dedicated CHIP product from Aetna Better Health Incorporated. Whether you’re new to Aetna Better Health Kids or a veteran, read the reminders below.

**Electronic claims submission**
You can send claims electronically for efficient service. All you have to do is use our payor identification number 23228. If you mail claims, be sure to mail to the address listed below:

Aetna Better Health Kids
Attn: Claims Department
PO Box 62198
Phoenix, AZ 85082

Remember, you’ll receive payment on the date that payment is mailed or electronically transferred.

**Medicaid enrollment**
In order to receive reimbursement for services rendered to an Aetna Better Health member you must first enroll with DPW. Here are some other requirements:

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<th>In-state</th>
<th>Out-of-state</th>
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<tbody>
<tr>
<td>License</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Board Certification</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Registration</td>
<td>With the appropriate state agency</td>
<td>With the appropriate agency in your state</td>
</tr>
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</table>

Providers outside the United States must have an active license or permit that is approved by a certified local state or government agency. If applicable, providers may submit proof of certification by Medicare.

For more information on how to enroll, visit www.dpw.state.pa.us/providers/promise/enrollmentinformation.
Quality is in all we do at Aetna Better Health!

We have programs to improve the medical care and delivery of services to your patients. We also have prevention and wellness programs that educate your patients on how to get the best care and services they need to live a healthier life. They help us understand where we may need to improve our process in order to make sure our members are satisfied with us as their health plan. Some of the ways we do this are:

- **Prevention and wellness outreach through telephone and postcard reminders for services such as:**
  - Well visits and dental visits
  - Lead screening
  - Childhood shots
  - Women’s health screenings, like mammograms and pap smears
  - Care for women who are pregnant

- **Quality improvement projects in areas such as dental care and diabetes control**

- **Quality audits**

  - **HEDIS® measures.** HEDIS® stands for Healthcare Effectiveness Data and Information Set. HEDIS is a tool that looks at:
    - Well-child visits completed
    - Shots given on time
    - Pregnancy visits completed
    - Dental visits completed

- **CAHPS survey.** CAHPS stands for Consumer Assessment of Healthcare Providers and Systems. CAHPS is a survey that the members complete to tell us how they feel about their doctor and health plan services. We use the results of this survey to improve care and services to our members.

Listed below is information on both HEDIS® and CAHPS.

In 2012, of the children who were 2 years old, more than 58 percent received blood tests for lead and 63 percent were up-to-date on their shots. This is better than 2011.

Of our members diagnosed with diabetes, more than 76 percent got a hemoglobin A1c test and more than 71 percent had their cholesterol checked. This is about the same as 2011.

72 percent of adult members’ ages 20 to 65 years visited their primary care provider. This is better than last year.

84 percent of women who had a baby saw their OB/GYN for early prenatal care. This is more than last year. 58 percent had a postpartum visit, which is less than those who had a visit last year.

Only 43 percent of members received dental care, the same as last year.

We believe that quality should be in everything that we do. We also take your opinions very seriously. We’ll work to improve in areas that you say we need to get better.

Call us at 1-866-638-1232 to find out more about our quality programs. You can also ask for a written description of our Quality Management Program.

What you need to know about Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT services aim to provide preventive health care to children and young adults up to the age of 21. These federally-mandated services are based on the recommendations of the American Academy of Pediatrics (AAP). Screenings offer a unique opportunity to perform a comprehensive evaluation of a child’s health. They also provide appropriate and timely follow-up diagnostic and treatment services.

If you’re a primary care provider who treats members up to the age of 21, you’re required to provide comprehensive health care, screening and preventive services. Schedule EPSDT screens for any new member up to the age of 21 within 45 days from the effective date of enrollment. Schedule EPSDT screens for any new member under the age of nineteen within 45 days from the effective date of enrollment. The only exception to this is if the child is already under the care of a primary care provider (PCP) and current with screens and immunizations. Also, don’t forget to contact all members who haven’t had an encounter during the previous 12 months or within the Medical Assistance appointment timeframes.

A complete visit means that you’ve completed all required components listed on the Aetna Better Health billing guide.
New Member Care Information portal

Coming soon! You’ll be able to access a new, secure, online portal on our website. The Member Care Information portal allows you to instantly connect to your patients and their care teams. All you have to do is fill out a short registration form available on our website. You can also contact your Provider Relations representative at 1-866-638-1232. They can set up a visit to walk you through the new portal and get you registered that day.

Through the Member Care Information portal, you can also access:

- A real-time listing of your patients
- Information on gaps in care for your practice
- Email capability with care managers

Obstetrical Needs Assessment Form (ONAF)

You can also complete the ONAF online through our new portal. Remember, the electronic submission of the ONAF is a Department of Public Welfare (DPW) requirement. You can help us meet this requirement by submitting your ONAF through our Member Care Information Portal.

Questions? Call your Provider Relations representative at 1-866-638-1232.

CVS Caremark

CVS Caremark Specialty Pharmacy recently became the preferred provider for specialty medications for Aetna Better Health and Aetna Better Health Kids members.

Using CVS Caremark Specialty Pharmacy will benefit both you and your patients

CVS Caremark Specialty Pharmacy provides medication, education and support for your Aetna Better Health patients. They also closely monitor patients’ clinical response at no additional charge.

CVS Caremark also:

- Helps determine patients’ benefits
- Determines coverage
- Communicates patients’ financial obligations
- Helps get all of the necessary authorizations
- Saves you time on administrative tasks
- Has a pharmacist available for consultations 24 hours a day, seven days a week

Also, CVS Caremark Specialty Pharmacy has expertise in patient-specific dosing, medical devices to administer the medication, and the special handling and delivery required with these injectable, infused and select oral medications.

Admissions and Customer Care representatives are available Monday through Friday 8 a.m. to 8 p.m. (ET). If you have questions or need more information, call CVS Caremark toll-free at 1-800-238-7828 or visit www.CVSCaremarkSpecialtyRx.com.

Questions? Call your Provider Relations representative at 1-866-638-1232.

As of November 1, 2013, Synagis will be available at CVS Caremark

What is Synagis® (palivizumab)?

Synagis is a prescription medication used to help prevent a serious lung disease caused by respiratory syncytial virus (RSV) in children at high risk for severe lung disease from RSV.

Who should not receive Synagis?

Children should not receive Synagis if they’ve ever had a severe allergic reaction to it. Signs and symptoms of a severe allergic reaction could include:

- Itchy rash
- Swelling of the face
- Difficulty swallowing
- Difficulty breathing
- Bluish color of the skin
- Muscle weakness or floppiness
- A drop in blood pressure
- Unresponsiveness

How is Synagis given?

Synagis is given as a shot, usually in the thigh muscle, each month during the RSV season. Your patients should receive their first Synagis shot before the RSV season starts. This helps protect them before RSV becomes active. When RSV is most active, your patient will need to receive Synagis shots every 28-30 days. This helps protect them from severe RSV disease for about a month.

Your patient should continue to receive monthly shots of Synagis until the end of RSV season. They may still get severe RSV disease after receiving Synagis. If your patient has an RSV infection, they should continue to get their monthly shots throughout the RSV season. This helps prevent severe disease from new RSV infections.

The effectiveness of Synagis shots given less than monthly throughout the RSV season hasn’t been established.

Synagis guidelines and forms

Synagis requires a prior authorization and is only approved for members who meet Aetna Better Health clinical guidelines. Also, Synagis will only be approved for use in the 2013-2014 Synagis season (November 1 - April 1). Submit your prior authorization using the Synagis prior authorization form found on our website at www.aetnabetterhealth.com/pennsylvania/providers/pharmacy.

Synagis dispensing and specialty pharmacy

Synagis is dispensed primarily through specialty pharmacy. Aetna Better Health’s preferred specialty pharmacy is CVS/Caremark Specialty Pharmacy. Call CVS Caremark toll-free at 1-800-238-7828, fax prescriptions to 1-800-323-2445 or visit www.CVSCaremarkSpecialtyRx.com.
Outpatient radiology billing and reimbursement

Effective October 1, 2013, our system will automatically reimburse you for only the technical component of your outpatient radiology claims. You’ll receive this reimbursement even if you bill without the appropriate technical claim (TC) modifier.

**Receive payments for both technical and professional components**
If you are actually performing both the technical and professional components, you can receive payment for both the technical and professional components by:
- Billing the professional component of the outpatient radiology claim on a separate claim, or
- Including the appropriate technical (TC) modifier along with the professional modifier (26) on your initial claim

Our claims payment system will pay the technical portion of the radiology service even if you don’t bill for the technical modifier. Therefore, you don’t have to change how you bill for these services. You can continue to perform only the technical component and bill without modifiers. Or, you can bill for the appropriate modifier for technical-only reimbursement.

Questions? Call your Provider Relations representative at 1-866-638-1232.

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Promoting correct claims using the appropriate modifiers

We update our fee schedule to reflect the current effective and term dates of new and replacement codes. The effective and term dates aren’t always in line with the Department of Public Welfare’s updates.

For brand-new code coverage, we provide coverage for these codes update receipt of a fee from DPW. If you have questions about a new code being covered under a member’s benefit plan, call us at 1-866-638-1232.

**Modifier updates**
If you’re an anesthesiologist, make sure you submit all appropriate anesthesia modifier(s). When you bill an anesthesia service without the appropriate modifier(s) or with modifier combinations other than those listed in this section, the claim is denied.

We follow industry standards regarding payment for the following modifiers:
- **QK**: Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals. **Payment Rule:** Limits payment to 50% of the amount that would have been allowed if personally performed by a physicians or non-supervised CRNA.
- **QX**: CRNA service with medical direction by a physician. **Payment Rule:** Limits payment to 50% of the amount that would have been allowed if personally performed by a physicians or non-supervised CRNA.
- **QY**: Medical direction of one CRNA by anesthesiologist. **Payment Rule:** Limits payment to 50% of the amount that would have been allowed if personally performed by a physicians or non-supervised CRNA.

**Modifier 50**
The American Medical Association’s CPT manual describes the use of Modifier 50 as “bilateral procedures that are performed at the same operative session.”

Appropriate Modifier 50 use:
- To report bilateral procedures performed at the same operative session as a single line item.
- Any bilateral procedure performed on both sides at the same operative session.
- Restricted to operative sessions only.
- The unit entry is reported as one unit.

Inappropriate modifier 50 use:
- To report surgical procedures identified by their terminology as “bilateral”
- To report surgical procedures identified by their terminology as “unilateral”.
- Do not submit two line items to report a bilateral procedure.

**Modifiers RT and LT**
The American Medical Associates CPT manual describes the use of Modifiers RT and LT as “codes, which identify procedures, which can be performed on paired organs, e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries.

Appropriate use of Modifiers RT and LT:
- Used whenever a procedure is performed on only one side.
- To identify which of the paired organs was operated upon.

Inappropriate use of Modifiers RT and LT:
- Do not use modifiers RT and LT when modifier 50 applies.

For more information on the appropriate use of modifiers, refer to:
- Centers for Medicare & Medicaid Services – www.cms.hhs.gov/mcd/
- American Medical Association – search.ama-assn.org/
New prior authorization tool

You can find out if a specific code requires prior authorization using our new prior authorization tool on the secure, web portal. All you have to do is register with the secure web portal if you haven’t already.

Fill out the registration form on our website at www.aetnabetterhealth.com/pennsylvania/providers/portal. Remember to specify codes for the requested services when sending a request for prior authorization. Contact us to update the authorization if you make changes before or during the procedure. If you don’t contact us and you perform non-specified services, we may deny the claim. This because you performed services that are inconsistent with the services authorized. Authorization is not a guarantee of payment.

Authorization updates

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<thead>
<tr>
<th>CPT Code</th>
<th>Providers affected</th>
<th>Update</th>
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<tbody>
<tr>
<td>L0637 - ASO</td>
<td>Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels (prefabricated, includes fitting and adjustment)</td>
<td>Durable medical equipment Effective October 1, 2013 this code requires authorization.</td>
</tr>
<tr>
<td>42820, Tonsillectomy</td>
<td>ENT providers</td>
<td>Effective October 1, 2013 this code requires authorization.</td>
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If you have questions about prior authorization requirements, call us at 1-866-638-1232.

Milliman Care Guidelines® ensure consistency

We use the Milliman Care Guidelines to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The Guidelines are updated regularly. You can ask for a copy of individual guidelines for a specific case. Simply fax the request to 1-877-363-8120.

Credentialing reminders

Address changes
If your practice has an address change, send us written notification and a W-9 form. Fax both documents to us at 860-754-5435, or e-mail Teya Phillips at PhillipsR2@aetna.com.

New provider joining practice
If you have a new provider joining your practice, tell our Provider Relations department as soon as possible. Then, we’ll send you a Provider Application Screening Form to complete and return so we can start the credentialing process. The Provider Application Screening Form is location on our website under the provider section. You can submit your completed form by faxing to 860-754-5435. Or, e-mail Teya Phillips at PhillipsR2@aetna.com.
NEW: Outpatient diagnostic radiology services through MedSolutions

MedSolutions will provide utilization management for outpatient diagnostic radiology services for Aetna Better Health members. MedSolutions is a radiology services organization that specializes in managing diagnostic services. The new radiology requirements will become effective on or after December 1, 2013.

Over the next several weeks, we’ll provide you with more program details. Please note that implementation of this program allows us to assist our providers and members to obtain the most appropriate imaging study. It also ensures that the study is performed by a participating network imaging provider.

Contact information
If you have questions or concerns, we’re here to help. Call us at 1-866-638-1232.

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<tr>
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<th>Aetna Better Health</th>
<th>Aetna Better Health Kids</th>
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<tr>
<td>For Members</td>
<td>Prompt 2</td>
<td>Prompt 1</td>
</tr>
<tr>
<td>For Providers</td>
<td>Prompt 3</td>
<td>Prompt 5</td>
</tr>
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</table>

You can also email your Provider Relations representative:
Joshua Edwards .................................................EdwardsJ3@aetna.com
Mosadi Averette .............................................AveretteM@aetna.com
Patrick Alouidor .............................................AlouidorP@aetna.com
Dawn Choi ........................................................ChoiD@aetna.com
Tim King ..........................................................KingT1@aetna.com
Rashateya Phillips ...........................................PhillipsR2@aetna.com
Yvonne Adams ....................................................AdamsY@aetna.com
Sumaia Nusrat ..................................................NusratS@aetna.com

Aetna Better Health quick facts

Established: 2010
Corporate location: 2000 Market Street, Suite 850
Philadelphia, PA 19103
Phone: 1-866-638-1232
Website: www.aetnabetterhealth.com/pennsylvania
Provider network: 13,000 providers
Management:
Denise Croce, CEO
Emmilyn Lawson, COO
Mark Landis, CFO
John H Robinson, MD, CMO
Dwayne Parker, Provider Relations Director