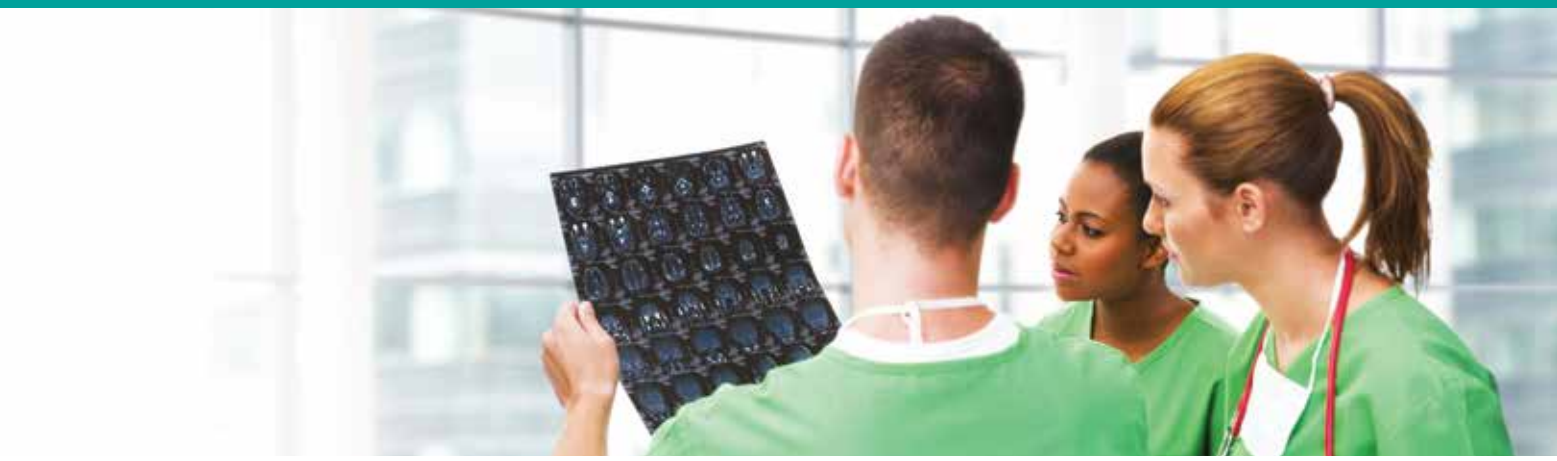
AETNA BETTER HEALTH® OF TEXAS
Provider Newsletter

Summer 2014



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www.aetnamedicaid.com/texas
1-800-306-8612 (Medicaid Tarrant)
1-800-248-7767 (Medicaid Bexar)
1-800-245-5380 (CHIP Tarrant)
1-866-818-0959 (CHIP Bexar)

TX- 14-04-30

Quality Improvement

Aetna Better Health of Texas has an ongoing Quality Assessment and Performance Improvement (QAPI) Program that is comprehensive in scope, including both the quality of clinical care and service for all aspects of our health care delivery system. It is tailored to the unique needs of the membership, in terms of age groups, disease categories and special risk status. We comply with all state and federal requirements for Quality Improvement (QI). The QAPI Program is overseen by the governing board and quality oversight committees. The CEO is directly involved and responsible for the overall quality program and implementation. Additionally, the health plan director has substantial involvement in QI activities. The Provider and Member Advisory Committees are instrumental in providing input and recommendations for improving the provision of care and services to Aetna Better Health of Texas Medicaid and CHIP Members.

Provider and member satisfaction survey results are analyzed to identify strengths and opportunities for improvement. Emphasis is placed on access and availability, customer service, service levels and quality improvement.

Aetna Better Health of Texas's quality improvement programs focus on high risk, high volume, problem prone diagnoses, preventive health and acute and chronic conditions, all of which are monitored and evaluated. We annually assess the demographics and health risks of the enrolled population and choose meaningful clinical issues that reflect the health needs of significant groups within that population.

Annually QM evaluates and modifies as necessary:

- the effectiveness of quality improvement interventions for the previous year, (demonstrated improvements in care and service) and trending of clinical and service indicator data;
- the appropriateness of the quality management program structure, processes, objectives, and resources;
- a work plan for the upcoming year that includes a schedule of activities, measurable objectives, benchmarks, continued monitoring of previously identified issues, and delegated services plans and performance

We strive to keep all network providers informed about the QI plan and the quality activities performed. We monitor the quality of care across all services and all treatment modalities, according to the written quality assessment and performance improvement plan. Information about the QI Program is available upon request.

Medical Management

The Medical Management department is responsible for integrating systems for managing, monitoring, evaluating, and improving the utilization of care and services members receive. The program is designed to assist members, practitioners, and providers in the appropriate utilization of care/service delivery systems, assess satisfaction with the processes, and discover opportunities to optimize members' health outcomes and manage costs. The departments within Medical Management include Care Management and Utilization Management.

Care Management

The Integrated Care Management (ICM) program uses a bio-psycho-social model (BPS) to identify and reach our most vulnerable members. The approach matches members with the resources they need to improve their health status and to sustain those improvements over time. The Care Management department uses evidence-based practices to identify members at high risk of not doing well over the next 12 months, and offers intensive care management services built upon a collaborative relationship with a single clinical case manager, caregiver and primary care provider. This relationship continues throughout the care management engagement. Members are stratified and placed in the appropriate level of care management.

For referrals to care management, call member services at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) during normal business hours (8 a.m. – 5 p.m. Monday through Friday). Messages left on weekends, during state-approved holidays and after normal business hours will be returned the next business day.

Utilization Management

The Aetna Better Health of Texas Utilization Management department makes decisions based on the appropriateness of care and service. Requests for coverage are reviewed to determine if the service requested is a covered benefit and is delivered in accordance with established guidelines.

Medical Management has adopted screening criteria and established review procedures which are periodically evaluated and updated. Utilization Management review decisions are made in accordance with currently accepted medical or health care practices, taking into account the special circumstances of each case. In addition to the Texas Medicaid Provider Procedures Manual, Aetna Better Health of Texas has adopted Milliman Care Guidelines®, which are nationally recognized objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis. The Utilization Management department also utilizes Aetna Better Health of Texas Clinical Policy Bulletins (CPBs) as supplemental guidelines in determining the safety, effectiveness and medical necessity of selected medical technologies.

When a service authorization request or authorization of service amount is questions regarding duration or scope, the health care provider will be given the opportunity to have a peer- to-peer discussion regarding the patient's treatment plan prior to the issuance of a determination. Reasonable attempts at consultation between the Medical Director and the treating physician will be made prior to an adverse determination. If a request for coverage is denied, the member (or a physician acting on behalf of the member) may appeal this decision through the complaint and appeal process. For more information regarding the prior authorization process, please refer to the Provider Manual.

Please call member services for status updates on service authorizations at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) during normal business hours (8 a.m. – 5 p.m. Monday through Friday). Messages left on weekends, during state-approved holidays and after normal business hours will be returned on the next business day number.

Medicaid member's rights and responsibilities

Member rights:

1) You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   a) Be treated fairly and with respect.
   b) Know that your medical records and discussions with your providers will be kept private and confidential.
2) You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is (the doctor or health care provider you will see most of the time and who will coordinate your care). You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a) Be told how to choose and change health plans and primary care provider.
   b) Choose any health plan that is available in your area and choose a primary care provider from that plan.
   c) Change your primary care provider.
   d) Change your health plans without penalty.
   e) Be told how to change your health plan or you primary care provider.
3) You have the right to ask questions and get answers about anything you don't understand. That includes the right to:
   a) Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b) Be told why care or services were denied and not given.
4) You have the right to agree to or refuse treatment and actively participate in treatment decisions.
5) That includes the right to:
   a) Work as part of a team with your provider in deciding what health care is best for you.
   b) Say yes or no to the care recommended by your provider.
6) You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
   a) Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
   b) Get a timely answer to your complaint.
   c) Use the plan's appeal process and be told how to use it.
   d) Ask for a fair hearing from the state Medicaid program and get information about how that process works.
7) You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a) Have telephone access to a medical professional 24-hours-a-day, 7-days-a-week to get any emergency or urgent care you need.
   b) Get medical care in a timely manner.
   c) Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d) Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e) Be given information you can understand about your health plan rules, including the health services you can get and how to get them.
8) You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you don't want to do, or is to punish you.
9) You have a right to know that the doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
10) You have the right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member responsibilities:

   a) You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   b) Learn and understand your rights under the Medicaid program.
   c) Ask questions if you don't understand your rights.
   d) Learn what choices of health plans are available in your area.
   e) You must abide by the health plan and Medicaid policies and procedures. That includes the responsibility to:
      a. Learn and follow your health plan rules and Medicaid rules.
      b. Choose your health plan and a primary care provider quickly.
      c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
      d. Keep your scheduled appointments.
      e. Cancel appointments in advance when you cannot keep them.
      f. Always contact your primary care provider first for your non-emergency medical needs.
      g. Be sure you have approval from your primary care provider before going to a specialist.
      h. Understand when you should and should not go to the emergency room.
   f) You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
      a. Tell your primary care provider about your health.
      b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
      c. Help your providers get your medical records.

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Medicaid member's rights and responsibilities

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g) You must actively be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.

Aetna Better Health of Texas Medicaid Members have both rights and responsibilities related to their membership and care. Aetna Better Health of Texas expects all providers to adhere to these rights and responsibilities adopted by HHSC contained in 1 TAC §353.201-§353.203.

CHIP member's rights and responsibilities

Member rights:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decides those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If your doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (Ob/Gyn) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an Ob/Gyn before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a few dollars depending on your income. This is called a "copayment" depending on your income. Copayments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

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CHIP member's rights and responsibilities

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18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member responsibilities:

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

a) You must try to follow healthy habits, such as encouraging your child to exercise, staying away from tobacco products and eating a healthy diet.
b) You must become involved in the doctor's decisions about your child's treatments.
c) You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
d) If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
e) You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
f) If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
g) If your child has CHIP, you are responsible for paying your doctor and other provider copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
h) You must report misuse of CHIP by health care providers, other members, or health plans.
i) Talk to your child's provider about all of your child's medications.

Aetna Better Health of Texas CHIP members have both rights and responsibilities related to their membership and care. Aetna Better Health of Texas expects all providers to adhere to these rights and responsibilities adopted by the HHSC contained in 1 TAC §353.201-§353.203.

CHIP Perinate member's rights and responsibilities

Member rights:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals and other providers.
2. You have a right to know how the perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a perinatal service is covered and/or medically necessary. You have the right to know about the people in the health plan who decides those things.
4. You have a right to know the names of the hospitals and other perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals and other providers.
10. You have the right to talk to you perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, inform you if they think your doctor or the health plan was right.
12. You have the right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

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CHIP Perinate member's rights and responsibilities

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Member responsibilities:

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

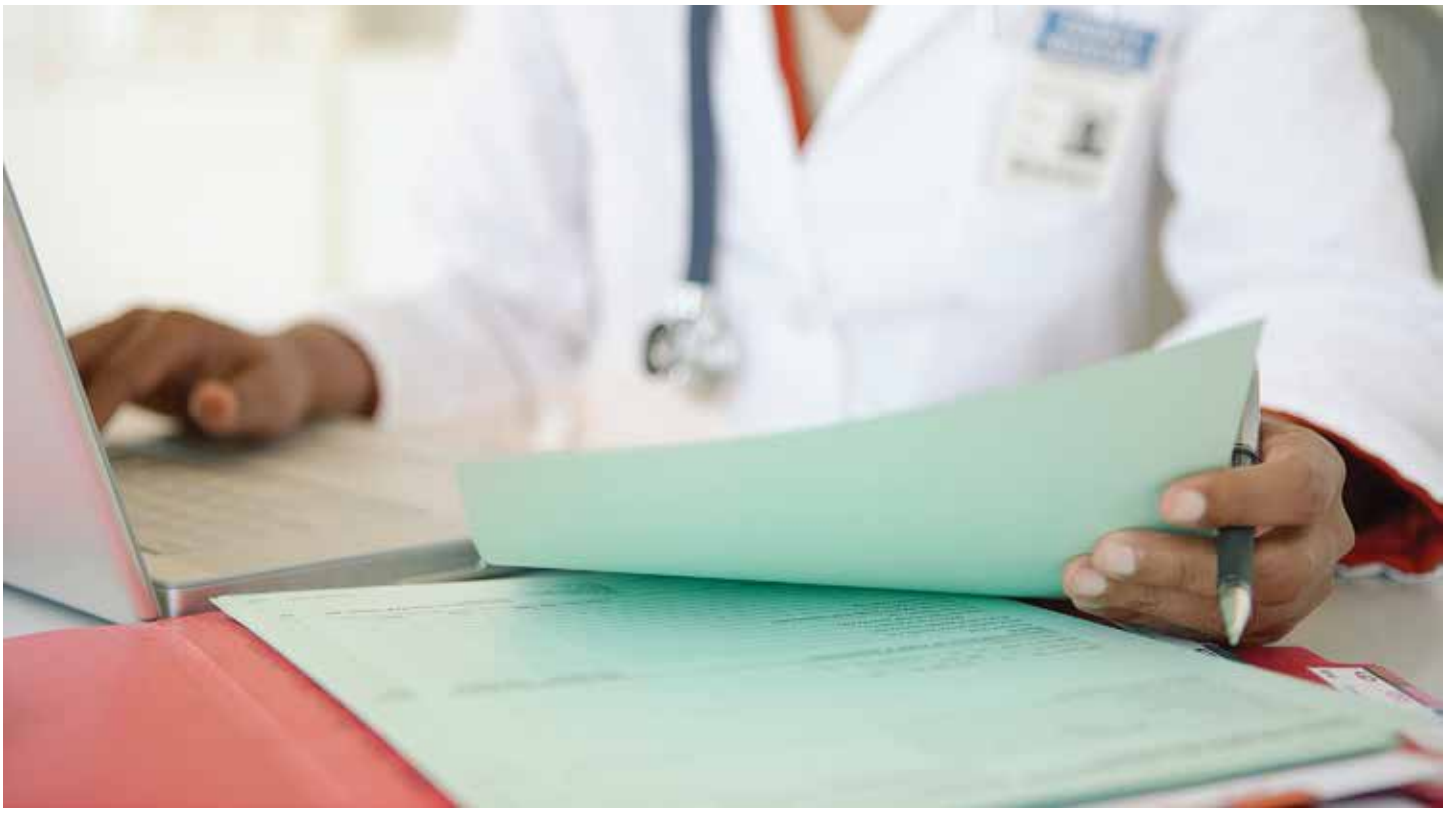
1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, try first to resolve it using the health plan's Complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. You must talk to your provider about your medications that are prescribed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll free at 1-800-368-1019. You can also view information concerning the HHS Office of Civil Rights on line at www.hhs.gov/ocr

Billing Medicaid Members

Except as specifically indicated in the Medicaid benefit descriptions, a provider may not bill or require payment, such as a co-pay, from members for Medicaid covered services. Providers may not bill, or take recourse against members for missing appointments or for denied or reduced claims for services that are reimbursed within the amount, duration, and scope of benefits of the STAR Program.

If you have a member that is regularly missing appointments, please call Aetna Better Health of Texas at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) and we will contact the member to review her/his rights and responsibilities, including missing appointments. For more information, please refer to theTexas Medicaid Provider Procedures Manual (TMPPM) found at www.tmhp.com



Understanding Acute Otitis Media

- Acute otitis media (AOM) occurs frequently in children. It is the most common diagnosis for which they receive antibiotics.
- The diagnosis of acute otitis media (AOM) requires bulging of the tympanic membrane or other signs of acute inflammation and middle ear effusion. The importance of accurate diagnosis is crucial to avoidance of unnecessary antibiotic treatment.

ANTIBIOTIC TREATMENT VERSUS OBSERVATION

- The choice of initial treatment with antibiotics or observation depends upon the age of the child and the laterality and severity of illness.
- The 2013 American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) guideline recommends[5]:
  - Immediate antibiotic treatment for children <6 months, children with severe signs or symptoms (defined by moderate or severe ear pain, ear pain for ≥48 hours, or temperature ≥39°C [102.2°F]) and bilateral AOM in children <24 months of age.
  - Either immediate antibiotic treatment or observation (with pain control) for children between 6 and 24 months with unilateral non-severe AOM and for children ≥24 months with unilateral or bilateral non-severe AOM.

INITIAL ANTIMICROBIAL THERAPY

- When the decision is made to treat acute otitis media (AOM) with antibiotics, the selection among available drugs is based upon: Clinical and microbiologic efficacy, Convenience of the dosing schedule, Acceptability (taste, texture) of the oral preparation, Cost and Absence of side effects and toxicity.

There is no evidence to support a particular antibiotic-regimen versus another for treatment of acute otitis media.[2]

American Academy of Pediatrics

Diagnosis and Management of Acute Otitis Media[1]

Table 6.
Recommended Antibacterial Agents for Patients Who Are Being Treated Initially With Antibacterial Agents or Have Failed 48 to 72 Hours of Observation or Initial Management With Antibacterial Agents

Temperature> or Equal to 39 degrees C and/or Severe Otalgia	At Diagnosis for Patients Being Treated		Clinically Defined Treatment Failure at 48-72 Hours After Initial Management With Observation Option		Clinically Defined Treatment Failure at 48-72 Hours After Initial Management With Antibacterial Agents	
	Recommended	Alternative for Penicillin Allergy	Recommended	Alternative for Penicillin Allergy	Recommended	Alternative for Penicillin Allergy
No	**Amoxicillin**, 80-90 mg/kg per day	Non-type I: **cefdinir, cefuroxime**, cefpodoxime; type I: **azithromycin, clarithromycin**	**Amoxicillin**, 80-90 mg/kg per day	Non-type 1: **cefdinir, cefuroxime**, cefpodoxime; type I: azithromycin, clarithromycin	**Amoxicillin-clavulanate**, 90 mg/kg per day of amoxicillin component, with 6.4 mg/kg per day of clavulanate	Non-type I: **ceftriaxone**, 3 days; type I: **clindamycin**
Yes	**Amoxicillin-clavulanate**, 90 mg/kg per day of amoxicillin, with 6.4 mg/kg per day of clavulanate	**Ceftriaxone**, 1 or 3 days	**Amoxicillin, clavulanate** 90 mg/kg per day of amoxicillin, with 6-4 mg/kg/day of clavulanate	**Ceftriaxone**, 1 or 3 days	**Ceftriaxone**, 3 days	Tympanocene-tesis, **clindamycin**

Bolded Items have Preferred products on the TX Medicaid PDL

For more information regarding any of these products please go to: http://txvendordrug.com/formulary/formulary-search.asp

References:

1.) American Academy of Pediatrics Subcommittee on Management of Acute Otitis Media. Diagnosis and management of acute otitis media. Pediatrics. 2004;113(5):1451-1465. http://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Issues-New-Guidelines-on-Treating-Ear-Infections-in-Children.aspx

2.) Takata GS, Chan LS, Shekelle P, Morton SC, Mason W, Marcy SM. Evidence assessment of management of acute otitits media: I. The role of antibiotics in treatment of uncomplicated acute otitis media. Pediatrics. 2001;108(2):239-247.

5.) American Academy of Pediatrics. Tables of antibacterial drug doses. In: Red Book: 20012 Report of the Committee on Infectious Diseases, 29th ed, Pickering LK (Ed), American Academy of Pediatrics, Elk Grove Village, IL 2012. p.808.

HEDIS Medical Record Review Audit

Aetna Medicaid is requesting your cooperation conducting the Healthcare Effectiveness Data and Information Set (HEDIS®) review of your office's medical records. As you may be aware, HEDIS is a set of standardized performance measures designed to ensure the public has the information it needs for reliable comparison of health plan performance. The performance measures in HEDIS are related to public health issues such as children's and women's health, cancer screening, heart disease, smoking, asthma, and diabetes. You will receive a notification if records are being reviewed from your office.

The medical record review (MRR) validation is a required component of the audit. The purpose of this validation is to confirm unbiased use of medical record data when reporting annual HEDIS rates to NCQA. It is the responsibility of the health care provider to maintain an orderly, precise, and legible document that describes the monitoring and care of his/her patient. Every patient encounter deserves a thoughtful evaluation and notation, no matter how trivial the event may be.

What benefit does medical record review have for the primary care provider (PCP)? Physicians may reduce their risk of allegations by adhering to and routinely updating their standards of care and actively engaging the patient in their own medical treatment and knowledge.

Aetna Better Health of Texas will contact your office to make arrangements for obtaining medical records; either at your office or by fax. We will work with your office staff to ensure your day-to-day workflow is not disturbed.

What can you do to promote efficiency and ease for all with the review of medical records? We recommend the following:

- Clarify the time/date of appointment, name of reviewer, and health plan represented.
- Respond promptly to a request for medical records by telephone, fax or mail please respond (our timeline for reporting is extremely aggressive).
- Designate an area where the reviewer can work.
- Photocopy of charts (they are needed for auditing purposes).
- Be flexible when scheduling an appointment for a reviewer to come to your office.

2014 HCPCS Procedure Code Changes for Speech Therapy Evaluation

*Please Note: We are following the same process for this code change as indicated. We will run reports on any claims denied for the new codes and reprocess them as soon as the fees are established and loaded in our claims payment system.

Information posted January 17, 2014

Note: This article applies to claims submitted to TMHP for processing. For claims processed by a Medicaid managed care organization (MCO), providers must refer to the MCO for information about benefits, limitations, and reimbursement.

On January 1, 2014, the TMHP applied the annual Healthcare Common Procedure Coding System (HCPCS) additions, changes, and deletions that were effective for dates of service on or after January 1, 2014. HCPCS is a set of health care procedure codes that is used by Medicaid and is based on the American Medical Association's Current Procedural Terminology (CPT), and is updated annually by the Centers for Medicare and Medicaid Services (CMS). Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program are required to comply with all HCPCS updates.

Effective for dates of service on or after January 1, 2014, speech therapy evaluation procedure code 92506 was discontinued and replaced by the more specific procedure codes 92521, 92522, 92523, and 92524 for Texas Medicaid and the CSHCN Services Program.

Note: This information also applies to Texas Medicaid School Health and Related Services (SHARS) providers. Additional information related to the four new codes will be published in a future HCPCS special bulletin.

Providers must begin billing with the new procedure codes for dates of service on or after January 1, 2014, and should bill the most appropriate procedure code for the service provided. The new procedure codes must complete the rate hearing process, and expenditures must be approved before the rates are adopted by Texas Medicaid and the CSHCN Services Program. Providers will be notified in a future notification if any procedure codes will not be reimbursed because the expenditures were not approved.

Claims for procedure codes that require a rate hearing must be submitted within the initial 95-day filing deadline. Services provided before the rate hearing is completed and expenditures are approved will be denied with an explanation of benefits (EOB) 02008, "This procedure code has been approved as a benefit pending the approval of expenditures. Providers will be notified of the effective dates of service in a future notification if expenditures are approved."

Once the reimbursement rates have been implemented for the four new procedure codes, TMHP will automatically reprocess affected claims. Providers are not required to appeal the claims unless they are denied for other reasons after the claims reprocessing is complete. When the affected claims are reprocessed, providers may receive payment, which will be reflected on Remittance and Status (R&S) Reports.

Providers should monitor the TMHP Code Updates-HCPCS web page at http://www.tmhp.com/Pages/CodeUpdates/HCPCS_2013.aspx for reimbursement rates and all other notifications about HCPCS procedure codes.

Please see the American Speech-Language-Hearing Association announcement for additional guidance on the new codes: http://www.asha.org/Practice/reimbursement/coding/New-CPT-Evaluation-Codes-for-SLPs/.

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

Preventive Health Guidelines

It is widely known that providing primary prevention services, such childhood immunizations, can reduce the incidence of illness, disease and accidents. Secondary prevention services, such as early detection of potentially serious illnesses, may reduce the impact of the illness on the patient, thereby decreasing the cost of care. Each primary care office visit should be viewed as the only opportunity for a comprehensive assessment of the member's health status. A copy of Aetna Better Health Texas's Preventive Health Guidelines is available a http://www.aetnabetterhealth.com/texas/providers/info/preventive-guidelines

Aetna Better Health of Texas Provider Manual

You can access an electronic version of our provider manual on the Aetna Better Health of Texas website. This manual has informational tools about prior authorization, billing procedures, eligibility and enrollment and much more. Go to http://www.aetnabetterhealth.com/texas/providers/manual/

Availability and Accessibility Requirements

Help us ensure your patients have timely and appropriate access to care. We want to remind providers of the required availability and accessibility standards, and ask that you review the standards listed below.

The following can be found in the primary care physician (PCP) contract: "PCPs provide covered services in their offices during normal business hours and are available and accessible to members, including telephone access, 24-hours-a-day, 7 days per week, to advise members requiring urgent or emergency services. If the PCP is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating physicians must be arranged."

After-hours access

The following are acceptable and unacceptable phone arrangements for contacting PCPs after normal business hours.

Acceptable:

- Office phone is answered after hours by an answering service, which meet the languages need of the major population groups served, that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes.
- Office phone is answered after normal business hours by a recording in which meet the languages need of the major population groups served, directing the patient to call another number to reach the PCP or another designated provider. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.
- Office phone is transferred after office hours to another location, where someone will answer the phone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable:

- Office phone is only answered during office hours.
- Office phone is answered after hours by a recording, which tells the patients to leave a message.
- Office phone is answered after hours by a recording, which directs patients to go to an emergency room for any services needed.
- Returning after-hour calls outside of 30 minutes.

Guidelines to Help You Treat ADHD

We encourage you to use evidence-based clinical practice guidelines (CPGs) to help screen, assess and treat common disorders, such as Attention-Deficit/ Hyperactivity Disorder (ADHD). These guidelines can help you give the best health care possible.

The American Academy of Pediatrics (AAP) guidelines state that children who are treated with medication for ADHD should have at least one follow-up visit with a prescribing practitioner within 30 days of the initial prescription fill and every quarter thereafter. We monitor compliance monthly through Healthcare Effectiveness

Data and Information Set (HEDIS®)* data collection and review.

You can find more information on the Centers for Disease Control and Prevention's website.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Do Alternative Medicines Work to Cure Colds?

Chew on vitamin C. Brew echinacea tea. These actions might seem like natural reactions when you feel a cold coming on. But they may not actually help wipe out your sneezes, sniffles, scratchy throat and cough. Despite what you read on the Internet, there's often little science to back up the healing claims of alternative cold treatments. Here's a quick run-down of what researchers do know.

Product	Bottom line	Side effects
Oral zinc	May reduce the length and severity of a cold if taken within 24 hours after symptoms start. May lower the number of colds in children if taken in low doses for at least five months.	Can cause stomach upset. May interact with antibiotics and penicillamine, a drug used for rheumatoid arthritis. Neve Can cause stomach upset. May interact with antibiotics and penicillamine, a drug used for rheumatoid arthritis. Never use intranasal zinc. It may cause you to permanently lose your sense of smell.
Vitamin C	May take the edge off cold symptoms if taken on a regular basis. Not proven to prevent colds. Not proven to shorten a cold if taken after symptoms start.	Can cause diarrhea or nausea if taken in high doses.
Echinacea. Never use intranasal zinc. It may cause you to permanently lose your sense of smell.	Generally not proven to prevent or treat colds. Some very specific preparations may help treat colds in a few cases.	Can cause allergic reactions.
Probiotics	Not proven to prevent or treat colds. Might lessen the risk for upper respiratory infections in a few cases.	Long-term side effects unknown.

Ongoing research into these and other alternative medicines may help clarify their usefulness. In the meantime, it's best to go with the tried-and-true trio of rest, fluids and over-the-counter medications. Aspirin or acetaminophen may ease symptoms. Decongestants and cough suppressants can also help. But never give aspirin to children. And don't give nonprescription cold medicines to children under 4 years old.

Sources: American Lung Association; National Institutes of Health

Urgent Care or Emergency Care? Which is Better For Your Child

As a parent, you have a pretty good idea when your child has an illness or injury that needs more than a hug and an over-the-counter medication. When you can't see your pediatrician - maybe it's the weekend or after office hours - you may think your only option for help is a hospital emergency department.

That is the best place to take your child if he or she is truly having a medical emergency. However, for nonemergency situations you do have another choice: an urgent care center. You may be able to see a doctor more quickly - and for less money - at an urgent care center than at a hospital.

So how do you know which is the best place to take your child?

Consider urgent care for things such as:

- A cold or cough that doesn't get better in several days or a cold that gets worse and is accompanied by a fever.
- A minor cut that might need stitches.
- A rash, especially with fever.
- A bout of vomiting and diarrhea that lasts for more than a few hours.
- A severe sore throat or a problem swallowing.
- A minor bone fracture.
- An insect or animal bite.

But you'll want to call 911 or go to the emergency department if your child has signs of a medical emergency. Those include:

Any significant change in behavior, such as being confused, delirious or excessively sleepy or becoming increasingly less responsive or alert.

- A severe headache or vomiting, especially after a head injury.
- Uncontrolled bleeding.
- Problems breathing.
- Increasing pain or severe, persistent pain.
- Severe or persistent diarrhea.
- You should also get emergency help if your child is unconscious.

Good things to know

Urgent care centers don't require an appointment. Most have evening and some weekend hours, but they aren't open 24 hours a day. Many of them offer services like x-rays, lab tests and medications.

Hospital emergency departments are open 24/7. They are staffed and equipped to handle any medical emergency.

Sources: American Academy of Pediatrics; American College of Emergency Physicians; National Association for Ambulatory Care.

5 Ways to Prevent a Return Trip to the Hospital

Having to stay in the hospital is probably not your idea of a good time. And when you're discharged, chances are you don't want to return. It's nice to have skilled, compassionate care you can depend on when you need it. But staying healthy - and avoiding a return trip to the hospital - is everyone's preference, and it's what we want for you too.

Unfortunately, a significant percentage of people discharged from hospitals nationwide are readmitted within 30 days, which is why reducing readmission rates is a goal of the Affordable Care Act. It's a goal we take seriously at our hospital. But it's one that we need your help to achieve.

When you leave the hospital, we'll strive to make it a smooth transition. We ask that you help us by doing the following:

1. Make sure you understand your condition. Ask: What you should do to help yourself get better. What - if any - limitations you now have. What potential problems you should watch for. What to do if problems occur.

   If you'll be handling certain medical tasks on your own or with the help of a family caregiver - things like changing a dressing, for instance - ask a member of the hospital staff to go over the procedure with you until you're comfortable with it.

2. Review your medications. Ask if you should continue taking everything you were taking before you were admitted and if any new medications have been prescribed. If you do need to take some new ones, be sure you know when and how to take them, how much to take, and for how long. Also be sure you understand why you're taking the new medicines.

   It's a good idea to keep a list of all your medications. That list - or other tools ranging from simple pillboxes to more high-tech gadgets - can help ensure you take your medicines correctly.

3. Keep your medical appointments. Often follow-up tests or doctor visits are scheduled before you leave the hospital. It's essential that you keep them. They're necessary for monitoring your progress and keeping you well.

4. Speak up if you need help. Can you bathe and dress yourself and cook your meals? If you have concerns about your ability to handle these and other tasks, don't hesitate to say so. We can arrange to get you some help.

   If you're worried about things like paying for your medications or getting transportation to your doctor visits, mention that as well.

5. Get a name and number. You may have questions or concerns after leaving the hospital. Be sure you're clear about whom to call for answers.

We're confident that by working together, we can help keep you healthy and out of the hospital as much as possible, which will help lower health care costs for everyone.

Brainy Ideas for Summer Fun

Ah, those lazy, hazy days of summer. Think vacations. Think school breaks. It seems like a good time for the entire family to just chill and not do any heavy mental lifting.

As tempting as that may sound, however, maintaining good brain health is a year-round activity. Here are a few fun and easy ways to help keep everyone's brain healthy this summer:

Get physical. Head outside with the kids for some hiking or biking - aerobic exercise gets the heart pumping. And that helps keep the brain fed with a healthy supply of blood and oxygen. It can even spur production of new brain cells, according to the Alzheimer's Association. One large study linked fitness in midlife with a reduced risk for dementia in older age.

Just make sure all bike riders wear a helmet - it helps protect the brain from trauma in case of an accident or fall.

Be a brainiac. Read a book while lounging at the beach. Break out word games for family game night. Forcing yourself to think can add new brain cells and solidify their connections.

Serve some food for thought. Summer is the perfect time to head to your local farmers market for foods high in brain-friendly antioxidants. Look for:

- Dark-colored vegetables, like kale, spinach, broccoli and beets.
- Berries - blue, black and red.
- Cherries and plums.

Also, when firing up the grill, throw on some salmon, trout, mackerel or other fish high in omega-3 fatty acids, which are good for the brain.

And, finally, don't forget that all-time favorite summer food - corn on the cob. It's a brain pleaser too. Don't slather it with butter, however. Eating too many foods high in cholesterol and saturated fat, like butter, may raise the risk for Alzheimer's disease.

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P.O. Box 569150
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