Aetna Better Health®
Provider Newsletter

Fall-Winter 2013

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TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

CHIP We've got your kids covered.

www.aetnamedicaid.com
1-800-248-7767 – Medicaid
1-866-818-0959 – CHIP

TX-13-10-19

Member's Eligibility Verification

You can access the Aetna® website portal to verify member's information such as eligibility and PCP. Access this link, txaetnamedicaid.abovehealth.com for more information.

You can call one of the following Service lines to create or reset your password:

Service Area	Medicaid	CHIP
Tarrant	1-800-306-8612	1-800-245-5380
Bexar	1-800-248-7767	1-866-818-0959

CHIP to TIERS

The Texas Health and Human Services Commission (HHSC) removed the alpha prefix and issued a nine (9) digit CHIP ID number. This change only affects the member's ID number and not his/her benefits.

Effective Dates for CHIP ID Changes:

- CHIP Perinate - September 3, 2013
- CHIP and CHIP Perinate Newborn - October 1, 2013

Claims Submissions

All claims will need to be submitted using the new CHIP ID number by the effective dates listed above based on date of service before or after 10/1/13.

Prior Authorizations

If you already have an existing Prior Authorization on file with the member's old CHIP ID number, it will be transitioned to the new numeric ID number. Any new authorizations received after 10/1/13 will need to be submitted with the new ID number.

Aetna Better Health sent out new CHIP ID cards in the mail. If a member has not received a new card shortly after the dates listed above, please have them contact Aetna Better Health Member Services at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) between the hours of 8:00 a.m. to 5:00 p.m. Central Standard Time.

Pharmacy Changes

The Immunization Branch of the Texas Department of State Health Services is currently in the process of notifying all physicians who participate in the Vaccines for Children Program (VFC) that as of October 1, 2013 there will be three categories of VFC vaccines that will be shipped by the CDC: Medicaid Vaccines, CHIPS Vaccines, and Federal 317 Vaccines. Each of these will have to be tracked separately and reported to DSHS like the Medicaid vaccines are currently.

The complicating problem is that these vaccines are NOT interchangeable. A Medicaid DTAP can only be given to a patient with a valid Medicaid number, a CHIPS DTAP only to a CHIPS patient, and a Federal 317 DTAP only to a 317 qualified patient.

The Federal 317 category includes those infants and children who are uninsured or underinsured. Underinsured are patients who have some commercial insurance coverage, but the insurance does not cover immunizations.

Our recommendation for keeping all of this straight is to use colored, self-adhesive dots to label the vaccines. These can be purchased inexpensively at a stationary store. Place a "key" on the storage refrigerator door showing which colored dot is related to each group. For example, a RED DOT = Medicaid, a BLUE DOT = CHIPS, and a YELLOW DOT = 317. Then, label each vaccine vial with the appropriate colored dot as it arrives in your office and before it is stored. Using this method, all of the like vaccines, e.g., DTAP, can be stored in the same bin in the refrigerator so the nursing staff can find them easily. It will also reduce the potential error of giving a vaccine from one category to a patient in a different category. Labeling the state required recording sheets with colored dots will also prevent mix ups in recording the immunization information on the correct form.

The minimal effort of having the office staff label the vaccines as they arrive in the office, will prevent hours of wasted time undoing mistakes and reporting variances to the health department. This translates into dollars saved in personnel costs.

The Immunization Branch is aware of this problem, but is not in a position to change the protocol. The vaccines are controlled and shipped by the CDC.

Texas Health Steps (THSteps)

Texas Health Steps (THSteps) is the Early and Periodic Screening, Diagnosis & Treatment program for children under the age of 21 on Medicaid. Services in this program include comprehensive, age-appropriate assessments, dental, hearing & vision screenings, immunizations and lab tests as indicated in the periodicity schedule which is published in the Texas Medicaid Provider Procedures Manual (TMPPM). To obtain a current copy of the latest periodicity schedule please visit: www.dshs.state.tx.us/thsteps/providers.shtm

What is the timeframe for a THSteps appointment?
Members should have a THSteps exam within the first 90 calendar days of Health Plan membership to establish a medical home. Additional THSteps exams should be completed in accordance with the periodicity schedule based on member's date of birth.

What is my responsibility as a provider?
Your responsibility as the child's provider is:

- To educate the child's parent or guardian of the health benefits of preventive care
- Schedule complete exams in a timely manner according to the periodicity schedule
- Perform complete exam and document all components of THSteps exam
- Cooperate with compliance monitoring of medical records documentation

What is a THSteps medical checkup?
The visit is a comprehensive medical checkup and MUST include all age-appropriate:

- Comprehensive health and development history, including developmental and nutritional assessment.
- Comprehensive unclothed physical.
- Appropriate immunizations as indicated in the recommended Childhood and Adolescent Immunization Schedule - United States
- Laboratory tests as indicated on the periodicity schedule (including lead blood level assessment appropriate for age and risk factors, anemia, and newborn screening)

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Texas Health Steps (THSteps) *Continued from page 2*

- Health education (including anticipatory guidance)
- Vision and hearing screening.
- Dental referral.

Who can provide THSteps services?
To enroll in the THSteps program, providers must be enrolled in the Texas Medicaid Program, and be one of the following:

- Physicians (MD and DO) currently licensed in the state where the service is provided. Health care providers or facilities (public or private) capable of performing the required medical checkup procedures under a physician's direction

For more information on the THSteps program, go to http://www.dshs.state.tx.us/thsteps/

THSteps Preventive Care Medical Checkup Requirement to Change for Elevated Blood Levels

Effective for dates of service on or after December 1, 2013, elevated blood lead level criteria will change for the Texas Health Steps preventive care medical checkup.

In accordance with Texas Administrative Code (TAC) Title 25 (Part 1) Chapter 37 Subchapter Q Rule §37.334, the elevated blood lead level requirement will be reduced from 10 mcg/dL to 5 mcg/dL.

For an elevated blood lead level of 5 mcg/dL or greater, the provider must perform a confirmatory test using a venous specimen. The confirmatory specimen may be sent to the Department of State Health Services (DSHS) Laboratory, or the client or specimen may be sent to a laboratory of the provider's choice.

Information related to blood lead screening and reporting for clients who are 15 years of age and older is available on the DSHS Blood Lead Surveillance Group's website at www.dshs.state.tx.us/lead/providers.shtm.

For more information, call the TMHP Contact Center at 1-800-925-9126.

Provider Claim Appeals:

Reminder on the Claims Appeal Process with Aetna Better Health

Aetna Better Health would like to reiterate some important reminders concerning appeal submissions.

An appealed claim is a claim that has been previously adjudicated and the provider is requesting review of the disposition through written notification to the MCO and in accordance with the appeal process as defined in the MCO Provider Manual.

Providers have 120 Days from the date of disposition to appeal a claim.

Providers must mail written requests of claim appeals. Providers submitting claim appeals must clearly document on the appeals form or attached Remit/EOB the information that is being appealed and identify the claim being appealed.

Appeal Process as Defined in the MCO Provider Manual:
A claim appeal is a written request by a provider to give further consideration to a claim reimbursement decision based on the original and or additionally submitted information. The document submitted by the provider must include verbiage including the word "appeal".

An appeal must meet the following requirements:

- It is a written request to Appeal a claim
- You're now requesting further consideration based on the original and or additionally submitted information
- The document submitted must include verbiage including the word "appeal".

The Health Plan will process appeals and adjudicate the claim within thirty (30) days from the date of receipt. A provider may appeal any disposition of a claim.

The claim may be appealed in writing by completing an appeal form, which can be located on the Aetna Better Health website, or by completing the following:

1) Submit a copy of the Remit/EOB page on which the claim is paid or denied.
2) Submit one copy of the Remit/EOB for each claim appealed.
3) Circle all appealed claims per Remit/EOB page.
4) Identify the reason for the appeal.
5) If applicable, indicate the incorrect information and provide the corrected information that should be used to appeal the claim.
6) Attach a copy of any supporting documentation that is required or has been requested by Aetna Better Health. Supporting documentation to prove timely filing should be the acceptance report from Aetna Better Health to the provider's claims clearinghouse. Supporting documentation must be on a separate page and not copied on the opposite side of the Remit/EOB.

Note: It is strongly recommended that providers submitting appeals retain a copy of the documentation being sent.

Please submit your appeals and all supporting documentation to the following address:

Aetna Better Health
Appeals and Correspondence
P.O. Box 569150
Dallas, TX 75356-9150

Pharmacy Corner

Medicaid PDL Formulary:
Texas Medicaid PDL changes occur daily although the large changes occur bi-annually in January and July.

Several off cycle PDL changes have recently occurred including the addition of generic Lexapro, Lovenox and Actos added to the PDL. In addition, for Pulmicort Respules 0.5mg/2ml and 0.25mg/2ml PDL criteria has changed from a maximum age of 24 months to 48 months. This will allow children up to the age of 48 months to receive Pulmicort Respules without a prior authorization.

Many changes have occurred to the PDL in 2013 that may affect your practice. You can find the most recent Texas PDL with all highlighted changes from July 2013 at: http://www.txvendordrug.com/downloads/pdl/TX-PDL-072413.pdf

You can also check the status of specific drugs on the PDL and find alternatives to Non-Preferred Drugs at: http://www.txvendordrug.com/formulary/formulary-search.asp

Grandfathering Removal for Antidepressants and Growth Hormone Texas Medicaid PDL:
HHSC removed grandfathering for drugs that are not on the PDL effective 11/1/13 for antidepressants and growth hormones. Therefore, all non-preferred antidepressants and growth hormones will reject at the pharmacy and will no longer be covered without Prior Authorization. If a non-preferred agent is needed, a prior authorization will have to be obtained.

Please note that current Non-Preferred prescriptions will not auto refill as Non-Preferred Agents and will not process without treatment failure, contraindication or allergic reaction with a preferred agent. If these apply to your patient, you may contact CVS Caremark Help Desk to request prior authorization at 1-877-874-3317. For your patient to receive a Preferred Drug, you will need to write a new prescription for a Preferred Agent.

A 72-hour emergency supply of the patient's current medication may be dispensed by the pharmacy if the prescribing provider cannot be reached or the pharmacy is unable to request a prior authorization.

Clinical Edits:
New Clinical Edits in 2013 for Texas Medicaid include: Kalydeco, Relistor, Erythropoiesis-Stimulating Agents, Alprazolam/Carisoprodol/Hydrocodone and a revised Opiod Overutilization Edit.

There are now approximately 46 Clinical Edits for Texas Medicaid. Prescribers are advised to review, complete, sign and date the clinical edits (PA) criteria form prior to issuing prescription(s) to patients. The completed form can be faxed to the Caremark pharmacy Prior Authorization Department at 1-866-255-7534 or contact the Prior Authorization Call Center at 855-656-0363.

NOTE: Incomplete information will result in a delayed decision by the pharmacy PA team which leads to an interruption of prescription coverage for our members.

For your convenience, prescribers may access Clinical Edit Prior Authorization forms by visiting the following web link: http://www.aetnamedicaid.com/faq3_en.asp?option=provider_pa_forms

New Pharmacy Benefits for Medicaid Members:
There are several new pharmacy benefits for Texas Medicaid members including:

1. Limited Home Health Supplies (LHHS): Include aerosol holding chambers, hypertonic saline, oral electrolytes and diabetic supplies including glucometers, test strips, lancets, syringes, needles and lancet devices
   To see a list of covered products including coverage and quantity guidelines visit: http://www.txvendordrug.com/formulary/limited-hhs.shtml

   http://www.txvendordrug.com/formulary/LHHS-Search.asp
2. Expanded Vitamin and Mineral Coverage: Expanded Vitamin and Mineral products added to the TX Medicaid formulary through pharmacy for Medicaid clients 20 years of age and younger (through the month of their 21st birthday). Covered specific products for specific indications. These OTC require a prescription in order to be processed at the pharmacy. Prescriptions for these products need to document the corresponding condition on the face of the prescription.
   To see a list of covered products and approved indication visit: http://www.aetnamedicaid.com/docs/New_Vitamin_and_Minerals.pdf
3. Pharmacy Administered Influenza Vaccines: Expanded coverage for Medicaid STAR and CHIP Perinate Members 21 and over. Coverage includes Injectable and Nasal Spray formulations.

Allergic Rhinitis

Second-generation antihistamines may be prescribed first line for allergic rhinitis. Along with prescribing appropriate medication, it important to counsel members and caregivers on environmental controls (Children's Hospital of Philadelphia: http://www.chop.edu/service/allergy/allergy-and-asthma-information/environmental-allergy-control.html). Intranasal steroids are useful for the management of allergic rhinitis when a second-generation oral antihistamine alone is not sufficient. Currently, no studies prove superiority of one intranasal corticosteroid product over another. See below the available preferred agents on the Texas Medicaid Formulary, recent preferred status changes for 2013 are highlighted in blue.

This summary provides the available products and their Texas Medicaid Preferred Drug List status.

TEXAS VENDOR DRUG PROGRAM FORMULARY[2]*
ALLERGIC RHINITIS – NASAL AGENTS
Highlights represent preferred status change in 2013

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Corticosteroids-Nasal			
Brand	**Generic**	**Brand**	**Generic**
NASONEX (mometasone)	fluticasone (generic Flonase)	Fluticasone formulations: FLONASE (fluticasone propionate) VERAMYST (fluticasone furoate) BECONASE AQ (beclomethasone) NASACORT AQ (triamcinolone) NASAREL (flunisolide) OMNARIS (ciclesonide) QNASL (beclomethasone dipropionate) RHINOCORT AQUA (budesonide) ZETONNA (ciclesonide)	triamcinolone flunisolide (generic Nasarel)
Antihistamines- Nasal			
Brand	**Generic**	**Brand**	**Generic**
ASTEPRO (azelastine) PATANASE (olopatadine)		ASTELIN (azelastine) ATROVENT nasal (ipratropium)	azelastine ipratropium nasal spray
Combinations			
Brand	**Generic**	**Brand**	**Generic**
		DYMISTA (azelastine/ fluticasone)	

TEXAS VENDOR DRUG PROGRAM FORMULARY2*
ALLERGIC RHINITIS – ORAL SECOND GENERATION ANTIHISTAMINES
(NON SEDATING OR MINIMALLY SEDATING)
Highlights represent preferred status change

Brand	Generic	Brand	Generic
	loratadine cetirizine	ALLEGRA (fexofenadine) CLARINEX (desloratadine) CLARITIN (loratadine) XYZAL (levocetirizine) ZYRTEC (cetirizine)	cetirizine chewable cetirizine solution 5mg/5ml desloratadine fexofenadine levocetirizine

*VDP-PDL Last Updated: July 2013

References:

Wallace DV, Dykewicz MS, Bernstein DI, Blessing-Moore J, Cox L, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph CC, Schuller D, Spector SL, Tilles SA. The diagnosis and management of rhinitis: an updated practice parameter. J Allergy Clin Immunol. 2008;122:S1-S84.

2 TX-VDP Formulary (Last Update July 2013)

Fee Schedule Changes

Program/Policy Changes Related to Managed Care Rates for September 1, 2013

The following information provides detail on the program and policy changes impacting managed care rates effective September 1, 2013. These changes were discussed during a July 16, 2013 conference call between HHSC and the MCOs. The information below describes how HHSC is implementing these changes in fee for service. For regular updates on program, policy, and rate actions impacting fee for service Medicaid, MCOs should check the following:

- TMHP's website: http://www.tmhp.com/Pages/Medicaid/Medicaid_home.aspx
- Rate Analysis Division's website: http://www.hhsc.state.tx.us/rad/
- Texas Register: http://www.sos.state.tx.us/texreg/index.shtml

Children's hospitals and rural hospitals moving to APR-DRG

- State-owned teaching hospitals and state psych hospitals are exempt.

10% Outlier reduction (excludes children's hospitals)

Hospital inpatient claims (excluding children's hospital claims) that qualify for an outlier payment either cost or day will have a 10 percent reduction off of the final outlier payment (does not apply to the DRG payment). The day outlier for all hospitals reimbursed by APR-DRG payment methodology calculation will be capped at cost. The formula for the calculation of the cost outlier will not change other than the 10 percent reduction. The day outlier formula needs to be updated to cap the day outlier at cost as follows:

1. Calculate day outlier according to current policy
2. Calculate the TEFRA payment
3. Calculate the APR-DRG payment
4. Subtract the APR-DRG payment from the calculated TEFRA payment
5 If the amount calculated in step 1 is less than step 4, then pay the greater of 1 or the cost outlier
6. If the amount calculated in step 1 is greater than step 4, then pay the greater of 4 or the cost outlier

After the outlier payment is determined, reduce it by 10 percent for non-children's hospitals.

5.3% Outpatient facility reimbursement reduction

Children's, rural and state-owned teaching hospitals

- High volume providers will be reimbursed at a rate of 76.03 percent of allowable charges, with the application of the hospital specific interim rate.

Non-high volume providers will be reimbursed at a rate of 72.27 percent of allowable charges, with the application of the hospital specific interim rate.

Hospitals in Rockwall County (Lake Pointe Medical Center and Texas Health Presbyterian Hospital) will be phased out of the rural hospital logic as follows: High volume providers in Rockwall County will be reimbursed at a rate of

- 74.69 percent of allowable charges in state fiscal year 2014 with the application of the hospital specific interim rate
- 73.34 percent of allowable charges in state fiscal year 2015 with the application of the hospital specific interim rate and
- 72.00 percent of allowable charges in state fiscal year 2016 with the application of the hospital specific interim rate.

Non-high volume providers in Rockwall County will be reimbursed at a rate of

- 70.99 percent of allowable charges in state fiscal year 2014 with the application of the hospital specific interim rate,
- 69.72 percent of allowable charges in state fiscal year 2015, with the application of the hospital specific interim rate and
- 68.44 percent of allowable charges in state fiscal year 2016, with the application of the hospital specific interim rate.

All other hospitals

- High volume providers will be reimbursed at a rate of 72.00 percent of allowable charges, with the application of the hospital specific interim rate.
- Non-high volume providers will be reimbursed at a rate of 68.44 percent of allowable charges, with the application of the hospital specific interim rate.

Non-emergent ER reimbursement reductions - 36 hour limitation, 24 visit limitation, flat fee

- HHSC will be providing more details on the 36 hour and 24 visit limitation pieces of this cost containment item as they become available.
- Rural hospitals - 60 percent of the allowed charges, after percentage reductions (no change from current reimbursement).
- Hospitals in Rockwall County - 60 percent of the allowed charges (after percentage reductions) in state fiscal years 2014 and 2015 (no change from current reimbursement).
- Beginning in state fiscal year 2016, Rockwall County hospitals will receive a flat rate of $51.36 per visit, which is 125 percent of the adult physician office visit fee.

All other hospitals - A flat rate of $51.36 per visit, which is 125 percent of the adult physician office visit fee, will be paid for services provided in the emergency department that do not qualify as emergency services (children's, state-owned and urban hospitals).

Hospital imaging reimbursement reduced to 125% of reimbursement in physician's office

Outpatient hospital imaging services will be reimbursed according to an outpatient hospital imaging service fee schedule that is based on a percentage of the Medicare fee schedule for similar services. If a resulting fee is greater than 125 percent of the Medicaid adult acute care fee for a similar service, the fee is reduced to 125 percent of the Medicaid adult acute care fee. A fee schedule will be provided on the TMHP website.

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Fee Schedule Changes *Continued from page 6*

5% ambulance reimbursement reduction - reductions are across the board and an updated fee schedule will be provided on the TMHP website.

Therapy reimbursement reduction depending on location of service
- Only for services - not evaluations or reevaluations.
- Updated fee schedule will be provided on the TMHP website.

Spell of illness policy implemented in STAR+PLUS only
- The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively.
- After 30 days of inpatient care is provided, reimbursement for additional care is not considered until the client has been out of an acute care facility for 60 consecutive days.
- Applies to acute and behavioral health hospital stays.
- Applies to adults in STAR+PLUS only.
- Solid organ transplants are exempt from this policy.
- The $200,000 annual limit does not apply.

Attendant Care rate increase ($0.25 rate increase for certain services)
- STAR+PLUS only
- $7.50/hr. base

Attendant Care enhancement allocation ($10 million GR allocation - not all for STAR+PLUS)
- Will be published on the Rate Analysis Department's website under primary home care services.

Reduce Medicaid rates in excess of Medicare - limited to non-therapy acute care rates.

ESRD/vent dependent members no longer can be disenrolled from STAR+PLUS
- HHSC is removing the option for MCOs to request disenrollment of members who are ventilator dependent or have end stage renal disease (ESRD) from the Uniform Managed Care Contract and Manual effective September 1, 2013.
- HHSC will not accept ESRD/vent disenrollment's starting July 17, 2013, as the effective date for these types of disenrollment's after July cut-off is September 1, 2013, which is when the policy goes into effect.

National Health Observation Dates

November:

American Diabetes Month
American Diabetes Association
(800) DIABETES (342-2383)
www.diabetes.org/in-my-community/programs/american-diabetes-month/

COPD Awareness Month
Lung Cancer Awareness Month
American Lung Association
(800) 548-8252
www.lung.org

Diabetic Eye Disease Month
Prevent Blindness America
(800) 331-2020
www.preventblindness.org

(1 - 30) National Alzheimer's Disease Awareness Month
Alzheimer's Association
(800) 272-3900
www.alz.org

National Family Caregivers Month
National Family Caregivers Association
(800) 896-3650
www.thefamilycaregiver.org

National Healthy Skin Month
American Academy of Dermatology
(888) 462-DERM (462-3376)
www.aad.org

National Hospice Palliative Care Month
National Hospice and Palliative Care Organization
(800) 646-6460
www.nhpco.org

National Stomach Cancer Awareness Month
No Stomach For Cancer, Inc.
(608) 335-0241
www.nostomachforcancer.org

(11 - 17) Drowsy Driving Prevention Week
National Sleep Foundation
(703) 243-1697
www.sleepfoundation.org

(21) Great American Smokeout
American Cancer Society
(800) ACS-2345 (227-2345)
www.cancer.org

(23) International Survivors of Suicide Day
American Foundation for Suicide Prevention
(888) 333-AFSP (2377)
www.afsp.org

(24 - 30) Gastroesophageal Reflux Disease Awareness Week
International Foundation for Functional Gastrointestinal Disorders
(888) 964-2001
www.aboutgerd.org/site/about-gerd/gerd-awareness-week

December

Safe Toys and Gifts Month
Prevent Blindness America
(800) 331-2020
www.preventblindness.org

(1 - 7) National Handwashing Awareness Week
Henry the Hand Foundation
(513) 769-HAND (4263)
www.henrythehand.com

(1st) World AIDS Day
World AIDS Campaign
+31 20 616 9045
www.worldaidscampaign.org/

Source: http://healthfinder.gov/NHO/nho.aspx?year=2013

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