Table of Contents
Federal False Claims Act (FCA). 1
Potential fraud or abuse issues and concerns ....................... 1
Program to pay providers for quality performance ......................... 2
Promoting correct claims coding using the appropriate modifiers ............ 2
Updated prior authorization requirements grid .......................... 3
Milliman Care Guidelines® ensure consistency ......................... 3
Claims reconsideration process versus provider appeal process .......... 3
Claims reconsideration process versus provider appeal process .............. 4
Ensure your claims get processed quickly ............................. 4
Credentialing Reminders ........................................ 4
Contact information ........................................ 5
Provider relations department contacts .................................. 5
Organizational announcement ........................................ 5
Aetna Better Health quick facts ....................................... 5

Federal False Claims Act (FCA)

Aetna Better Health supports efforts to find, prevent and report fraud and abuse within the Medicaid system. These efforts are consistent with our mission to provide care to our members, while being fiscally responsible. Our management of limited resources is a key part of this responsibility.

Here are some examples of actions that we will report to the State’s investigative agencies:

- Consistently showing a pattern of sending false encounters or service reports
- Consistently showing a pattern of overstated reports or upcoded levels of service
- Altering, falsifying or destroying clinical record documentation
- Making false statements relating to credentials
- Misrepresenting medical information to justify enrollee referrals
- Failing to render medically necessary covered services that providers are obligated to provide according to their contract
- Charging enrollees for covered services

Aetna Better Health’s CHIP business

Effective July 1, 2013, if you are currently providing services under the Aetna HMO contract for CHIP members (physical and behavioral health) we will no longer be able to process claims or payments under the Aetna HMO claims platform. All claims for CHIP members will be processed through provider agreements with Aetna Better Health for dates of service on and after July 1, 2013. These agreements must recognize CHIP in the participation schedules. Providers that bill Aetna Health Inc. after this date will be denied or paid at the non-par rates.

Electronic Payor Identification Number
Aetna Better Health’s EDI number is 23228.
Program to pay providers for quality performance

We set certain quality standards that allow primary care providers (PCPs) to receive additional payment if he or she meets those standards. These PCPs must have a minimum number of members in their assigned panels and must meet our established guidelines. The standards are based on the national HEDIS® measures or other health care areas that need more focus. This program is referred to as a pay-for-performance program or P4P. Aetna Better Health pays for improved performance in:

- Breast cancer screening for women ages 42–69
- Complete diabetes care including Hemoglobin A1c (HbA1c) testing
- Prenatal care in the first trimester
- Frequency of ongoing prenatal care > 81 percent of expected visits
- Postpartum care
- Adolescent well visits
- Annual dental visit for members 2–21 years of age
- Cervical cancer screening

For more information about P4P, call your provider relations representative at 1-866-638-1232.

Promoting correct claims coding using the appropriate modifiers

New and replacement codes

Aetna Better Health follows the Department of Public Welfare (DPW) quarterly fee schedule updates for the effective and term dates of new and replacement codes. The effective and term dates are not always in line with CMS updates. Aetna Better Health will implement and/or update our system to match the effective and term dates as DPW identifies.

For brand-new code coverage, we will provide coverage for these codes update receipt of a fee from DPW. If you have questions about a new code coverage, please contact Aetna Better Health.

Revenue codes 270, 271, 272, 370 and/or 710

We have implemented these revenue codes that require the combination of a HCPCS or CPT code when billing. If you bill these revenue codes without the HCPCS or CPT code, the reimbursement will be completed at the default percentage outlined within your contract. If you bill with the appropriate HCPCS/CPT combination, the services will pay according to the fee schedule and contracted rate.

- Revenue codes are only accepted for inpatient claims processing for APR/DRG payments.
- Aetna Better Health does not reimburse any outpatient claims using just revenue codes.

Skilled Nursing Facility (SNF) coding requirements

Since November 1, 2012, we processed claims for services provided in a SNF according to the DPW Long-Term Care Provider Handbook (837 Institutional/UB-04). Per DPW, a SNF is required to bill place of service 26 (nursing Facility) and revenue codes 0100 for facility days; 0183 for therapeutic leave days and 0185 for hospital reserve bed days. For revenue code 0185, there is a maximum reserve of 15 calendar days per stay.

Code T1015

The state fee schedule has rates for T1015 when billed with the U7 or U8 modifier. However, reimbursement is not applicable for T1015 when billed with the U9 modifier. From a claims payment view, the pricing for therapies should be billed with a U7 or U8 modifier along with GN, GO or GP, dependent upon the type of therapy being provided. For FQHCs and RHC providers, refer to your provider agreement for correcting coding requirements and reimbursements.

Modifier 25

The American Medical Association’s CPT manual describes the use of Modifier 25 as “the physician may need to indicate that on the day of a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.”

Appropriate Modifier 25 use

- This modifier may be appended to Evaluation and Management codes (99201-99499) or to general ophthalmologic codes (92002-92014).
- This modifier should be used when the Evaluation and Management service is distinct and separately identifiable from the service or procedure being performed.
- This modifier should only be added to Evaluation and Management services in conjunction with the service or procedure (CMS’ 0 and 10-day Global Surgery periods) on the same day.

Inappropriate Modifier use

- This modifier should not be used on Evaluation and Management codes the same day as the procedure or service, when the patient’s purpose for being in the office was strictly for the performance of the procedure or service.
- This modifier should not be appended to an Evaluation and Management service that resulted in the decision to perform major surgery (CMS’ 90-day Global Surgery period).
- Appending this modifier to non-evaluation and management services is an incorrect coding practice.

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/

SPRING 2013 2
Updated prior authorization requirements grid

We have updated our prior authorization requirements grid. To find the updated code-specific prior authorization requirements, log in to www.aetnabetterhealth.com/pennsylvania. Prior authorization requirements are located on the provider web page.

You are required to specify codes for the services being requested when sending a request for prior authorization. After you receive your authorization, if you make changes before or during the procedure, you must contact us to update the authorization. If you do not contact us and you perform non-specified services, we may deny the claim. The reason would be services performed that are inconsistent with the services authorized.

If you have any questions about prior authorization requirements, call Aetna Better Health 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.
Potential fraud or abuse issues and concerns

We encourage providers to report compliance matters, including potential fraud or abuse issues, such as:

- Members living outside the state of Pennsylvania
- Use of an Aetna Better Health ID that is not the member’s
- Potential drug-seeking members

You can report suspected fraud or abuse by calling:

- Aetna Better Health Compliance Hot Line at 1-800-333-0119
- Medicare Advantage Provider Compliance hotline at 1-866-379-8477
- A Fraud and Abuse form will be available on our website in July, 2013.

Ensure your claims get processed quickly

We encourage you to send claims electronically for efficient service. If you mail claims, be sure to mail to the address below. Payment of the claim is considered to be made on the date the payment was mailed or electronically transferred.

Electronic claims submission

Aetna Better Health uses one clearinghouse provider for electronic claim submissions. Our payer ID is 23228. Our clearinghouse will process electronic claims within 20 days after they receive the clean claim.

Paper claims submission

Send CMS 1500 and/or UB04 forms to the following address:

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

Process paper claims within 40 days after receipt of the claim. Please refer to the Pennsylvania Medicaid Provider CMS 1500 and UB04 Reimbursement Handbook located on the DPW website.

Electronic Payor Identification Number

Aetna Better Health’s EDI number is 23228.

Credentialing Reminders

Address changes

If your practice has an address change, you must 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.
- Fax to 860-754-5435.
- Or, e-mail Teya Phillips at PhillipsR2@aetna.com
Contact information

Call Aetna Better Health toll free at 1-866-638-1232
Member services and eligibility inquiry .................................... Prompts 1
Medical prior authorization .......................................................... Prompts 2
Claims/customer service ............................................................. Prompts 3
Pharmacy prior authorization ...................................................... Prompts 4
Contracting, credentialing, provider relations ..................... Prompts 5

Provider relations department contacts

Our provider relations department is ready to help you with your questions and/or concerns. Please call us at 1-866-638-1232.
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

Organizational announcement

Aetna Better Health is pleased to announce new Provider Relations Manager Karen Butler. Karen comes to Aetna Better Health with a wealth of knowledge and experience in both hospital and professional billing management. She looks forward to providing exceptional service.

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
Emmylyn Lawson, COO
Mark Landis, CFO
Barry Baker, MD, CMO
Dwayne Parker, Provider Relations Director