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Welcome to Aetna Better Health

Introduction
Welcome to Aetna Better Health. We are pleased you have decided to participate with the Aetna Better Health STAR (Medicaid), the Children’s Health Insurance Program (CHIP)/CHIP Perinate Newborn and/or the CHIP Perinate (future reference is CHIP).

Background
The Aetna Better Health’s Medicaid and CHIP programs are dedicated to delivering quality health care to recipients eligible for State funded health care coverage.

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

Currently, we offer Medicaid and CHIP benefits to eligible recipients who live in the Tarrant and Bexar Service Areas. These Service Areas (SAs) encompass the following counties in Texas:

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<td></td>
<td>Medina</td>
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This Provider Manual is a source of detailed information about programs and processes used to administer benefits to Aetna Better Health Medicaid and CHIP/CHIP Perinate Members. From provider requirements, access standards, prior authorization processes and claim filing, this manual provides easily accessible information to help guide you through your day-to-day business practices with us and allows you more time to focus on what’s important to you – the health and wellbeing of your patients.

Before you use this manual, take a moment to review these important highlights for participating health care professionals.

Patient Advocacy – Health care professionals should be advocates on behalf of their patients who are Aetna Better Health Medicaid and CHIP Members and should be familiar with the Member Rights and Responsibilities featured in this manual.

Informed decision making – Health care professionals are responsible for providing their patients with all information that is relevant to their conditions. This includes all health care alternatives, including potential risks and benefits, even if an option is not covered by the Plan.

Access to Care – Members have the right to receive medical care 24-hours a day, 7-days a week. All Aetna
Better Health Medicaid and CHIP Members may select a Primary Care Provider or, when appropriate, be referred to any specialist within the network. Behavioral Health services do not require a Primary Care Provider Referral, but may require prior authorization. Emergency care is covered anywhere in the United States.

**Care management** – Health care professionals should provide us with the complete and accurate medical information required to make appropriate coverage determinations. Actions by us that deny, terminate or reduce covered benefits can be appealed.

**Provider network** – We provide our Members with a network built upon strong relationships with Aetna Better Health participating providers and hospitals, as well as practitioners and facilities with a history of providing reliable services for Medicaid and CHIP populations. As indicated in all Aetna Better Health provider agreements, participating health care professionals are not employees or agents of Aetna or any of its affiliates.

**Member benefits** – Aetna Better Health provides all benefits covered under Traditional Medicaid and CHIP, as well as some additional services. If you are unsure whether a particular service or treatment is covered under a Member’s plan, please refer to the Covered Services Sections of this Provider Manual or you may consult the current edition of the Texas Medicaid Provider Procedures Manual.

**Automated services** - Use the Secure Web Portal link on the website [http://www.aetnabetterhealth.com/texas](http://www.aetnabetterhealth.com/texas) to access Member Eligibility, Claims Status and Prior Authorizations.

**Provider portal (Member eligibility)** – Providers can call Provider Services at **1-800-306-8612** Tarrant County or **1-800-248-7767** Bexar County service areas to request access to the Aetna Provider Web Portal which is found at [https://medicaid.aetna.com/MWP/landing/home](https://medicaid.aetna.com/MWP/landing/home).

**Medical Home** – Aetna Better Health Medicaid and CHIP Members have a primary care “medical home” to address their medical and related social needs in a comprehensive, coordinated fashion.

**Quality of care and service** – We have a strong commitment to the principles of Quality Assessment and Performance Improvement. We will monitor information in areas such as access to care, utilization patterns, risk-adjusted mortality and morbidity data and patient satisfaction. We will also provide comparative feedback to providers to facilitate continuous improvement in the quality of care and service provided to our Medicaid and CHIP populations.

**Member communications** – We will not impose restrictions on a Aetna Better Health’s Medicaid or CHIP providers’ free communication with a Member about the Member’s medical conditions, treatment options, referral policies, and other Aetna Better Health policies, including financial incentives or arrangements and all managed care plans with which the network provider contracts. We appreciate your attention to these important issues and thank you for your participation. We are always eager to hear from you regarding what we can do to make doing business with us easier.
## Important contact information

**Write to:**
Aetna Better Health  
PO Box 569150  
Dallas, TX 75356-9150  
[www.aetnabetterhealth.com/texas](http://www.aetnabetterhealth.com/texas)

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<td>1-800-306-8612</td>
<td>1-800-245-5380</td>
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<tr>
<td>Bexar</td>
<td>1-800-248-7767</td>
<td>1-866-818-0959</td>
</tr>
<tr>
<td>Fax</td>
<td>1-866-510-3710</td>
<td>1-866-510-3710</td>
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**Medical Management**

| Tarrant                            | 1-800-306-8612    | 1-800-245-5380   |
| Bexar                              | 1-800-248-7767    | 1-866-818-0959   |
| Fax                                | 1-866-835-9589    | 1-866-835-9589   |

**Claims Administration**

| Tarrant                            | 1-800-306-8612    | 1-800-245-5380   |
| Bexar                              | 1-800-248-7767    | 1-866-818-0959   |
| Medicaid Eligibility Verification  | 1-800-925-9126 (AIS) | 1-800-925-9126 (AIS) |
| STAR Help Line                     | 1-800-964-2777    |                  |
| CHIP Help Line                     | 1-800-647-6558    |                  |
| Medicaid Transportation Program (MTP) | 1-877-633-8747 (Bexar) | 1-855-687-3255 (Tarrant) |
| TTY                                | 1-800-735-2989    | 1-800-735-2989   |

**Behavioral Health Hotline**

(24 hours a day, 7 days a week)

| Tarrant                            | 1-800-306-8612    | 1-800-245-5380   |
| Bexar                              | 1-800-248-7767    | 1-866-818-0959   |
| Block Vision                       | 1-800-879-6901    | 1-800-879-6901   |

**For general questions regarding prescriptions:**

Aetna Better Health  
1-800-306-8612  
1-800-245-5380

**For questions for Rxproviders:**

| CVS Caremark Pharmacy Helpdesk     | 1-877-874-3317    | 1-877-874-3317   |
| Prior Authorization Request Line   | 1-855-656-0363    | 1-855-656-0363   |
| Fax                                | 1-866-255-7534    | 1-866-255-7534   |

**For mail order prescriptions:**

1-800-875-0867  
1-800-875-0867

**For dental questions or dentist info:**

Delta Dental Insurance Company  
1-866-576-5899  
1-866-561-5891

DentaQuest  
1-800-516-0165  
1-800-508-6775

MCNA Dental  
1-800-494-6262  
1-800-494-6262
Provider Manual overview

Objectives of program
We have identified specific objectives to effectively manage and provide quality health care for the Aetna Better Health Medicaid and CHIP Members. The program objectives are to:

- Ensure network adequacy and timely access to care
- Provide timely claim payment
- Provide comprehensive behavioral health care
- Incorporate a cultural competency program to address the diverse cultural needs of our Members and
- Provide disease management programs appropriate for the populations we serve.

Role of primary care provider/Medical Home
The primary care provider (PCP) is the medical home for the Member. This provider delivers appropriate preventive and other primary care services within the scope of their practice and oversees the continuity and coordination of care among all health care practitioners involved in providing services to Aetna Better Health Medicaid and/or CHIP Members.

Role of specialty care provider
The specialty care provider can provide services after a referral has been made by the Member’s primary care provider. It is the responsibility of the specialist’s office to ensure that the Member has a valid referral from the primary care provider and authorization from Aetna Better Health Medical Management for services on the prior authorization list prior to rendering services. Members do not need primary care provider referrals for behavioral health, obstetrical/gynecological care, or other Plan specific services that are not on the prior authorization list. However, communication with the primary care provider is encouraged to promote continuity of care.

Role of CHIP Perinate provider
A CHIP perinatal provider can be an obstetrician/gynecologist (OB/GYN), a family practice doctor or another qualified health care provider that provides prenatal care.

Role of pharmacy
The pharmacy is a place where drugs are compounded or dispensed. The pharmacist is the dispenser of prescription drugs to Aetna Better Health Medicaid and CHIP members when the physician prescribes a medication(s). Aetna Better Health contracts with CVS Caremark to manage the pharmacy network.

Role of Main Dental Home
Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is 6 months or older must have a designated Main Dental Home.

A Main Dental Home serves as the Member’s main dentist for all aspects of oral health care. The Main Dental Home has an ongoing relationship with that Member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The Main Dental Home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists can serve as Main Dental Homes.
How to help a member find dental care
The Dental Plan Member ID card lists the name and phone number of a Member’s Main Dental Home provider. The Member can contact the dental plan to select a different Main Dental Home provider at any time. If the Member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan’s system, and the Member is mailed a new ID card within 5 business days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker’s toll-free telephone number at 1-800-964-2777.

Network limitations
We have an open provider network for all Aetna Better Health Medicaid and CHIP Members. We do limit a Member’s selection of a primary care provider or a referral to a specialist to the Aetna Better Health Medicaid and CHIP networks.

Texas Health Steps Services
Texas Health Steps (THSteps), formerly known as Early and Periodic Screening, Diagnosis and Treatment program, is specifically a children’s program under Texas Medicaid which provides medical and dental preventive care and treatment to Medicaid clients who are birth through 20 years of age. Aetna Better Health will assist members and their parents or guardians to:

- Find a qualified Texas Health Steps provider enrolled in Medicaid
- Set up appointments to see a doctor or dentist
- Coordinate with HHSC’s Medical Transportation Program (MTP) to arrange transportation.
- Answer questions about eligible services.

For more information about THSteps, please refer to the Texas Health Steps website at http://www.dshs.state.tx.us/thsteps/ or the Texas Medicaid Provider Procedures Manual (TMPPM) at www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

Children of Migrant Farmworkers
Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under these circumstances is an accelerated service, but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup, previously missed under the periodicity schedule, is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

Member education and information
New members will be encouraged to obtain a Texas Health Steps exam with their primary care provider within the first 90 days of enrollment on the health plan. Providers may conduct these exams and bill as an exception to periodicity or, if the member is not new to their practice and is current with their preventative health services, provide documentation of the completed timely exam upon request.

We will educate members about the importance of regularly scheduled Texas Health Steps medical checkups. Reminders will be made by mail and by telephone in the month prior to the due date. If the member refused preventative health services, we will record that information in our files for future reporting.
Provider education and training

We will also provide appropriate training to all network providers and provider staff regarding the scope of benefits available and the Texas Health Steps program. Training includes Texas Health Steps benefits, the periodicity schedule for Texas Health Steps medical and dental checkups, immunizations, and other services available under the Texas Health Steps program. Texas Health Steps services available to Medicaid recipients under age 21 include transportation, case management and other assistance in complying with or following the periodicity schedule.

Providers will also be educated and trained regarding the requirements imposed upon HHSC and contracted HMO’s under the Consent Decree entered in Frew v. Janek, et. al., Civil Action No. 3:93CV65, in the United States District Court for the Eastern District of Texas, Paris Division, and subsequent Corrective Action Orders.

Provider training related to the Frew Corrective Action Orders will include encouragement to treat each Texas Health Steps visit as an opportunity for a comprehensive assessment of the Member health and development status. Texas Health Steps medical checkups are a requirement for children under the age of 21. The recommended services at each checkup are based on the optimal time for assessing growth and development at different stages of the member’s life. Detailed information on the Texas Health Steps program is available to providers in the Texas Medicaid Provider Procedures Manual (TMPPM), Texas Medicaid bimonthly bulletins, or the HHSC Uniform Managed Care Contract (Section 6).

Initial medical checkup upon enrollment

New member checkups are a priority for Aetna Better Health Medicaid. All members under 21 years old should receive a Texas Health Steps medical checkup no later than 90 days from their enrollment date with the health plan. An Aetna Better Health Medicaid member may self-refer to any participating Texas Health Steps provider to receive checkups. When a Texas Health Steps checkup is performed by a provider other than the member’s primary care provider, the record of that exam should be sent to the primary care provider to ensure proper continuity of care. Each primary care provider will be provided with a monthly panel report that includes a listing of new members who should receive a Texas Health Steps exam as soon as possible. Primary care providers that do not perform Texas Health Steps exams are expected to encourage members to obtain these services from a participating Texas Health Steps provider.

Periodic infant, children and adolescent preventive visits

A complete age appropriate checkup must be done and documented in the member’s medical record in accordance with the Texas Health Steps periodicity schedule (Attachment C).

Elements of a complete Texas Health Steps checkup

To be considered complete, a Texas Health Steps checkup must contain all appropriate services, as indicated on the periodicity schedule:

- Complete health history, including developmental and nutritional assessment
- Comprehensive unclothed physical exam, including graphic recording of height, weight, head circumference, body mass index. Comprehensive unclothed physical examinations should include the assessment of the child’s skin, head, eyes, ears, nose, mouth, throat, teeth, breasts, heart/pulses, lungs, abdomen, genitalia, skeletal/spine, neurological system.
- Immunizations recommended by the American Academy of Pediatrics in the current Childhood and Immunization Schedule
- Laboratory tests, including newborn screenings, blood lead level assessment appropriate for age and
risk factors, and anemia screening
- Health education and anticipatory guidance
- Vision and hearing screening
- Referral for dental checkups every six months beginning at 6 months of age

**Texas Health Steps checkups for pregnant teens**

Pregnant members under age 21 should continue to receive their required Texas Health Steps checkup in addition to their necessary obstetrical care. If the member’s Obstetrician (OB) is a primary care provider and a Texas Health Steps provider, the OB can complete the Texas Health Steps medical checkup. Alternatively, the OB should arrange for the member to receive a checkup from the member’s primary care provider or any participating Texas Health Steps provider within the initial 90 days of enrollment for new Aetna Better Health Medicaid members or according to the Periodicity Schedule for current members.

**Timing of Texas Health Steps checkups**

A member is due for a THSteps medical checkup based on his or her date of birth and the ages indicated on the periodicity schedule. Children younger than three years of age are due at frequent intervals. Children and youth three years of age and older are considered due for a checkup on their birthday and are encouraged to have a yearly checkup as soon as practical.

**Managed care organizations are required to ensure members receive timely medical checkups.**

A new member is due for a THSteps medical checkup as soon as practicable, but no later than 90 days of enrollment. A checkup for an existing member from birth through 35 months of age is considered timely if received within 60 days beyond the periodic due date based on the client’s birth date. For existing members 36 months of age and older, a checkup is due beginning on the child’s birthday and is considered timely if it occurs within 364 calendar days after the child’s birthday in a nonleap year or 365 days after the child’s birthday in a leap year. Checkups received before the periodic due date are not reportable as timely medical checkups.

**Refusal of services**

If the patient’s parent or guardian refuses to set an appointment for their initial or periodic Texas Health Steps checkup, providers must document the refusal in the format provided by HHSC. This document will need to be included as part of the patient’s medical record.

**Billing for Texas Health Steps medical checkups**

- Providers must only bill for a complete Texas Health Steps medical checkup. Medical record reviews may be conducted by Aetna Better Health and HHSC to monitor documentation of completeness.
- Aetna Better Health cannot reimburse providers for an incomplete checkup.
- All required components of the Texas Health Steps medical checkup are included in the reimbursement amount paid by Aetna Better Health.
- A provider who bills for a Texas Health Steps service is acknowledging the completeness of a comprehensive medical checkup in accordance with Texas Health Steps policy.
- Diagnosis and billing codes (details on billing can be found in the TMPPM under the Texas Health Steps section).
- (TPI/NPI) and include the Texas Health Steps indicator.
  - Diagnosis code V20.2
  - CPT codes for new patient services are 99381-99385 (according to patients age)
— CPT codes for established patient services are 99391-99395 (according to patient’s age)
- The exception-to-periodicity modifier, when applicable
- Providers must bill for Texas Health Steps services using their state issued Texas Health Steps ID number

The Texas Health Steps Quick Reference Guide is located in Appendix L.

**Texas Health Steps providers**

To enroll in the Texas Health Steps program, providers must be enrolled in Texas Medicaid in addition to one of the following:

- Physician (MD or 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.
- Family (FNP) and pediatric nurse practitioners (PNP) enrolled independently.
- Some certified nurse-midwives (CNM).
- Some women’s health care nurse practitioners.
- Some adult nurse practitioners (ANP).
- Some physician assistants (PA).

For more details, consult the TMPPM.

Providers who are not already certified to perform Texas Health Steps medical checkups, and who are acting as primary care providers for members under the age of 21 are encouraged to become Texas Health Steps providers.

**Texas Health Steps provider forms**

Please visit the Texas Health Steps website at [http://www.dshs.state.tx.us/thsteps/forms.shtm](http://www.dshs.state.tx.us/thsteps/forms.shtm) for the most provider forms such as:

- Child Health Clinical Records
- Texas Health Steps Provider Outreach Referral Form
- TB and Lead questionnaires
- Hearing Checklist for Parents
- Lab Supplies

**Referrals for conditions identified during a Texas Health Steps medical checkup**

If a problem is identified that requires evaluation and management significantly beyond what is usually completed during Texas Health Steps medical checkups, the Primary Care Provider can arrange for additional services as needed.

**Physician Specialist care**

The primary care provider should follow the routine process as addressed in this manual for making a referral to a Specialist as detailed in the Referral section of the manual.

**Routine dental exams and services**

Dental services for STAR members are covered from birth through age of 20 years under the Texas Health Steps Program. Routine dental exams and services are available from six months through 20 years of age.
Children should have their first dental checkup at six months and every six months thereafter. Services include all medically necessary dental treatment (ex: exams, cleanings, x rays, fluoride treatment, and restorative treatment) Children under the age of 6 months can receive dental services on an emergency basis. These dental services are provided through the members’ DMO. For a listing of DMO phone numbers, please refer to page 3 of this manual. Recipients under age 21 may also self-refer to a Texas Health Steps Dental provider. Members or providers may call 1-877-847-8377 for a list of Texas Health Steps dental providers.

First Dental Home (FDH) - the FDH program is for children from the age of 6 months through 35 months. The purpose of this program is to establish a dental home for children and reduce the incidence of Early Childhood Caries. FDH is offered by dentists who have been trained and certified by the DSHS. These children may be seen as frequently as every 3 months depending on their caries risk. For a listing of DMO phone numbers, please refer to page 3 of this manual. To find a certified FDH provider go to http://www.tmhp.com/OPL/providerManager/AdvSearch.aspx or call 1-877-847-8377.

**Oral Evaluation and Fluoride Varnish (OEFV) in the Medical Home**

Oral Evaluation and Fluoride Varnish (procedure code 99429) is aimed at improving oral health outcomes for clients who are 6 through 35 months of age with a limited set of preventive dental services (not a dental checkup) in the medical home.

An OEFV is not a required component of a THSteps medical checkup, but providers are encouraged to participate in this preventive intervention. OEFV is limited to THSteps medical checkup providers who have completed the required benefit education and are certified by the DSHS Oral Health Program to perform OEFV services. Training for certification is available as a free continuing education course on the THSteps website at www.txhealthsteps.com. For more information please go to: http://www.dshs.state.tx.us/dental/OEFV.shtm

**Emergency dental services**

**Medicaid emergency dental services:**
Aetna Better Health is responsible for emergency dental services provided to Medicaid members in a hospital, or ambulatory surgical center setting. We will pay for devices for craniofacial anomalies, hospital, physician, and related medical services (e.g. anesthesia and drugs) for:

- Treatment of dislocated jaw, traumatic damage to teeth, and removal of cysts;
- Treatment of oral abscess of tooth or gum origin

**CHIP emergency dental services:**
Aetna Better Health is responsible for emergency dental services provided to CHIP Members and CHIP Perinate Newborn Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of dislocated jaw, traumatic damage to teeth, and removal of cysts;
- Treatment of oral abscess of tooth or gum origin

**Non-emergency dental services**

**Medicaid non-emergency dental services:**
Aetna Better Health is **not responsible** for paying for routine dental services provided to Medicaid Members. These services are paid through Dental Managed Care Organizations.
Aetna Better Health is responsible for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members age 6 months through 35 months.

**Billing guidelines**
- In conjunction with a Texas Health Steps medical checkup, utilize CPT code 99429 with U5 modifier.
- Must be billed with one of the following medical checkup codes:
  - 99381
  - 99382
  - 99391
  - 99392
- Reimbursed at $34.16 in addition to the Texas Health Steps checkup reimbursement.
- Federally qualified health centers and Rural Health Centers do not receive additional encounter reimbursement.

**Documentation Criteria**
- Must document all components of OEFV on the documentation form provided during the training.
- Keep record of the referral to a dental home.

OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.
- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist Members with establishing a Main Dental Home and document Member’s Main Dental Home choice in the Members’ file.

**CHIP non-emergency dental services:**
Aetna Better Health is not responsible for paying for routine dental services provided to CHIP and CHIP Perinate Members. These services are paid through Dental Managed Care Organizations. Aetna Better Health is responsible for paying for treatment and devices for craniofacial anomalies.

**Vision exams and services**
Aetna Better Health Medicaid members under age 21 are eligible for an eye examination with refraction for the purpose of obtaining eyewear during each State fiscal year (September 1-August 31). The eye exam limitation can be extended for a STAR member under age 21 if the Primary Care Provider believes the eye examination is medically necessary. Please refer to the Covered Service grid that begins on page 5 of this manual and current Texas Medicaid Provider Procedures Manual for further details.

**Hearing exams and services**
Hearing screening is a mandatory part of each Texas Health Steps medical checkup, as per the Periodicity Schedule. Diagnostic screening services are available when medically necessary. The Program for Amplification for Children of Texas (PACT) provides diagnostic hearing services and hearing aids to Medicaid children with permanent hearing loss. These services are provided through audiologists who are PACT providers, and all services must be preapproved.
A list of providers may be accessed at https://www.dshs.state.tx.us/audio/pactparent.shtm.
PACT does not cover implantable bond conduction hearing aids or cochlear implants, which are covered through CCP.

**Comprehensive Services Care Program**
The Comprehensive Care Program (CCP) is a federally mandated expansion of the Medicaid program for Medicaid recipients under age 21 (Texas Health Steps members). CCP covers health care services that are medically necessary and appropriate and are federally allowable under the Medicaid services. Examples of CCP services include: durable medical equipment, medical supplies, case management, private duty nursing, counseling services, speech therapy, prosthetics, orthotics, inpatient psychiatric, inpatient rehabilitation, and extended hospitalization.

Services are available under Texas Health Steps-CCP for members ineligible for Texas Medicaid Home Health services and for those specific services not provided under Home Health. This expansion of services is provided only for those children who are under the age of 21 and eligible to receive Medicaid services.

Aetna Better Health Care Coordinators will work closely with the Texas Health Steps Case Management for Children and Pregnant Women program providers to ensure access to other medically necessary services. Members become ineligible for Texas Health Steps-CCP services on the day of their 21st birthday (Reference: Texas Medicaid Provider Procedures Manual and Texas Medicaid Bulletin).

**Laboratory tests**
Aetna Better Health Medicaid providers are required to comply with the Texas Health Steps program requirements for submitting laboratory tests. Per the Texas Medicaid Provider Procedures Manual: All required laboratory testing for THSteps clients must be performed by the Department of State Health Services (DSHS) Laboratory in Austin, TX, with the following exceptions:

- Specimens collected for type 2 diabetes, hyperlipidemia, HIV, and syphilis screening may be sent to the laboratory of a provider’s choice or to the DSHS Laboratory in Austin if submission requirements can be met.
- Initial blood lead testing using point-of-care testing.

**Newborn examinations**
The required components of the initial Texas Health Steps medical checkup are a history and physical examination; length, weight, and head circumference; vision screening (appropriate for age); Hepatitis B immunization; neonatal genetic/metabolic screen; and health education with the parents or guardians.

All newborn children of Aetna Better Health members should have an initial newborn checkup before discharge from the hospital and again within 2 weeks from the time of birth. A second newborn heredity metabolic screen is to be obtained between one and two weeks of age by the newborn’s physician or health-care practitioner, and is a required component of the THSteps medical checkup Providers must send all Texas Health Steps newborn neonatal genetic/metabolic laboratory tests to the DSHS Bureau of Laboratories (at this time, newborn screening can only be performed at DSHS BOL). Providers must include detailed identifying information for all screened newborns and inform the member’s mother to allow HHSC to link the neonatal genetic/metabolic screens performed at the hospital with screens performed at the two week follow-up.
**Medical Record**
All information collected during Texas Health Steps medical checkups must be maintained by the Primary Care Provider in the patient medical record for possible review by HHSC. All patient identifiable information must meet the confidentiality regulations as specified by the Health Insurance Portability and Accountability Act (HIPAA) guidelines. A complete Texas Health Steps medical checkup must be documented and include the following core components:
- Comprehensive health and development history, including developmental and nutritional assessment.
- Comprehensive unclothed physical including graphic recording of head circumference.
- 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).
- Health education (including anticipatory guidance).
- Vision and hearing screening.
- Direct referral to dental checkups beginning at 6 months of age.

**Medicaid Managed Care Covered services**
The following chart details the Member benefit package available to Aetna Better Health Plan Medicaid Members. Please refer to the current Texas Medicaid Provider Procedures Manual, found at [www.tmhp.com](http://www.tmhp.com) at [www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx) for the listing of limitations and exclusions.

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<thead>
<tr>
<th>Medicaid covered services</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>Hospital – (Inpatient Services)</strong></td>
<td>Inpatient hospital services include medically necessary items and services ordinarily furnished by a hospital under the direction of a physician for the care and treatment of inpatient members. Inpatient hospital services include the following items and services:</td>
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<td>• Bed and board in semi-private accommodations, intensive care or coronary care unit; includes meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital’s charge for its most prevalent semi-private accommodations. Bed and board in private accommodations is covered if required for medical reasons, as certified by a physician.</td>
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<td>• Whole blood and packed red blood cells reasonable and necessary for treatment of illness or injury, unless they are otherwise available without cost.</td>
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<td>• Maternity care includes usual and customary care for all pregnant members and specialized prenatal care for women with specific problems.</td>
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<tr>
<td></td>
<td>• Newborn care includes routine care and specialized nursery care for newborns with specific problems.</td>
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<tr>
<td></td>
<td>• All medically necessary ancillary services and supplies ordered by a provider.</td>
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</table>
### Medicaid covered services

| Hospital – (All Outpatient Services) | Hospital outpatient services include those services performed in the emergency room or clinic setting of a hospital.  
| --- | --- |
|  | • This includes services provided to members in a hospital setting who are not confined for inpatient care.  
|  | • Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services deemed medically necessary and furnished by or under the direction of a physician to an outpatient by a hospital.  
|  | • This does not include drugs or biologicals taken home by the member.  
|  | • Supplies provided by a hospital supply room for use in physician’s offices in the treatment of patients are not reimbursable as outpatient services. |
| Inpatient Mental Health Services | • Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders.  
|  | • Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Medicaid Program and are subject to UR requirements.  
|  | • Includes inpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities.  
|  | • Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition. |
| Outpatient Mental Health Services | • Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders.  
|  | • Includes outpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, or placements as a Condition of Probation as authorized by the Texas Family Code.  
|  | • Provider types include Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist (LMFT).  
|  | • Covered services are a benefit for clients suffering from a mental psychoneurotic or personality disorder when provided in the office, home, SNF, outpatient hospital, nursing home or other outpatient setting.  
|  | • Does not require a primary care provider referral.  
|  | • Psychological and Neuropsychological testing are covered for specific diagnoses.  
<p>|  | • Psychological testing |</p>
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<tr>
<th>Medicaid covered services</th>
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<tbody>
<tr>
<td>• Neuropsychological test battery</td>
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<tr>
<td>• Additional services such as mental health screenings are covered under the Texas Health Steps-CCP program.</td>
</tr>
<tr>
<td>• Medicaid clients age 21 years and older may receive mental health counseling provided by a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Clinical Social Worker, and a Licensed Marriage and Family Therapist.</td>
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<tr>
<th>Inpatient Medical with Substance Abuse Treatment Services</th>
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<tbody>
<tr>
<td>• Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition.</td>
</tr>
<tr>
<td>• Admissions for a single diagnosis of chemical dependency or abuse (alcohol, opioids, barbiturates, amphetamines) without an accompanying medical complication are not a benefit.</td>
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<tr>
<th>Outpatient Substance Abuse Treatment Services</th>
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<tbody>
<tr>
<td>• Counseling for children and adolescents must be rendered in accordance with the DSHS Chemical Dependency Treatment Facility Licensure Standards and determined by a qualified credentialed counselor to be reasonable and necessary for a person who is chemically dependent.</td>
</tr>
<tr>
<td>• Counseling is available for children and adolescents age 13-17 years.</td>
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<tr>
<td>• Younger children (age 10-12 years) and young adults (age 18-20 years) may receive counseling when assessment criteria is met.</td>
</tr>
<tr>
<td>• Group counseling is limited to 135 hours per client, per calendar year.</td>
</tr>
<tr>
<td>• Individual counseling is limited to 26 hours per client per calendar year.</td>
</tr>
<tr>
<td>• Inpatients residing in a DSHS facility are not eligible for outpatient services.</td>
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<tr>
<td>• Does not require a Primary Care Provider referral.</td>
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<tr>
<th>Federally Qualified Health Clinics (FQHCs)</th>
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<tr>
<td>• Members may seek professional medical services with any Aetna Better Health contracted FQHC.</td>
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<tr>
<th>Rural Health Clinic Services (RHCs)</th>
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<tr>
<td>The following services are benefits of Rural Health Clinics under Texas Medicaid:</td>
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<tr>
<td>• Physician Services</td>
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<tr>
<td>• Advanced nurse practitioner, clinical nurse specialist, certified nurse midwife, clinical social worker, or physician assistant services</td>
</tr>
<tr>
<td>• Services and supplies furnished as incidental to physician, nurse practitioner or physician assistant services</td>
</tr>
<tr>
<td>• Visiting nurse services on part time or intermittent basis to home bound members in areas determined to have a shortage of home health agencies</td>
</tr>
<tr>
<td>• Basic lab services essential to immediate diagnosis and treatment.</td>
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<tr>
<th>Professional Services</th>
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<tr>
<td>• Services provided by or under the personal supervision of a physician within their scope of practice are covered when reasonable and medically necessary. This includes visits in the office, home, inpatient, or outpatient location under Medicaid guidelines further identified in the most current</td>
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<tr>
<td>Medicaid covered services</td>
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<tr>
<td><strong>Texas Medicaid Provider Procedures Manual.</strong> Services provided by advanced nurse practitioners and behavioral health services that fall under general medicine, are included in this category.</td>
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| OB/GYN Services | Females may seek Obstetrics and Gynecological Services from any participating network obstetrician/gynecologist (OB/Gyn) provider without a referral from their primary care provider. These care providers must perform services within the scope of their professional specialty practice. A properly credentialed OB/Gyn must practice in accordance with Section 4, Article 21.53D of the Texas Insurance Code and follow rules promulgated by the Texas Department of Insurance (TDI). |

| Lab and X-Ray Services | Medicaid benefits are provided for professional and technical services ordered by a qualified practitioner and provided under the personal supervision of a qualified practitioner in a setting other than a hospital (inpatient or outpatient). Medicaid does not reimburse baseline or screening laboratory studies. All laboratory testing sites providing services must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. |

| Podiatry Services | Podiatrists eligible to be enrolled as Medicaid providers are authorized to perform procedures on the ankle or foot as approved by the Texas Legislature under their license as DPM and when such procedures would also be reimbursable to a physician (M.D. or D.O.) under Texas Medicaid. Podiatry services are only eligible for members under the age of 21. Some of these services may be provided by the Primary Care Provider. |

<p>| Vision Services | Members under age 21 are limited to one examination with refractions for the purpose of obtaining eyewear once every state fiscal year (September 1 through August 31). For members under the age of 21, this can be exceeded where a school nurse or teacher requests the eye exam, or when determined to be medically necessary. Members age 21 and over are allowed one eye exam for refractive error once every 24 months. Eye examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed above. Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction which cannot be accomplished by glasses. Vision services provided through Block Vision. Additional eye health care provided by an in-network optometrist or ophthalmologist (other than surgery) can be provided without a referral from the member’s Primary Care Provider. Covered surgical/laser care requires prior |</p>
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<th>Medicaid covered services</th>
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<td><strong>Medicaid covered services</strong></td>
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<td>authorization.</td>
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<td><strong>Ambulance Services</strong></td>
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<td><strong>Home Health Services</strong></td>
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</table>
| **Hearing Aid Services** | - Persons under 21 years of age should be referred to the Department of State Health Services (DSHS) Program for Amplification for Children of Texas (PACT).  
- Hearing aid evaluation with combined audiometric assessment is available for Medicaid members over 21 years of age. |
| **Chiropractic Services** | The following chiropractic services are available only to Medicaid members under 21 years of age:  
- Texas Medicaid reimburses the treatment of spinal subluxation requiring manual manipulation of the spine. Benefits include up to 12 treatments per benefit period. A benefit period is defined as 12 consecutive months, beginning with the date the member receives the first covered chiropractic treatment. |
| **Ambulatory Surgical Center (ASC) Services** | - Covered services are minor surgical services that normally do not require hospital admission or inpatient stay. Only the procedures specified on the Centers for Medicare and Medicaid Services (CMS) approved list and selected Medicaid-only procedures are covered services provided in an ASC. Covered services are based on CMS Ambulatory Surgical Code groupings 1 through 9 and HHSC group 10. |
| **Certified Nurse Midwife (CNM) Services** | - Covered services include those services that are normally outside of the maternity cycle to the extent that the midwives are authorized to perform under state law. CNMs may be reimbursed for primary care services provided to women throughout the life span and newborns for the first two (2) months of life, in addition to the maternity cycle (antepartum,
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<th>Medicaid covered services</th>
<th>intrapartum, and postpartum).</th>
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<tr>
<td><strong>Birthing Center</strong></td>
<td>A Birthing Center is:</td>
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<td>• A facility that is not an administrative, organizational, or financial part of a hospital.</td>
</tr>
<tr>
<td></td>
<td>• Organized and operated to provide maternity services to outpatients.</td>
</tr>
<tr>
<td></td>
<td>• Complies with all applicable federal, state, and local laws and regulations.</td>
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<td></td>
<td>Birthing Center services include:</td>
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<tr>
<td></td>
<td>• Admission</td>
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<td></td>
<td>• Labor – ante partum care</td>
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<td></td>
<td>• Delivery</td>
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<td></td>
<td>• Postpartum care</td>
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<tr>
<td></td>
<td>• Total obstetrical care</td>
</tr>
</tbody>
</table>

| **Maternity Clinic Services (MCS)**              | A maternity service clinic is: |
|                                                 | • A facility that is not an administrative, organizational, or financial part of a hospital. |
|                                                 | • Organized and operated to provide maternity services to outpatients. |
|                                                 | • Complies with all applicable federal, state, and local laws and regulations. |
|                                                 | • Maternity clinic services are those medical services provided by registered nurses and determined with or by a licensed physician to be reasonable and medically necessary for the care of a pregnant adolescent or woman during her prenatal period and subsequent 60-day postpartum period. |
|                                                 | MCS benefits do not include deliveries. Covered clinic services include, but are not necessarily limited to, risk assessment, medical services, specific laboratory/screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling, and patient education regarding maternal and child health. |

<p>| <strong>Family Planning Services</strong>                     | Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Covered services must include, but are not limited to: |
|                                                 | • Family planning annual visit |
|                                                 | • Comprehensive health history and physical examination |
|                                                 | • Follow-up office visit       |
|                                                 | • Member education and counseling to include preconception counseling |
|                                                 | • Laboratory tests, prescriptions and contraceptive devices |
|                                                 | • Pregnancy testing           |
|                                                 | • Sterilization services (federal sterilization consent form required) |
|                                                 | • Federal law requires under §1915(b) waivers that members be allowed to |</p>
<table>
<thead>
<tr>
<th>Medicaid covered services</th>
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<tbody>
<tr>
<td>retain the right to choose any Medicaid participating family planning provider.</td>
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<tr>
<td><strong>Genetic Services</strong></td>
<td>**Genetic services are services to evaluate members regarding the possibility of</td>
</tr>
<tr>
<td>a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders. These services must be prescribed and performed by or under the supervision of a clinical geneticist (M.D. or D.O.). Covered services include genetic history and physical examination; genetic laboratory services and echography; genetic radiological services; genetic diagnostic procedures; and genetic counseling.</td>
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<tr>
<td><strong>Transplant Services</strong></td>
<td>**Transplant services include liver, heart, lung, heart/lung, bone marrow, cornea, peripheral stem cell, and kidney transplants. Coverage of organ transplants is limited to those services that are determined reasonable, medically necessary, and standard medical procedures. Coverage does not include donor expenses or services. Coverage of each type of solid organ transplant is limited to a lifetime benefit of one initial transplant and one subsequent re-transplant due to rejection. Coverage for solid organ transplant includes procurement of the organ and services associated with the procurement. Benefits are not available for any experimental or investigational services, supplies, or procedures.</td>
</tr>
<tr>
<td><strong>Respiratory Care</strong></td>
<td>**Covered respiratory services include: oxygen, nebulizers, breathing treatments, medication for breathing treatments, and inhalers.</td>
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<tr>
<td><strong>Adult Well-Check</strong></td>
<td>**Annual physical for adults age 21 and over once per calendar year.</td>
</tr>
<tr>
<td><strong>Texas Health Steps Medical Checkups</strong></td>
<td>**Texas Health Steps is federally mandated and provides basic primary care medical screening services for all Medicaid members under 21 years of age. Medical checkups are covered for persons under 21 when delivered in accordance with the periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the member’s life and identifies the time period, based on the member’s age, when screening services are covered.</td>
</tr>
<tr>
<td><strong>Texas Health Steps -Comprehensive Care Program (CCP)</strong></td>
<td>**A federally mandated program that provides for any health care service that is medically necessary and appropriate for all members under 21 years of age, regardless of the limitations of Texas Medicaid.</td>
</tr>
<tr>
<td><strong>Renal Dialysis</strong></td>
<td>Renal dialysis services are available for members with one of the following diagnosis:</td>
</tr>
<tr>
<td>• Acute renal disease – a renal disease with a relatively short course, the cause of which is usually correctable.</td>
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</table>
| • Chronic renal disease (end-stage renal disease) – a stage of renal disease that requires continuing dialysis or kidney transplantation to
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<th>Medicaid covered services</th>
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<tbody>
<tr>
<td><strong>Total Parenteral Nutrition (TPN)/Hyper-alimentation</strong></td>
<td><strong>TPN</strong> is a covered benefit for eligible members who require long-term support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot support nutrition. Covered services include but are not necessarily limited to:</td>
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<td></td>
<td>• Parenteral hyperalimentation solutions and additives as ordered by member’s physician.</td>
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<td></td>
<td>• Supplies and equipment including refrigeration, if necessary, that are required for the administration of prescribed solutions and additives.</td>
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<td></td>
<td>• Education of the member and/or appropriate family members or support persons regarding the administration of TPN before administration initially begins. (Education must include the use and maintenance of required supplies and equipment.)</td>
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<td></td>
<td>• Visits by a Registered Nurse appropriately trained in the administration of TPN.</td>
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<td></td>
<td>• Customary and routine laboratory work required to monitor the member’s status.</td>
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<td></td>
<td>• Enteral supplies and equipment, if medically necessary in conjunction with TPN.</td>
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<tr>
<td><strong>Physical Therapy</strong></td>
<td><strong>Covered benefits include services to members suffering from an acute musculoskeletal and/or neuromusculoskeletal condition.</strong></td>
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<td><strong>Services provided as a result of an exacerbation of a chronic condition necessitating therapy to restore function may also be covered. The Physical Therapist must have the following on file for each member treated:</strong></td>
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<tr>
<td></td>
<td>• A treatment plan established by the member’s physician and/or Physical Therapist that identifies diagnosis, modalities, frequency of treatment, expected duration of treatment, and anticipated outcomes.</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td><strong>Occupational therapy services are a covered benefit if performed in an inpatient or outpatient hospital setting and if it meets the following criteria:</strong></td>
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<td></td>
<td>• It is prescribed by the member’s physician and performed by a qualified occupational therapist.</td>
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<td></td>
<td>• The therapy is prescribed for an acute condition with a diagnosis involving the muscular, skeletal, and neurological body systems.</td>
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<td>• It is designed to improve or restore an individual’s ability to perform those tasks required for independent functioning.</td>
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<tr>
<td></td>
<td>• The physician expects the therapy to result in a significant practical improvement in the individual’s level of functioning within 30 days.</td>
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<tr>
<td>Medicaid covered services</td>
<td>Speech and Language Therapy</td>
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</tbody>
</table>
| • For members less than 21 years of age, additional services must be provided under the Texas Health Steps – CCP Program if they are federally allowable, medically necessary, and appropriate. | Speech and language evaluations are used to assess the therapeutic needs of patients having speech and/or language difficulties as a result of disease or trauma. Speech-language pathology therapy is allowed only for acute or sub-acute pathological or traumatic conditions of the head or neck that would affect speech production. To be covered, benefits must be:  
  • Prescribed by a physician and provided as an inpatient or outpatient hospital service.  
  • Prescribed by a physician and performed by or under his personal supervision.  
  • The therapy may be performed by either a speech-language pathologist or audiologist if they are either on staff at the hospital or under the personal supervision of the physician. | All ABH members are entitled to a pharmacy benefit as described later in this manual. | All providers must obtain prior authorization for the member’s use of medical equipment and supplies over $1000. The member’s Primary Care Provider/Specialist must complete the Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form) prescribing the DME and/or supplies must be signed before requesting prior authorization for DME equipment and supplies. All signatures must be current, unaltered, original and handwritten. Computerized or stamped signatures will not be accepted. The Title XIX form must include the procedure code and quantities for services requested. The Title XIX must be maintained by the DME provider and the prescribing physicians in the client’s medical record. The completed Title XIX form with the original signature must be maintained by the prescribing physician. | Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished within the United States by a provider qualified to furnish emergency services. Emergency services includes health care provided in an in-network or out-of-network hospital emergency department or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize medical conditions. Emergency services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is necessary |
### Medicaid covered services

| Screening, Brief Intervention and Referral to Treatment Benefit (SBIRT) | Aetna Better Health provides for SBIRT, a comprehensive approach to the delivery of early intervention and treatment services for Members with substance use disorders and those at risk of developing such disorders. Substance use screenings performed in hospital emergency departments can be covered and reimbursed and are encouraged as a means of early identification and resolution of substance use problems. To learn more about the screening, brief intervention and referral to treatment benefit (SBIRT) and how it can be provided and billed, please refer to the following TMHP links: Screening Brief intervention and Referral to Treatment Benefit for Texas Medicaid [http://www.tmhp.com/Texas_Medicaid_Bulletin/228_M.pdf](http://www.tmhp.com/Texas_Medicaid_Bulletin/228_M.pdf) |

### Coordination with Medicaid and CHIP services not covered by Managed Care Organizations (Non-Capitated Services)

The following are programs (non-capitated services) available to Medicaid managed care Members that are administered through the HHSC.

**Primary and preventative dental services (including orthodontia)**

*except Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members aged 6 through 35 months*

Preventative and primary dental services such as routine check-ups, cleanings, X-rays, sealants, fillings, tooth removal, crowns/caps, root canals and orthodontia can be obtained by Medicaid and CHIP members through a Dental MCO (listed on page 3 under Important Contact Numbers). For more information on how to help a Member find dental care, please refer to the How To Help A Member Find Dental Care section of this manual.

**Texas Health Steps Environmental Lead Investigation (ELI)**

ELI services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. For more information please consult the TMHP manual or Texas Childhood Lead Poisoning Prevention Program (TXCLPPP) website at [http://www.dshs.state.tx.us/lead/child.shtm](http://www.dshs.state.tx.us/lead/child.shtm).

**Texas agency administered programs and Case Management services**

The following are services that are not a part of Aetna Better Health Program services; however, Aetna Better Health members can also qualify for:

- **Early Childhood Intervention Program (ECI)**. ECI can offer services in the home or in the community for children, birth to three years old who are developmentally delayed. Some of the services for children include: screenings, physical, occupational, speech and language therapy, and activities to help children learn better.
- **DSHS Targeted Case Management Programs**. DSHS can offer various mental health and mental retardation programs, such as psychiatric treatment, child and adolescent counseling, and crisis intervention.
• **Women, Infants, and Children (WIC) Program.** WIC can help infants and children under five years old, and pregnant and breastfeeding women who qualify to get nutritious food, nutrition education, and counseling.

**Essential public health services**

Aetna Better Health is required through its contractual relationship with HHSC to coordinate with public health entities regarding essential public health services. Providers must assist Aetna Better Health in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases that are preventable by immunizations as defined by State law
- Assisting in notifying or referring to the local public health entity, as defined by state law, any communicable disease outbreaks involving Members
- Referring TB cases to the local Public Health Entity for contact investigation and evaluation and preventive treatment of persons whom the Member has come into contact
- Referring STD/HIV cases to the local Public Health Entity for contact investigation and evaluation and preventive treatment of persons with whom the Member has come into contact
- Referring to Women, Infant and Children (WIC) services and information sharing
- Referring lead screening tests to the DSHS Laboratory and assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- Reporting of immunizations provided to the statewide ImmTrac Registry, including parental consent to share data
- Working with Dental Contractors on coordination of care protocols as well as for reciprocal referral and communication of data and clinical information regarding the Member’s Medically Necessary dental Covered Services; and
- Cooperating with activities required of public health authorities to conduct the annual population and community based needs assessment
- Aetna Better Health provides case management services to assist public health providers and primary care providers in effectively referring Members to appropriate public health providers, specialists, and health related services.

**School Health and Related Services (SHARS) – Medicaid only**

The Texas SHARS program is for children under age 21 with disabilities who need audiology, medical, occupational therapy, physical therapy, psychological, speech therapy, school health, and assessment and counseling services. For more information, refer to [www.tea.state.tx.us/SHARS.html](http://www.tea.state.tx.us/SHARS.html).

**Early Childhood Intervention Specialized Skills Training**

Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for more information or contact your local Early Childhood Intervention program.

**Early Childhood Intervention (ECI) Case Management/Service Coordination**

ECI case management/service coordination is provided to children from birth to age 3 with developmental delays, medically diagnosed conditions with a high probability of developmental delay, or whose development is different from their peers, such as:

- Cognitive: difficulty with playing, learning and thinking
- Motor: gross, fine and oral
- Communication: limited understanding or responses in communicating with others
- Social-emotional: attachment problems, limited parent/family interactions or behavior concerns
• Self-help skills: feeding
• Atypical development
• Age appropriate performance on test instruments, but have:
  — Atypical sensory-motor development: muscle tone, reflex or postural reaction responses, oral-motor skills and sensory integration
  — Atypical language or cognition: State regulation, attention span, perseveration, information processing
  — Atypical emotional or social patterns: social responsiveness, affective development, attachment patterns, and self-targeted behaviors

Children with auditory and/or vision concerns should also be referred for eligibility determination.

ECI provides evaluations to determine eligibility and the need for services. Families with children enrolled in Medicaid or CHIP do not pay for any ECI services. Families and professionals work together to develop an Individual Family Service Plan (IFSP) based on the assessment of the Member’s level of development and the unique strengths and needs of the child and family. Services are provided in the home and in community settings. Services can include:
• Assistive technology: services and devices
• Developmental services
• Early identification, screening and assessment
• Family counseling and education
• Medical services (diagnostic or evaluation services used to determine eligibility)
• Nursing, social work, nutrition, and psychological services
• Occupational therapy, physical therapy, speech-language therapy, audiology and vision services
• Service coordination

Federal and State legislation require providers to refer Members to ECI within 2 working days of identification. Members may also self-refer to ECI services without a referral from the Primary Care Provider.

Members and providers can contact the ECI CareLine staff by calling:
1-800-250-2246
TTY: 512-424-6770
Email: careline@dars.state.tx.us

Our network providers must cooperate and coordinate with local ECI programs to comply with Federal and State requirements relating to the development, review and evaluation of IFSP. Medically Necessary Health and Behavioral Health Services contained in an IFSP must be provided to the Member in the amount, duration, scope and setting established in the IFSP.

Department of Aging and Disability Services (DADS) Targeted Case Management
Service Coordination is provided to assist individuals who meet the Texas priority population definition for Mental Illness or Mental Retardation in gaining access to social, educational and other needed services.

Department of Assistive and Rehabilitative Services (DARS) Mental Health Rehabilitation
Mental health rehabilitative services are to persons, regardless of age, who have a single severe mental disorder, excluding mental retardation. The purpose of the program is to assist people with disabilities to participate in their communities by achieving employment of choice, living as independently as possible and accessing high quality services.
Department of State Health Services (DSHS) Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women provides services to children with a health condition/health risk, birth through 20 years of age and to high-risk pregnant women of all ages, in order to encourage the use of cost-effective health and health-related care. Together, the case manager and family shall assess the medical, social, educational and other medically necessary service needs of the eligible recipient. Disclosure of medical records or information between Providers, HMOs and Case Managers does not require a medical release from the member. Detailed program information and available services can be found on the program’s website at http://www.dshs.state.tx.us/caseman/default.shtm

**Texas Health Steps Medical Case Management (Medicaid Only)**

Case management services are provided to assist Medicaid-eligible recipients under 21 years of age determined to have special health care needs or are medically complex. Case Managers assist Members in gaining access to necessary medical, social, educational and other services to reduce morbidity and mortality among children, to encourage the use of cost-effective health and health-related care, to make referrals to appropriate providers, and to discourage over utilization or duplication of services. For more information on the THSteps case management services or finding a case manager, please call toll-free 1-877-847-8377 (1-877-THSTEPS).

**Texas Health Steps Personal Care Services (PCS) for Members birth through age 20**

For more information regarding Texas Health Steps personal care service please refer to the TMHP manual at www.tmhp.com. Clients, parents, or guardians may also call the TMHP PCS Client Line at 1-888-276-0702 for more information on PCS.

**Women, Infants, and Children (WIC) program**

WIC can help infants and children under five years old and pregnant and breastfeeding women who qualify to get nutritious food, nutrition education, and counseling. Our network Providers must coordinate with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. For more information on the WIC program, please go to www.dshs.state.tx.us/wichd/ or call toll-free at 1-800-942-3678.

**Department of Assistive and Rehabilitative Services (DARS) Blind Children’s Vocational Discovery and Development Program**

DARS Blind Children’s Vocational Discovery and Development Program offers a wide range of services that are tailored to each child and family's needs and circumstances. Services may include:

- Assist your child in developing the confidence and competence needed to be an active part of their community
- Provide support and training to you in understanding your rights and responsibilities throughout the educational process
- Assist you and your child in the vocational discovery and development process
- Provide training in areas like food preparation, money management, recreational activities and grooming
- Supply information to families about additional resources.
- For information on any Division for Blind Services program or to apply for services, contact any DBS office located throughout Texas. To find the nearest office call the Division for Blind Services at 1-800-628-5115.
**Department of Assistive and Rehabilitative Services (DARS) Case Management for the visually impaired**

DARS case management services are available for visually impaired Medicaid eligible clients under 16 years of age. This is limited to one contact per client per month. DARS staff work in partnership with Texans who are blind or visually impaired to get high quality jobs, live independently, or help a child receive the training needed to be successful in school and beyond. For more information on State services for the visually impaired, please go to [www.dars.state.tx.us/dbs/index.shtml](http://www.dars.state.tx.us/dbs/index.shtml) or call the Division for Blind Services toll-free at 1-800-628-5115.

**Tuberculosis services provided by DSHS-approved Providers**

Our network providers must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The Network Providers must report to DSHS or the local TB control program any Member who is noncompliant, drug resistant, or who is or may be posing a public health threat.

**Medical Transportation Program (Medicaid Only)**

The Medical Transportation Program (MTP) provides transportation services to Medicaid eligible clients that have no transportation by the most cost-effective means. MTP may also pay for an attendant if a Provider documents the need, the Member is a minor, or there is a language barrier. MTP can reimburse gas money if the Member has an automobile but no funds for gas. To arrange for services, please contact MTP at 1-877-633-8747 (Bexar) or Logisticare at 1-855-687-3255 (Tarrant).

**Department of Aging and Disability Services (DADS) hospice services**

DADS manages the Hospice Program through provider enrollment contracts with hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Texas Medicaid and Healthcare Partnership (TMHP) pays for services related to the treatment of the client’s terminal illness and for certain physician services (not the treatments).

Hospice care includes pain management and other palliative medical and support services designed to keep clients comfortable during the last weeks and months before death. For more information on these programs, please refer to Section 4.4.3. in the Physician section of the Texas Medicaid Provider Procedures Manual found at [www.tmhp.com/HTMLmanuals/TMPMM/2011/Frameset.html](http://www.tmhp.com/HTMLmanuals/TMPMM/2011/Frameset.html).

**CHIP covered services**

Aetna Better Health provides CHIP services as outlined below. Please refer to the following pages for a listing of limitations and exclusions.

There is no lifetime maximum on benefits; however; 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays apply for CHIP members until a family reaches its specific cost-sharing maximum. Covered services for CHIP Members must meet the CHIP definition of "Medically Necessary."

**Medically necessary health services** means:

1. Dental services and non-behavioral health services that are:
   a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member,
or endanger life;
b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member’s Health conditions.
c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
d) consistent with the Member’s diagnoses;
e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
f) not experimental or investigative; and
g) not primarily for the convenience of the Member or Provider.

2. Behavioral Health Services that:
   a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
d) are the most appropriate level or supply of service that can be safely provided;
e) could not be omitted without adversely affecting the Member’s mental and/or physical health or the quality of care rendered;
f) are not experimental or investigative; and
g) are not primarily for the convenience of the Member or Provider.

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<tr>
<th>CHIP covered benefit</th>
<th>Limitations</th>
<th>Co-payments*</th>
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| **Inpatient General Acute and Inpatient Rehabilitation Hospital Services** | • Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition.  
• Requires authorization for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section. | Inpatient co-payment per admission can vary between $15-$125 based on FPL. |
<p>| • Hospital-provided Physician or Provider services |                                                                             |                                                                |
| • Semi-private room and board (or private if medically necessary as certified by attending) |                                                                             |                                                                |
| • General nursing care                    |                                                                             |                                                                |
| • Special duty nursing when medically necessary |                                                                             |                                                                |
| • ICU and services                        |                                                                             |                                                                |
| • Patient meals and special diets         |                                                                             |                                                                |
| • Operating, recovery and other treatment rooms |                                                                             |                                                                |
| • Anesthesia and administration (facility technical component) |                                                                             |                                                                |</p>
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<tr>
<th>CHIP covered benefit</th>
<th>Limitations</th>
<th>Co-payments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgical dressings, trays, casts, splints</td>
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<td>• Drugs, medications and biologicals</td>
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<td>• Blood or blood products that are not provided free-of-charge to the patient and their administration</td>
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<tr>
<td>• X-rays, imaging and other radiological tests (facility technical component)</td>
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<tr>
<td>• Laboratory and pathology services (facility technical component)</td>
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<tr>
<td>• Machine diagnostic tests (EEGs, EKGs, etc.)</td>
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<td>• Oxygen services and inhalation therapy</td>
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<tr>
<td>• Radiation and chemotherapy</td>
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<tr>
<td>• Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care</td>
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<tr>
<td>• In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.</td>
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<tr>
<td>• Hospital, physician and related medical services, such as anesthesia, associated with dental care.</td>
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<tr>
<td>• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient</td>
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</tr>
<tr>
<td>CHIP covered benefit</td>
<td>Limitations</td>
<td>Co-payments*</td>
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</tr>
<tr>
<td>services associated with miscarriage or non-viable pregnancy include, but are not limited to:</td>
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<tr>
<td>- dilation and curettage (D&amp;C) procedures;</td>
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<td>- appropriate provider-administered medications;</td>
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<td>- ultrasounds; and</td>
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<td>- histological examination of tissue samples.</td>
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<tr>
<td>• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</td>
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<tr>
<td>- cleft lip and/or palate; or</td>
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<tr>
<td>- severe traumatic, skeletal and/or congenital craniofacial deviations; or</td>
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<td>- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
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<tr>
<td>• Surgical implants</td>
<td></td>
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</tr>
<tr>
<td>• Other artificial aids including surgical implants</td>
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<tr>
<td>• Inpatient services for a mastectomy and breast reconstruction include:</td>
<td></td>
<td></td>
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<tr>
<td>- all stages of reconstruction on the affected breast;</td>
<td></td>
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<tr>
<td>CHIP covered benefit</td>
<td>Limitations</td>
<td>Co-payments*</td>
</tr>
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<td>-------------------------------------------------------------------------------------</td>
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<tr>
<td>- external breast prosthesis for the breast(s) on which medically necessary</td>
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<tr>
<td>mastectomy procedures(s) have been performed;</td>
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<tr>
<td>- surgery and reconstruction on the other breast to produce symmetrical appearance;</td>
<td></td>
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<tr>
<td>and</td>
<td></td>
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<tr>
<td>- treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit</td>
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<td></td>
</tr>
</tbody>
</table>

**Skilled Nursing Facilities (Includes Rehabilitation Hospitals)**

Services include, but are not limited to, the following:

- Semi-private room and board
- Regular nursing services
- Rehabilitation services
- Medical supplies and use of appliances and equipment furnished by the facility

- Requires authorization and physician prescription.
- 60 days per 12-month period limit.

None

**Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center**

Services include, but are not limited to, the following services provided in a

- May require prior authorization and physician prescription.

$0 co-payment for generic drugs.

$3 co-payment for brand drugs.
<table>
<thead>
<tr>
<th>CHIP covered benefit</th>
<th>Limitations</th>
<th>Co-payments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>hospital clinic or emergency room, a clinic or health center, hospital based emergency department or an ambulatory health care setting:</td>
<td></td>
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<tr>
<td>• X-ray, imaging, and radiological tests (technical component)</td>
<td></td>
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<tr>
<td>• Laboratory and pathology services (technical component)</td>
<td></td>
<td></td>
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<tr>
<td>• Machine diagnostic tests</td>
<td></td>
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<tr>
<td>• Ambulatory surgical facility services</td>
<td></td>
<td></td>
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<tr>
<td>• Drugs, medications and biologicals</td>
<td></td>
<td></td>
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<tr>
<td>• Casts, splints, dressings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical, occupational and speech therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Renal dialysis</td>
<td></td>
<td></td>
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<tr>
<td>• Respiratory services</td>
<td></td>
<td></td>
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<tr>
<td>• Radiation and chemotherapy</td>
<td></td>
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<tr>
<td>• Blood or blood products that are not provided free-of-charge to the patient and the administration of these products</td>
<td></td>
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<tr>
<td>• Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.</td>
<td></td>
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</tr>
<tr>
<td>• Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:</td>
<td></td>
<td></td>
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<tr>
<td>• dilation and curettage</td>
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<tr>
<td>CHIP covered benefit</td>
<td>Limitations</td>
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<tr>
<td>(D&amp;C) procedures;</td>
<td>- appropriate provider administered medications; - ultrasounds; and - histological examination of tissue samples.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Surgical implants</td>
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</tr>
<tr>
<td></td>
<td>• Other artificial aids including surgical Implants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:</td>
<td></td>
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<tr>
<td></td>
<td>- all stages of reconstruction on the affected breast; - external breast prosthesis</td>
<td></td>
</tr>
<tr>
<td>CHIP covered benefit</td>
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<td>Co-payments*</td>
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<tr>
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</tr>
<tr>
<td>for the breast(s) on which medically necessary mastectomy procedures(s) have been performed; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
<td>May require authorization for specialty referral from a PCP to an in-network specialist. Requires authorization for all out-of-network specialty referrals.</td>
<td>$3 co-payment for office visit.</td>
</tr>
<tr>
<td>Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit</td>
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</tbody>
</table>

**Physician/Physician Extender Professional Services**

Services include, but are not limited to the following:

- American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)
- Physician office visits, in-patient and outpatient services
- Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation
- Medications, biologicals and materials administered in...
| CHIP covered benefit                                                                 | Limitations                                                                 | Co-payments*
|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------
<p>| Physician’s office                                                                  |                                                                              |                     |
| • Allergy testing, serum and injections                                              |                                                                              |                     |
| • Professional component (in/outpatient) of surgical services, including:           |                                                                              |                     |
|   - Surgeons and assistant surgeons for surgical procedures including appropriate   |                                                                              |                     |
|   follow-up care                                                                     |                                                                              |                     |
|   - Administration of anesthesia by Physician (other than surgeon) or CRNA         |                                                                              |                     |
|   - Second surgical opinions                                                        |                                                                              |                     |
|   - Same-day surgery performed in a Hospital without an over-night stay            |                                                                              |                     |
|   - Invasive diagnostic procedures such as endoscopic examinations                 |                                                                              |                     |
| • Hospital-based Physician services (including Physician-performed technical and   |                                                                              |                     |
|   interpretive components)                                                         |                                                                              |                     |
| • Physician and professional services for a mastectomy and breast reconstruction    |                                                                              |                     |
|   include:                                                                           |                                                                              |                     |
|   - all stages of reconstruction on the affected breast;                           |                                                                              |                     |
|   - external breast prosthesis for the breast(s) on which medically necessary      |                                                                              |                     |
|   mastectomy procedures(s) have been performed;                                    |                                                                              |                     |</p>
<table>
<thead>
<tr>
<th>CHIP covered benefit</th>
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<th>Co-payments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>- surgery and</td>
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<td>reconstruction on the</td>
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<td>other breast to produce</td>
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<tr>
<td>symmetrical appearance;</td>
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<td>- and treatment of physical</td>
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<td>complications from the mastectomy and</td>
<td></td>
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<tr>
<td>treatment of lymphedemas.</td>
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<tr>
<td>• In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.</td>
<td></td>
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<tr>
<td>• Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.</td>
<td></td>
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</tr>
<tr>
<td>• Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:</td>
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<td>- dilatation and curettage (D&amp;C) procedures;</td>
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<tr>
<td>- appropriate provider-administered medications;</td>
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<tr>
<td>- ultrasounds; and</td>
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<tr>
<td>- histological examination</td>
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<td>CHIP covered benefit</td>
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<td>of tissue samples.</td>
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<td>- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
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</tr>
<tr>
<td><strong>Birthing Center Services</strong></td>
<td>Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)</td>
<td>None</td>
</tr>
<tr>
<td><strong>Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.</strong></td>
<td>Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.</td>
<td>None</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</strong></td>
<td>• May require prior authorization and physician prescription.</td>
<td>None</td>
</tr>
<tr>
<td>Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home),</td>
<td>• $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not</td>
<td></td>
</tr>
<tr>
<td>CHIP covered benefit</td>
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<tr>
<td><strong>Including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to:</strong></td>
<td>counted against this cap.</td>
<td>None</td>
</tr>
<tr>
<td>- Orthotic braces and orthotics</td>
<td></td>
<td></td>
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<tr>
<td>- Dental Devices</td>
<td></td>
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<tr>
<td>- Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses</td>
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<tr>
<td>- Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease</td>
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<tr>
<td>- Hearing aids</td>
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<tr>
<td>- Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home and Community Health Services</strong></td>
<td>Requires prior authorization and physician prescription.</td>
<td>$15 inpatient co-payment.</td>
</tr>
<tr>
<td>Services that are provided in the home and community, including, but not limited to:</td>
<td>Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker.</td>
<td></td>
</tr>
<tr>
<td>- Home infusion</td>
<td>Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services.</td>
<td></td>
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<tr>
<td>- Respiratory therapy</td>
<td>Services are not intended to replace 24-hour inpatient or skilled nursing facility services</td>
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</tr>
<tr>
<td>- Visits for private duty nursing (R.N., L.V.N.)</td>
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<tr>
<td>- Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).</td>
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<tr>
<td>- Home health aide when included as part of a plan of care during a period that skilled visits have been approved.</td>
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<tr>
<td>- Speech, physical and occupational therapies.</td>
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</tbody>
</table>

- Requires prior authorization and physician prescription.
- Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker.
- Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services.
- Services are not intended to replace 24-hour inpatient or skilled nursing facility services.
- Services are not intended to replace 24-hour inpatient or skilled nursing facility services.
<table>
<thead>
<tr>
<th>CHIP covered benefit</th>
<th>Limitations</th>
<th>Co-payments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state operated facilities, including but not limited to: • Neuropsychological and psychological testing.</td>
<td>authorization for non-emergency services. • Does not require PCP referral. • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
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</tr>
<tr>
<td><strong>Outpatient Mental Health Services</strong></td>
<td>• May require prior authorization. • Does not require PCP referral. • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
<td>$3 co-payment for office visit.</td>
</tr>
<tr>
<td>Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a stateoperated facility • Neuropsychological and psychological testing. • Medication management • Rehabilitative day treatments • Residential treatment services</td>
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<tr>
<td>CHIP covered benefit</td>
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<tr>
<td>• Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment)</td>
<td>binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
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<tr>
<td>• Skills training (psycho-educational skill development)</td>
<td></td>
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<tr>
<td>Inpatient Substance Abuse Treatment Services</td>
<td>• Requires prior authorization for non-</td>
<td>$15 inpatient co-payment.</td>
</tr>
<tr>
<td>CHIP covered benefit</td>
<td>Limitations</td>
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</tbody>
</table>
| Inpatient substance abuse treatment services include, but are not limited to:  
  - Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. | emergency services.  
  - Does not require PCP referral. | |
| Outpatient Substance Abuse Treatment Services |  
  - Prevention and intervention services that are provided by physician and nonphysician providers, such as screening, assessment and referral for chemical dependency disorders.  
  - Intensive outpatient services  
  - Partial hospitalization  
  - Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.  
  - Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training. |  
  - May require prior authorization.  
  - Does not require PCP referral. | $3 co-payment for office visit. |

Rehabilitation Services  
- Requires prior | None |
<table>
<thead>
<tr>
<th>CHIP covered benefit</th>
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<th>Co-payments*</th>
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</thead>
</table>
| Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following:  
- Physical, occupational and speech therapy  
- Developmental assessment | authorization and physician prescription. | None |
| **Hospice Care Services**  
Services include, but are not limited to:  
- Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death  
- Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services. |  
- Requires authorization and physician prescription.  
- Services apply to the hospice diagnosis.  
- Up to a maximum of 120 days with a 6 month life expectancy.  
- Patients electing hospice services may cancel this election at anytime. | None |
| **Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services**  
Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include, but are not limited to, the following:  
- Emergency services based on prudent lay person definition of emergency health condition  
- Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by innetwork |  
- Does not require authorization for post-stabilization services. | $3 co-payment for non-emergency ER. |
<table>
<thead>
<tr>
<th>CHIP covered benefit</th>
<th>Limitations</th>
<th>Co-payments*</th>
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</thead>
</table>
| and out-of-network providers  
• Medical screening examination  
• Stabilization services  
• Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services  
• Emergency ground, air and water transportation  
• Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts, and treatment relating to oral abscess of tooth or gum origin, |  
• Requires authorization. |  
| Transplants  
Covered services include:  
• Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses. |  
• The health plan may reasonably limit the cost of the frames/lenses.  
• Does not require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. |  
| Vision Benefit  
• Covered services include:  
• One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization  
• One pair of non-prosthetic eyewear per 12-month period |  
• Does not require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one |  
| Chiropractic Services  
Covered services do not require physician prescription and are limited to spinal subluxation |  
• Does not require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one |  

$3 co-payment for office visit.
<table>
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</thead>
<tbody>
<tr>
<td><strong>Drug Benefits</strong></td>
<td>Does not require authorization for additional visits.</td>
<td>None</td>
</tr>
<tr>
<td>Covered up to $100 for a 12-month period limit for a plan-approved program</td>
<td>• Does not require authorization. • Health Plan defines plan-approved program. • May be subject to formulary requirements.</td>
<td>None</td>
</tr>
<tr>
<td><strong>Value-added Services</strong></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>• Nurse Line</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Aetna CHIP members have access to the Aetna Nurse Line (Informed Health Line), 24 hours a day, 7 days per week. Services provided are: Answers to health care questions General health information Assessment of current symptoms Home care advice, if appropriate Direction to the most appropriate site of care For non-English speaking members, language translation services are provided. Sports physicals Smoking cessation program which includes assessment,</td>
<td>Smoking Cessation Program Must be a member 12 years or older for assessment and counseling; 18 years of age or older for nicotine replacement products unless prescribed by physician. $200 per 12 month period (in addition to $100/12 month standard CHIP benefit)</td>
<td>None</td>
</tr>
<tr>
<td><strong>Weight Management Program</strong></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Must be a member 12 – 19 years of age Body Mass Index (BMI) greater than 85th percentile.</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>CHIP covered benefit</td>
<td>Limitations</td>
<td>Co-payments*</td>
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<tr>
<td>-------------------------------------------------------------------------------------</td>
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<tr>
<td>counseling, and pharmacological therapy (nicotine replacement products).</td>
<td>• Precertification required.</td>
<td></td>
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<tr>
<td>• Weight management program which includes family counseling with a nutritionist/dietician.</td>
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<tr>
<td>• Contact lenses benefit which includes a fitting exam with additional benefits to be applied towards the purchase of contact lenses to correct vision. 20% discount available for non-disposable lenses.</td>
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</tr>
<tr>
<td>Contact Lenses</td>
<td>• Must be a member 12 – 18 years of age</td>
<td></td>
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<tr>
<td>• $100 per 12 month period</td>
<td>• Must be medically necessary.</td>
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<tr>
<td>• Must be a member 12 – 18 years of age</td>
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</tbody>
</table>

* Co-payments do not apply to preventive services or pregnancy-related assistance.

**Exclusions from covered services for CHIP Members**

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning).
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, “External Review by Independent Review Organization”).
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Dental devices solely for cosmetic purposes.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
• Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
• Medications prescribed for weight loss or gain
• Acupuncture services, naturopathy and hypnotherapy
• Immunizations solely for foreign travel
• Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes).
• Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
• Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
• Corrective orthopedic shoes
• Convenience items
• Over-the-counter medications
• Orthotics primarily used for athletic or recreational purposes
• Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
• Housekeeping
• Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
• Services or supplies received from a nurse, that do not require the skill and training of a nurse
• Vision training and vision therapy
• Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
• Donor non-medical expenses
• Charges incurred as a donor of an organ when the recipient is not covered under this health plan
• Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP DME/Supplies

<table>
<thead>
<tr>
<th>SUPPLIES</th>
<th>COVERED</th>
<th>EXCLUDED</th>
<th>COMMENTS/MEMBER CONTRACT PROVISIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ace Bandages</td>
<td></td>
<td>X</td>
<td>Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.</td>
</tr>
<tr>
<td>Alcohol, rubbing</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Alcohol, swabs</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply not covered, unless RX provided at time of dispensing.</td>
</tr>
<tr>
<td>Alcohol, swabs</td>
<td>X</td>
<td></td>
<td>Covered only when received with IV therapy or central line kits/supplies.</td>
</tr>
<tr>
<td>Ana Kit Epinephrine</td>
<td></td>
<td>X</td>
<td>A self-injection kit used by patients highly allergic to bee stings.</td>
</tr>
<tr>
<td>SUPPLIES</td>
<td>COVERED</td>
<td>EXCLUDED</td>
<td>COMMENTS/MEMBER CONTRACT PROVISIONS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------</td>
<td>----------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Arm Sling</td>
<td>X</td>
<td></td>
<td>Dispensed as part of office visit.</td>
</tr>
<tr>
<td>Attends (Diapers)</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.</td>
</tr>
<tr>
<td>Bandages</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Basal Thermometer</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Batteries – initial</td>
<td>X</td>
<td></td>
<td>For covered DME items</td>
</tr>
<tr>
<td>Batteries – replacement</td>
<td>X</td>
<td></td>
<td>For covered DME when replacement is necessary due to normal use.</td>
</tr>
<tr>
<td>Betadine</td>
<td></td>
<td>X</td>
<td>See IV therapy supplies.</td>
</tr>
<tr>
<td>Books</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Clinitest</td>
<td>X</td>
<td></td>
<td>For monitoring of diabetes.</td>
</tr>
<tr>
<td>Colostomy Bags</td>
<td></td>
<td></td>
<td>See Ostomy Supplies.</td>
</tr>
<tr>
<td>Communication Devices</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Jelly</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply. Contraceptives are not covered under the plan.</td>
</tr>
<tr>
<td>Cranial Head Mold</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dental Devices</td>
<td>X</td>
<td></td>
<td>Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>X</td>
<td></td>
<td>Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.</td>
</tr>
<tr>
<td>Diapers/Incontinent Briefs/Chux</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.</td>
</tr>
<tr>
<td>Diaphragm</td>
<td></td>
<td>X</td>
<td>Contraceptives are not covered under the plan.</td>
</tr>
<tr>
<td>Diastix</td>
<td>X</td>
<td></td>
<td>For monitoring diabetes.</td>
</tr>
<tr>
<td>Diet, Special</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Distilled Water</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Central Line</td>
<td>X</td>
<td></td>
<td>Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.</td>
</tr>
<tr>
<td>Dressing Supplies/Decubitus</td>
<td>X</td>
<td></td>
<td>Eligible for coverage only if receiving covered home care for wound care.</td>
</tr>
<tr>
<td>Dressing Supplies/Peripheral IV Therapy</td>
<td>X</td>
<td></td>
<td>Eligible for coverage only if receiving home IV therapy.</td>
</tr>
<tr>
<td>Dressing Supplies/Other</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dust Mask</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>SUPPLIES</td>
<td>COVERED</td>
<td>EXCLUDED</td>
<td>COMMENTS/MEMBER CONTRACT PROVISIONS</td>
</tr>
<tr>
<td>--------------------</td>
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<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ear Molds</td>
<td>X</td>
<td></td>
<td>Custom made, post inner or middle ear surgery</td>
</tr>
<tr>
<td>Electrodes</td>
<td>X</td>
<td></td>
<td>Eligible for coverage when used with a covered DME.</td>
</tr>
<tr>
<td>Enema Supplies</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Enteral Nutrition Supplies</td>
<td>X</td>
<td></td>
<td>Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease</td>
</tr>
<tr>
<td>Eye Patches</td>
<td>X</td>
<td></td>
<td>Covered for patients with amblyopia.</td>
</tr>
</tbody>
</table>
| Formula            |         | X        | Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include:  
  - Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product  
  Does not include formula:  
  - For members who could be sustained on an age-appropriate diet.  
  - Traditionally used for infant feeding  
  - In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product)  
  - For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met.  
  Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are not medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally. |
<p>| Gloves             |         | X        | Exception: Central line dressings or wound care provided by home care agency.                      |</p>
<table>
<thead>
<tr>
<th>SUPPLIES</th>
<th>COVERED</th>
<th>EXCLUDED</th>
<th>COMMENTS/MEMBER CONTRACT PROVISIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrogen Peroxide</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Hygiene Items</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Incontinent Pads</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.</td>
</tr>
<tr>
<td>Insulin Pump (External) Supplies</td>
<td>X</td>
<td></td>
<td>Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.</td>
</tr>
<tr>
<td>Irrigation Sets, Wound Care</td>
<td>X</td>
<td></td>
<td>Eligible for coverage when used during covered home care for wound care.</td>
</tr>
<tr>
<td>Irrigation Sets, Urinary</td>
<td>X</td>
<td></td>
<td>Eligible for coverage for individual with an indwelling urinary catheter.</td>
</tr>
<tr>
<td>IV Therapy Supplies</td>
<td>X</td>
<td></td>
<td>Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.</td>
</tr>
<tr>
<td>K-Y Jelly</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Lancet Device</td>
<td></td>
<td>X</td>
<td>Limited to one device only.</td>
</tr>
<tr>
<td>Lancets</td>
<td></td>
<td>X</td>
<td>Eligible for individuals with diabetes.</td>
</tr>
<tr>
<td>Med Ejector</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Needles and Syringes/Diabetic</td>
<td></td>
<td></td>
<td>See Diabetic Supplies</td>
</tr>
<tr>
<td>Needles and Syringes/IV and Central Line</td>
<td></td>
<td></td>
<td>See IV Therapy and Dressing Supplies/Central Line.</td>
</tr>
<tr>
<td>Needles and Syringes/Other</td>
<td>X</td>
<td></td>
<td>Eligible for coverage if a covered IM or SubQ medication is being administered at home.</td>
</tr>
<tr>
<td>Normal Saline</td>
<td></td>
<td></td>
<td>See Saline, Normal</td>
</tr>
<tr>
<td>Novopen</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>X</td>
<td></td>
<td>Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.</td>
</tr>
<tr>
<td>Parenteral Nutrition/Supplies</td>
<td>X</td>
<td></td>
<td>Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.</td>
</tr>
<tr>
<td>Saline, Normal</td>
<td>X</td>
<td></td>
<td>Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.</td>
</tr>
<tr>
<td>Stump Sleeve</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
### SUPPLIES

<table>
<thead>
<tr>
<th>SUPPLIES</th>
<th>COVERED</th>
<th>EXCLUDED</th>
<th>COMMENTS/MEMBER CONTRACT PROVISIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stump Socks</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suction Catheters</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syringes</td>
<td></td>
<td>See Needles/Syringes.</td>
<td></td>
</tr>
<tr>
<td>Tape</td>
<td></td>
<td>See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy Supplies</td>
<td>X</td>
<td>Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.</td>
<td></td>
</tr>
<tr>
<td>Under Pads</td>
<td></td>
<td>See Diapers/Incontinent Briefs/Chux.</td>
<td></td>
</tr>
<tr>
<td>Unna Boot</td>
<td>X</td>
<td>Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.</td>
<td></td>
</tr>
<tr>
<td>Urinary, External Catheter &amp; Supplies</td>
<td>X</td>
<td>Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan</td>
<td></td>
</tr>
<tr>
<td>Urinary, Indwelling Catheter &amp; Supplies</td>
<td>X</td>
<td>Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.</td>
<td></td>
</tr>
<tr>
<td>Urinary, Intermittent</td>
<td>X</td>
<td>Cover supplies needed for intermittent or straight catherization.</td>
<td></td>
</tr>
<tr>
<td>Urine Test Kit</td>
<td>X</td>
<td>When determined to be medically necessary.</td>
<td></td>
</tr>
<tr>
<td>Urostomy supplies</td>
<td></td>
<td>See Ostomy Supplies.</td>
<td></td>
</tr>
</tbody>
</table>

### CHIP Perinate Newborn Covered Services

Aetna Better Health provides services to CHIP Perinate Newborns as outlined below. Please refer to the following pages for a listing of limitations and exclusions.

There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinate Newborns.

Covered services for CHIP Perinate Newborns must meet the CHIP definition of "Medically Necessary."

**Medically necessary health services** means:

1. Dental services and non-behavioral health services that are:
   a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member, or endanger life;
   b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member’s health conditions;
   c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
d) consistent with the Member’s diagnoses;

e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

f) not experimental or investigative; and

g) not primarily for the convenience of the Member or Provider.

2. Behavioral Health Services that:

a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

d) are the most appropriate level or supply of service that can be safely provided;

e) could not be omitted without adversely affecting the Member’s mental and/or physical health or the quality of care rendered;

f) are not experimental or investigative; and

g) are not primarily for the convenience of the Member or Provider.

<table>
<thead>
<tr>
<th>CHIP Perinate Newborn covered benefit</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</td>
<td>Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition.</td>
<td>None</td>
</tr>
</tbody>
</table>

Services include:
- Hospital-provided Physician or Provider services
- Semi-private room and board (or private if medically necessary as certified by attending)
- General nursing care
- Special duty nursing when medically necessary
- ICU and services
- Patient meals and special diets
- Operating, recovery and other treatment rooms
- Anesthesia and administration (facility technical component)
- Surgical dressings, trays, casts, splints
- Drugs, medications and biologicals
- Blood or blood products that are not provided free-of-charge to the patient and their administration
- X-rays, imaging and other radiological tests (facility technical component)
- Laboratory and pathology services

Requires authorization for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section.
<table>
<thead>
<tr>
<th>CHIP Perinate Newborn covered benefit (facility technical component)</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Machine diagnostic tests (EEGs, EKGs, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oxygen services and inhalation therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Radiation and chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital, physician and related medical services, such as anesthesia, associated with dental care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgical implants.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other artificial aids including surgical implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient services for a mastectomy and breast reconstruction include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- all stages of reconstruction on the affected breast;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- surgery and reconstruction on the other breast to produce symmetrical appearance; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- cleft lip and/or palate; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- severe traumatic, skeletal and/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHIP Perinate Newborn covered benefit</td>
<td>Limitations</td>
<td>Co-payments</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Congenital craniofacial deviations; or</strong>&lt;br&gt;- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
<td><strong>Requires authorization and physician prescription</strong>&lt;br&gt;<strong>60 days per 12-month period limit.</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

**Skilled Nursing Facilities**<br>(Includes Rehabilitation Hospitals)

Services include, but are not limited to, the following:
- Semi-private room and board
- Regular nursing services
- Rehabilitation services
- Medical supplies and use of appliances and equipment furnished by the facility

**Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center**

Services include but are not limited to the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:
- X-ray, imaging, and radiological tests (technical component)
- Laboratory and pathology services (technical component)
- Machine diagnostic tests
- Ambulatory surgical facility services
- Drugs, medications and biologicals
- Casts, splints, dressings
- Preventive health services
- Physical, occupational and speech therapy
- Renal dialysis
- Respiratory services
- Radiation and chemotherapy
- Blood or blood products that are not provided free-of-charge to the patient and the administration of these products
- Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory setting.

**May require prior authorization and physician prescription**

None.
<table>
<thead>
<tr>
<th>CHIP Perinate Newborn covered benefit</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>surgical facility,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgical implants.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other artificial aids including surgical implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- all stages of reconstruction on the affected breast;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- surgery and reconstruction on the other breast to produce symmetrical appearance; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- cleft lip and/or palate; or</td>
<td></td>
<td></td>
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<tr>
<td>- severe traumatic, skeletal and/or congenital craniofacial deviations; or</td>
<td></td>
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<tr>
<td>- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/Physician Extender Professional Services</td>
<td>May require authorization for specialty referral from a PCP to an in-network specialist.</td>
<td>None</td>
</tr>
<tr>
<td>Services include, but are not limited to the following:</td>
<td>Requires authorization for all out-of-network specialty referrals.</td>
<td></td>
</tr>
<tr>
<td>▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)</td>
<td></td>
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<tr>
<td>▪ Physician office visits, in-patient and outpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHIP Perinate Newborn covered benefit</td>
<td>Limitations</td>
<td>Co-payments</td>
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<tr>
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</tr>
<tr>
<td>Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications, biologicals and materials administered in Physician’s office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy testing, serum and injections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional component (in/outpatient) of surgical services, including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Administration of anesthesia by Physician (other than surgeon) or CRNA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Second surgical opinions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Same-day surgery performed in a Hospital without an over-night stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Invasive diagnostic procedures such as endoscopic examinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital-based Physician services (including Physician-performed technical and interpretive components)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician and professional services for a mastectomy and breast reconstruction include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- all stages of reconstruction on the affected breast;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- surgery and reconstruction on the other breast to produce symmetrical appearance; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHIP Perinate Newborn covered benefit</td>
<td>Limitations</td>
<td>Co-payments</td>
</tr>
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<td>--------------------------------------</td>
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</tr>
</tbody>
</table>
| Surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:  
- cleft lip and/or palate; or  
- severe traumatic, skeletal and/or congenital craniofacial deviations; or  
- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. | Covers services rendered to a newborn immediately following delivery. | None |
| Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center. | | None |
| **Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies**  
Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to:  
- Orthotic braces and orthotics  
- Dental devices  
- Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses  
- Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease  
- Hearing aids  
- Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A) | May require prior authorization and physician prescription  
- $20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). | None |
<p>| <strong>Home and Community Health Services</strong> | Requires prior authorization and physician prescription | None |</p>
<table>
<thead>
<tr>
<th>CHIP Perinate Newborn covered benefit</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
</table>
| Services that are provided in the home and community, including, but not limited to:  
  • Home infusion  
  • Respiratory therapy  
  • Visits for private duty nursing (R.N., L.V.N.)  
  • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).  
  • Home health aide when included as part of a plan of care during a period that skilled visits have been approved.  
  • Speech, physical and occupational therapies. | • Services are not intended to replace the CHILD’S caretaker or to provide relief for the caretaker.  
   • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services.  
   • Services are not intended to replace 24-hour inpatient or skilled nursing facility services. | | |

### Inpatient Mental Health Services

Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:

- Neuropsychological and psychological testing.

| | Requires prior authorization for non-emergency services  
| | Does not require PCP referral.  
| | When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. | None |

### Outpatient Mental Health Services

Mental health services, including for serious mental illness, provided on an outpatient basis, include , but are not limited to:

- The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.
- Neuropsychological and psychological testing
- Medication management
- Rehabilitative day treatments

| | May require prior authorization.  
| | Does not require PCP referral.  
<p>| | When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or | None |</p>
<table>
<thead>
<tr>
<th>CHIP Perinate Newborn covered benefit</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential treatment services (partial hospitalization or rehabilitative day treatment)</td>
<td>termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
<td>None</td>
</tr>
<tr>
<td>Skills training (psycho-educational skill development)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412 Subchapter G, Division 1, §412.303(31). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.</td>
<td></td>
</tr>
</tbody>
</table>

Inpatient Substance Abuse Treatment Services

Services include, but are not limited to:
- Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.
- Requires prior authorization for non-emergency services
- Does not require PCP referral.

Outpatient Substance Abuse Treatment Services

Services include, but are not limited to:
- Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.
- May require prior authorization.
- Does not require PCP referral.
### CHIP Perinate Newborn covered benefit

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive outpatient services</td>
<td>Requires prior authorization and physician prescription</td>
<td>None</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.</td>
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</tr>
</tbody>
</table>

### Rehabilitation Services

Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following:
- Physical, occupational and speech therapy
- Developmental assessment

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Co-payments</th>
</tr>
</thead>
</table>

### Hospice Care Services

Services include, but are not limited to:
- Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death
- Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Co-payments</th>
</tr>
</thead>
</table>

### Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services

Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include but are not limited to the following:
- Emergency services based on prudent lay
<table>
<thead>
<tr>
<th>CHIP Perinate Newborn covered benefit</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>person definition of emergency health condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical screening examination</td>
<td></td>
<td></td>
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<tr>
<td>Stabilization services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency ground, air and water transportation</td>
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<tr>
<td>Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services include but are not limited to the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Requires authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services include:</td>
<td></td>
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<tr>
<td>- One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization</td>
<td></td>
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</tr>
<tr>
<td>- One pair of non-prosthetic eyewear per 12-month period</td>
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<td></td>
</tr>
<tr>
<td>- The health plan may reasonably limit the cost of the frames/lenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Does not require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered services do not require physician prescription and are limited to spinal subluxation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Does not require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Does not require authorization for additional visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco Cessation Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Does not require authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Health Plan defines plan-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHIP Perinate Newborn covered benefit</td>
<td>Limitations</td>
<td>Co-payments</td>
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<td>--------------------------------------</td>
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</tr>
<tr>
<td>Covered up to $100 for a 12-month period limit for a plan-approved program</td>
<td>• May be subject to formulary requirements.</td>
<td></td>
</tr>
<tr>
<td>Case Management and Care Coordination Services</td>
<td>• These services include outreach, informing, case management, care coordination and community referral.</td>
<td>None</td>
</tr>
<tr>
<td>Value-added Services</td>
<td>Home Assessments</td>
<td>None</td>
</tr>
<tr>
<td>• Nurse Line</td>
<td>• Members must be actively enrolled in Aetna Better Health Health Plan’s case or disease management programs</td>
<td></td>
</tr>
<tr>
<td>Aetna Better Health CHIP Perinate Newborn members have access to the Nurse Line, 24 hours a day, 7 days per week. Services provided are:</td>
<td>For non-English speaking members, language translation services are provided.</td>
<td></td>
</tr>
<tr>
<td>- Answers to health care questions</td>
<td>• Home assessments will be conducted with CHIP Perinate Newborn members who are actively enrolled in case or disease management programs and have asthma or other chronic diseases.</td>
<td></td>
</tr>
<tr>
<td>- General health information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Assessment of current symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Home care advice, if appropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Direction to the most appropriate site of care</td>
<td></td>
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</tr>
</tbody>
</table>

### Exclusions from covered services for CHIP Perinate newborn members

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning).
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D,

- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, that do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP Perinate newborn DME/Supplies

<table>
<thead>
<tr>
<th>SUPPLIES</th>
<th>COVERED</th>
<th>EXCLUDED</th>
<th>COMMENTS/MEMBER CONTRACT PROVISIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ace Bandages</td>
<td></td>
<td>X</td>
<td>Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.</td>
</tr>
<tr>
<td>Alcohol, rubbing</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Alcohol, swabs (diabetic)</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply not covered, unless RX provided at time of dispensing.</td>
</tr>
<tr>
<td>Alcohol, swabs</td>
<td>X</td>
<td></td>
<td>Covered only when received with IV therapy or central line kits/supplies.</td>
</tr>
<tr>
<td>Ana Kit Epinephrine</td>
<td>X</td>
<td></td>
<td>A self-injection kit used by patients highly allergic to bee stings.</td>
</tr>
<tr>
<td>Arm Sling</td>
<td></td>
<td>X</td>
<td>Dispensed as part of office visit.</td>
</tr>
<tr>
<td>Attends (Diapers)</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan</td>
</tr>
<tr>
<td>Bandages</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Basal Thermometer</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Batteries – initial</td>
<td>X</td>
<td>.</td>
<td>For covered DME items</td>
</tr>
<tr>
<td>Batteries – replacement</td>
<td>X</td>
<td></td>
<td>For covered DME when replacement is necessary due to normal use.</td>
</tr>
<tr>
<td>Betadine</td>
<td></td>
<td>X</td>
<td>See IV therapy supplies.</td>
</tr>
<tr>
<td>Books</td>
<td></td>
<td>X</td>
<td>For monitoring of diabetes.</td>
</tr>
<tr>
<td>Clinitest</td>
<td></td>
<td>X</td>
<td>See Ostomy Supplies.</td>
</tr>
<tr>
<td>Communication Devices</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Jelly</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply. Contraceptives are not covered under the plan.</td>
</tr>
<tr>
<td>Cranial Head Mold</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dental Devices</td>
<td>X</td>
<td></td>
<td>Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td></td>
<td>X</td>
<td>Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.</td>
</tr>
<tr>
<td>Diapers/Incontinent Briefs/Chux</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan</td>
</tr>
<tr>
<td>Diaphragm</td>
<td></td>
<td>X</td>
<td>Contraceptives are not covered under the plan.</td>
</tr>
<tr>
<td>SUPPLIES</td>
<td>COVERED</td>
<td>EXCLUDED</td>
<td>COMMENTS/MEMBER CONTRACT PROVISIONS</td>
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<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Diastix</td>
<td>X</td>
<td></td>
<td>For monitoring diabetes.</td>
</tr>
<tr>
<td>Diet, Special</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Distilled Water</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Central Line</td>
<td>X</td>
<td></td>
<td>Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.</td>
</tr>
<tr>
<td>Dressing Supplies/Decubitus</td>
<td>X</td>
<td></td>
<td>Eligible for coverage only if receiving covered home care for wound care.</td>
</tr>
<tr>
<td>Dressing Supplies/Peripheral IV Therapy</td>
<td>X</td>
<td></td>
<td>Eligible for coverage only if receiving home IV therapy.</td>
</tr>
<tr>
<td>Dressing Supplies/Other</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dust Mask</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ear Molds</td>
<td>X</td>
<td></td>
<td>Custom made, post inner or middle ear surgery</td>
</tr>
<tr>
<td>Electrodes</td>
<td>X</td>
<td></td>
<td>Eligible for coverage when used with a covered DME.</td>
</tr>
<tr>
<td>Enema Supplies</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Enteral Nutrition Supplies</td>
<td>X</td>
<td></td>
<td>Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease.</td>
</tr>
<tr>
<td>Eye Patches</td>
<td>X</td>
<td></td>
<td>Covered for patients with amblyopia.</td>
</tr>
<tr>
<td>Formula</td>
<td></td>
<td>X</td>
<td>Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does not include formula:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- For members who could be sustained on an age-appropriate diet.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Traditionally used for infant feeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- In pudding form (except for clients with documented oropharyngeal motor dysfunction</td>
</tr>
</tbody>
</table>
who receive greater than 50 percent of their daily caloric intake from this product)
- For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met.

Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are not medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.

<table>
<thead>
<tr>
<th>SUPPLIES</th>
<th>COVERED</th>
<th>EXCLUDED</th>
<th>COMMENTS/MEMBER CONTRACT PROVISIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gloves</td>
<td></td>
<td>X</td>
<td>Exception: Central line dressings or wound care provided by home care agency.</td>
</tr>
<tr>
<td>Hydrogen Peroxide</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Hygiene Items</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Incontinent Pads</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.</td>
</tr>
<tr>
<td>Insulin Pump (External) Supplies</td>
<td></td>
<td>X</td>
<td>Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.</td>
</tr>
<tr>
<td>Irrigation Sets, Wound Care</td>
<td></td>
<td>X</td>
<td>Eligible for coverage when used during covered home care for wound care.</td>
</tr>
<tr>
<td>Irrigation Sets, Urinary</td>
<td></td>
<td>X</td>
<td>Eligible for coverage for individual with an indwelling urinary catheter.</td>
</tr>
<tr>
<td>IV Therapy Supplies</td>
<td></td>
<td>X</td>
<td>Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.</td>
</tr>
<tr>
<td>K-Y Jelly</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Lancet Device</td>
<td></td>
<td>X</td>
<td>Limited to one device only.</td>
</tr>
<tr>
<td>Lancets</td>
<td></td>
<td>X</td>
<td>Eligible for individuals with diabetes.</td>
</tr>
<tr>
<td>Med Ejector</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Needles and Syringes/Diabetic</td>
<td></td>
<td></td>
<td>See Diabetic Supplies</td>
</tr>
<tr>
<td>Needles and Syringes/IV and Central Line</td>
<td></td>
<td></td>
<td>See IV Therapy and Dressing Supplies/Central Line.</td>
</tr>
<tr>
<td>Needles and Syringes/Other</td>
<td></td>
<td>X</td>
<td>Eligible for coverage if a covered IM or SubQ medication is being administered at home.</td>
</tr>
<tr>
<td>Normal Saline</td>
<td></td>
<td>X</td>
<td>See Saline, Normal</td>
</tr>
<tr>
<td>Novopen</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td></td>
<td>X</td>
<td>Items eligible for coverage include: belt, pouch, bags,</td>
</tr>
<tr>
<td>SUPPLIES</td>
<td>COVERED</td>
<td>EXCLUDED</td>
<td>COMMENTS/MEMBER CONTRACT PROVISIONS</td>
</tr>
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</tr>
<tr>
<td>wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenteral Nutrition/Supplies</td>
<td>X</td>
<td></td>
<td>Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.</td>
</tr>
<tr>
<td>Saline, Normal</td>
<td>X</td>
<td></td>
<td>Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.</td>
</tr>
<tr>
<td>Stump Sleeve</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stump Socks</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suction Catheters</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syringes</td>
<td></td>
<td></td>
<td>See Needles/Syringes.</td>
</tr>
<tr>
<td>Tape</td>
<td></td>
<td></td>
<td>See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.</td>
</tr>
<tr>
<td>Tracheostomy Supplies</td>
<td>X</td>
<td></td>
<td>Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.</td>
</tr>
<tr>
<td>Under Pads</td>
<td></td>
<td></td>
<td>See Diapers/Incontinent Briefs/Chux.</td>
</tr>
<tr>
<td>Unna Boot</td>
<td>X</td>
<td></td>
<td>Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.</td>
</tr>
<tr>
<td>Urinary, External Catheter &amp; Supplies</td>
<td>X</td>
<td></td>
<td>Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan</td>
</tr>
<tr>
<td>Urinary, Indwelling Catheter &amp; Supplies</td>
<td>X</td>
<td></td>
<td>Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.</td>
</tr>
<tr>
<td>Urinary, Intermittent</td>
<td>X</td>
<td></td>
<td>Cover supplies needed for intermittent or straight catheterization.</td>
</tr>
<tr>
<td>Urine Test Kit</td>
<td>X</td>
<td></td>
<td>When determined to be medically necessary.</td>
</tr>
<tr>
<td>Urostomy supplies</td>
<td></td>
<td></td>
<td>See Ostomy Supplies.</td>
</tr>
</tbody>
</table>

**CHIP Perinate (unborn child) covered services**

Aetna Better Health provides services to CHIP Perinate members (unborn child) as outlined below. Please refer to the following pages for a listing of limitations and exclusions.

There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinate members (unborn child).
Covered services for CHIP Perinate members (unborn child) must meet the CHIP definition of "Medically Necessary."

**Medically necessary health services** means:

1. Dental services and non-behavioral health services that are:
   a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member, or endanger life;
   b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member’s health conditions;
   c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
   d) consistent with the Member’s diagnoses;
   e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
   f) not experimental or investigative; and not primarily for the convenience of the Member or Provider.

2. Behavioral Health Services that:
   a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
   b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
   c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
   d) are the most appropriate level or supply of service that can be safely provided;
   e) could not be omitted without adversely affecting the Member’s mental and/or physical health or the quality of care rendered;
   f) are not experimental or investigative; and
   g) are not primarily for the convenience of the Member or Provider.

<table>
<thead>
<tr>
<th>CHIP Perinate covered benefit</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient General Acute</strong></td>
<td>For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however professional services charges associated with labor with delivery are a covered benefit.</td>
<td>None</td>
</tr>
<tr>
<td>Services include:</td>
<td>For CHIP Perinates in families with incomes above 185% up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges</td>
<td></td>
</tr>
<tr>
<td>• Covered medically necessary Hospital-provided services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Operating, recovery and other treatment rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anesthesia and administration (facility technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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CHIP Perinate covered benefit

- (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).
- Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  - dilation and curettage (D&C) procedures,
  - appropriate provider-administered medications,
  - ultrasounds, and
  - histological examination of tissue samples.

Comprehensive Outpatient Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center

Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:
- X-ray, imaging, and radiological tests (technical component)
- Laboratory and pathology services (technical component)
- Machine diagnostic tests
- Drugs, medications and biologicals that are medically necessary prescription and injection drugs
- Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  - dilation and curettage (D&C) procedures,
  - appropriate provider-administered medications,
  - ultrasounds, and
  - histological examination of tissue samples.

Limitations

- and facility charges associated with labor with delivery until birth.

Co-payments

- May require prior authorization and physician prescription

Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth.

Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation, or miscarriage or non-viable pregnancy.

Amniocentesis, Cordocentesis, Fetal Intruterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis.

Laboratory tests for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or
<table>
<thead>
<tr>
<th>CHIP Perinate covered benefit</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.</td>
<td>Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.</td>
<td>None</td>
</tr>
</tbody>
</table>

**Physician/Physician Extender Professional Services**

Services include, but are not limited to the following:

- Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth.
- Physician office visits, in-patient and out-

May require authorization for specialty referral from a PCP to an in-network specialist.

Requires authorization for all out-of-network specialty referrals.

Professional component of the ultrasound of the pregnant uterus when medically indicated for
<table>
<thead>
<tr>
<th>CHIP Perinate covered benefit</th>
<th>Limitations</th>
<th>Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient services</td>
<td>suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation.</td>
<td>None</td>
</tr>
<tr>
<td>Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</td>
<td>Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.</td>
<td>None</td>
</tr>
<tr>
<td>Medically necessary medications, biologicals and materials administered in Physician's office</td>
<td></td>
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<tr>
<td>Professional component (in/outpatient) of surgical services, including:</td>
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<tr>
<td>- Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth.</td>
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</tr>
<tr>
<td>- Administration of anesthesia by Physician (other than surgeon) or CRNA</td>
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<td></td>
</tr>
<tr>
<td>- Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital-based Physician services (including Physician-performed technical and interpretive components)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&amp;C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.</td>
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</tbody>
</table>

| Birthing Center Services | Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) Applies only to CHIP Perinate Members (unborn child) with incomes at 186% FPL to 200% FPL. | None |

| Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center. | Covers prenatal, birthing, and postpartum services rendered in a | None. |
CHIP Perinate covered benefit

Limitations

Co-payments

licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:

(1) One (1) visit every four (4) weeks for the first 28 weeks or pregnancy;
(2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and
(3) one (1) visit per week from 36 weeks to delivery.

More frequent visits are allowed as Medically Necessary. Benefits are limited to:

Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review.

Visits after the initial visit must include:

- interim history (problems, marital status, fetal status);
- physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and
- laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or
<table>
<thead>
<tr>
<th>CHIP Perinate covered benefit</th>
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</tr>
</thead>
<tbody>
<tr>
<td>hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).</td>
<td>Does not require prior authorization. Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician’s files and is subject to retrospective review. Visits after the initial visit must include: interim history (problems, maternal status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy;</td>
<td>None</td>
</tr>
<tr>
<td>CHIP Perinate covered benefit</td>
<td>Limitations</td>
<td>Co-payments</td>
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<td>-------------------------------</td>
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</tr>
<tr>
<td><strong>Multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</strong></td>
<td>Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.</td>
<td>None</td>
</tr>
<tr>
<td>Health Plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth.</td>
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</tr>
<tr>
<td>▪ Emergency services based on prudent lay person definition of emergency health condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Stabilization services related to the labor and delivery of the covered unborn child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Emergency ground, air and water transportation for labor and threatened labor is a covered benefit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case Management Services</strong></td>
<td>These covered services include outreach informing, case management, care coordination and community referral.</td>
<td>None</td>
</tr>
<tr>
<td>Case management services are a covered benefit for the Unborn Child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Care Coordination Services</strong></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Care coordination services are a covered benefit for the Unborn Child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drug Benefits</strong></td>
<td>Services must be medically</td>
<td>None</td>
</tr>
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<td></td>
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</tbody>
</table>
CHIP Perinate covered benefit

Services include, but are not limited to, the following:
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and
- Drugs and biologicals provided in an inpatient setting.

Limitations

necessary for the unborn child.

Co-payments

None

Value-added Services

- Nurse Line
  Aetna Better Health CHIP Perinate members have access to the Nurse Line, 24 hours a day, 7 days per week. Services provided are:
  - Answers to health care questions
  - General health information
  - Assessment of current symptoms
  - Home care advice, if appropriate
  - Direction to the most appropriate site of care

For non-English speaking members, language translation services are provided.

- Sports physicals
- Smoking cessation program which includes assessment, counseling, and pharmacological therapy (nicotine replacement products).
- Contact lenses benefit which includes a fitting exam with additional benefits to be applied towards the purchase of contact lenses to correct vision. 20% discount available for non-disposable lenses.

Smoking Cessation Program

- Members must be 12 years or older for assessment and counseling; 18 years of age or older for nicotine replacement products unless prescribed by physician.
- $200 per 12 month period (in addition to $100/12 month standard CHIP benefit)

Contact Lenses

- Members must be 12 – 18 years of age
- $100 per 12 month period
- Must be medically necessary.

Exclusions from Covered Services for CHIP Perinate Members

- For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. “Initial Perinatal Newborn admission” means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services.
- Inpatient mental health services.
• Outpatient mental health services.
• Durable medical equipment or other medically related remedial devices.
• Disposable medical supplies.
• Home and community-based health care services.
• Nursing care services.
• Dental services.
• Inpatient substance abuse treatment services and residential substance abuse treatment services.
• Outpatient substance abuse treatment services.
• Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
• Hospice care.
• Skilled nursing facility and rehabilitation hospital services.
• Emergency services other than those directly related to the delivery of the covered unborn child.
• Transplant services.
• Tobacco Cessation Programs.
• Chiropractic Services.
• Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
• Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or post partum care.
• Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, “External Review by Independent Review Organization”).
• Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
• Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
• Mechanical organ replacement devices including, but not limited to artificial heart.
• Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery.
• Prostate and mammography screening.
• Elective surgery to correct vision.
• Gastric procedures for weight loss.
• Cosmetic surgery/services solely for cosmetic purposes.
• Dental devices solely for cosmetic purposes.
• Out-of-network services not authorized by the Health Plan except for emergency care related to the labor and delivery of the covered unborn child.
• Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
• Medications prescribed for weight loss or gain
• Acupuncture services, naturopathy and hypnotherapy.
• Immunizations solely for foreign travel.
• Routine foot care such as hygienic care (routine foot care does not include treatment of injury or complications of diabetes).
• Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
• Corrective orthopedic shoes.
• Convenience items.
• Over-the-counter medications
• Orthotics primarily used for athletic or recreational purposes
• Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
• Housekeeping.
• Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
• Services or supplies received from a nurse that do not require the skill and training of a nurse.
• Vision training, vision therapy, or vision services.
• Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered.
• Donor non-medical expenses.
• Charges incurred as a donor of an organ.
• Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

Prescription benefits

Aetna Better Health covers prescription medications. Our members can get their prescriptions at no cost (Medicaid) or with copays (CHIP) when:
• They get their prescriptions filled at a network pharmacy
• Their prescriptions are on the formulary or preferred drug list (PDL). Note: PDL applies only to Medicaid members.

It is important that you as the provider know about other prescriptions your patient is already taking. Also, ask them about non-prescription medicine or vitamin or herbal supplements they may be taking.

CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of the drug.

Medicaid Preferred Drug List (PDL)

Texas Medicaid maintains a Preferred Drug List comprised of various therapeutic classes. You can find out if a medication is on the preferred drug list. Many preferred drugs are available without prior authorization (PA). Check the list of covered drugs at: www.txvendordrug.com. Prescribers are expected to adhere to the Texas Medicaid Preferred Drug List. Not doing so can cause a delay in your patient receiving their medication.

The pharmacy will coordinate members prescriptions with you should the pharmacy encounter any rejects for prescribing non-preferred drugs. The pharmacy will also ensure the member receives all eligible prescriptions.
The pharmacy will also be able to coordinate those members having other benefits such as Medicare Part D or other insurance plans.

The Texas Medicaid Preferred Drug List is now available on the Epocrates drug information system. ([online.epocrates.com/home](https://online.epocrates.com/home)) The service is free and provides instant access to information on the drugs covered by the Texas formulary on a Palm, Pocket PC handheld device, or SmartPhone.

All contracted pharmacies will submit claims electronically in the most current NCPDP file format. This submission of the claim also verifies member eligibility and whether the drug is preferred or non-preferred.

**Formulary Drug List**
The Texas Drug Code Formulary at [www.txvendordrug.com](http://www.txvendordrug.com) covers more than 32,000 line items of drugs including single source and multi-source (generic) products. You can check to see if a medication is on the state’s formulary list. Remember before prescribing these medications to your patient that it may require prior authorization. If you want to request a drug to be added to the formulary, please contact an Aetna Provider Relations Representative for assistance.

**Over-the-counter drugs**
Aetna Better Health also covers certain over-the-counter drugs if they are on the PDL. Like other drugs, over-the-counter drugs must have a prescription written by the member’s physician. Check the list of covered drugs at [www.txvendordrug.com](http://www.txvendordrug.com). All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

**Durable medical equipment**
Aetna Better Health also covers certain basic durable medical equipment (DME) and medical supplies through the pharmacy benefit for Medicaid members. Aetna Better Health reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children (birth through age 20), Aetna Better Health also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must become an enrolled provider with Aetna Better Health.

**Specialty medications**
Aetna Better Health also covers Specialty Medications through the pharmacy benefit for Medicaid members. You can find the Specialty Drug List at [www.txvendordrug.com](http://www.txvendordrug.com). The Specialty Drug List is updated Quarterly and contains medications that may be exclusively provided through Aetna Better Health’s specialty pharmacy network. All specialty prescriptions must be filed at a network pharmacy.

**Pharmacy vaccination program**
Beginning 9/1/13, participating pharmacies will be allowed to transmit influenza claims for Texas Medicaid and CHIP Medicaid members 21 and older for Aetna Better Health. The patient will not need a prescription, but will need to show their Medicaid STAR ID card. Members under 21 years of age will continue to be referred to their physicians office or other Texas Vaccines for Children’s Program (TVFC) locations to receive their influenza vaccine.
How to transmit a claim:
Pharmacy Submits NCPDP B1 Claim

Bill for Product: Vaccine NDC required on Claim
HHSC will not include vaccine NDCs on Formulary.
$0 reimbursement for children under age 21

Bill for Service: DUR/PPS Segment Required, Submit ‘Professional Service Code’ = MA-Medication Administered

Any additional questions, please reach out to CVS Caremark 24 hours a day at 1-877-874-3317, Option 3.

Vitamins and minerals
As of September 1, 2013, network pharmacies are allowed to provide covered vitamin and mineral products to clients 20 years of age and younger who are enrolled in Medicaid for Aetna Better Health. The State of Texas Health and Human Services Commission (HHSC) is adding certain vitamins and minerals to the Medicaid formulary to be available through a pharmacy effective September 1, 2013.

The following is a list of the vitamins and minerals and corresponding conditions for which the products may be dispensed by a pharmacy.

- The products can only be provided to Medicaid clients 20 years of age and younger (through the month of their 21st birthday), and only for the specific conditions.
- These products 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.

The CCP vitamins and minerals list and corresponding conditions can be found here: http://www.txvendordrug.com/formulary/formulary-information.shtml

All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

Clinician-administered drugs
Clinician-administered drugs that do not have a rebatable NDC will not be reimbursed by Texas Medicaid or the CSHCN Services Program.

Long-acting reversible contraception
Long-acting reversible contraception (LARC) products are available as a pharmacy benefit for Texas Medicaid and Texas Women’s Health Program (TWHP) clients. Beginning August 1, 2014, long-acting reversible contraception (LARC) products will be available as a pharmacy benefit of Texas Medicaid and Texas Women’s Health Program (TWHP). These LARC products will only become available through a limited number of specialty pharmacies that work with LARC manufacturers. The list of pharmacies is forthcoming.
Providers who prescribe and obtain LARC products through the specialty pharmacies listed will be able to return unused and unopened LARC products to the manufacturer's third-party processor. Prescribers should refer to the manufacturer for specific instructions or the general state-provided instructions.

After August 1, 2014, LARC will remain a medical benefit and providers will continue to have the option to receive reimbursement for LARC as a clinician-administered drug.

**Mail order form for Aetna Better Health members**
While mail order is an option, the use of pharmacy mail order delivery is not required. You can assist your member in completing the Mail Order Delivery (MOD) form at [http://www.aetnabetterhealth.com/texas](http://www.aetnabetterhealth.com/texas) if you are prescribing a maintenance medication. Prescription drugs must be ordered by a licensed prescriber within the scope of the prescriber’s practice. Signatures on prescriptions must be legible in order for the prescription to be dispensed. For the most current and up-to-date version of the PDL, go to the website at [www.txvendordrug.com](http://www.txvendordrug.com)

**Procedure for obtaining pharmacy prior authorization**
Prescriptions written for non-PDL drugs will be available with prior authorization. This will involve the prescriber or one of his/her designated agents calling the Prior Authorization line at 1-855-656-0363 or via fax at 1-866-255-7534 to obtain approval before the drug can be dispensed. For fax requests, please use the appropriate authorization form designed specifically for pharmacy requests available on the website at [www.aetnabetterhealth.com/texas](http://www.aetnabetterhealth.com/texas). Incomplete forms will result in a denial.

Please also include any supporting medical records that will assist with the review of the prior authorization request. Allow 24 hours for completion of a request. In certain circumstances, upon demonstration of medical necessity, enrollees may obtain approval to receive medication not on the PDL through the pharmacy prior authorization process.

**Emergency prescription supply**
A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits. The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member’s medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

'8' in ""Prior Authorization Type Code' (field 461-EU)
'801' in ""Prior Authorization Number Submitted"" (Field 462-EV)
'3' in ""Days Supply"" in the claim segment of the billing transaction (Field 405-D5)
The quantity submitted in "Quantity dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply, e.g., an inhaler, unbreakable package, the pharmacy may still indicate an emergency prescription and enter the full quantity dispensed

Call Pharmacy Help Desk **1-877-874-3317** for more information about the 72-hour emergency prescription supply policy.

**Excluded drugs**

There are some prescriptions that are not covered by Aetna Better Health. These include:

- Erectile Dysfunction drugs
- Drug Efficacy Study Implementation (DESI) Drugs

For the most current and up-to-date information on the excluded prescriptions, go to the website at [www.txvendordrug.com](http://www.txvendordrug.com).

**Durable medical equipment and other products normally found in a pharmacy**

Aetna Better Health reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children (birth through age 20), Aetna Better Health also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20) refer to the Pharmacy Billing section of this manual.

Call Aetna Better Health at **1-800-248-7767**, Bexar or **1-800-306-8612** for Tarrant for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

For claims submission:

**Electronic claims:**

Emdeon – Use Payer ID 38692

If your electronic billing vendor is unable to convert to 38692, you may have them continue to use the Aetna commercial Payer ID 60054. If using this payer ID, we recommend that you use “MC” prior to the member number to make sure the claims are processed correctly.

If your electronic billing vendor can convert to 38692, but doesn’t submit directly to Emdeon, we recommend that you use “MC” prior to the member number to make sure the claims are processed correctly.

**Paper claims:**

Aetna Medicaid and CHIP Services

Attention: Claims Department

P.O. Box 60938
Behavioral health

Definition of behavioral health
Behavioral health is defined as those services provided for the assessment and treatment of problems related to mental health and substance abuse. Substance abuse includes abuse of alcohol and other drugs.

In order to meet the behavioral health needs of our Members, Aetna Better Health will provide a continuum of services to Members at risk of or suffering from mental, addictive or other behavioral disorders. We are an experienced behavioral health care organization and have contracted with providers who are experienced in providing behavioral health services to the Medicaid and CHIP populations.

These services include: assessment and treatment planning, substance abuse services, medication management, inpatient services, intensive outpatient services, case management services and outpatient therapy.

For more detail on the behavioral health benefits, please refer to the Medicaid and CHIP Covered Services sections of this manual.

Overview of Services
Behavioral health services are covered services for the treatment of mental, emotional or chemical dependency disorders.

We provide coverage of medically necessary behavioral health services as indicated below:
1) Texas Health Steps behavioral health services for Medicaid members birth through age 20 that are necessary to correct or ameliorate a mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a mental illness or condition:
   a) Must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole and
   b) May include consideration of other relevant factors, such as the criteria described in parts (2)(a-g) of this paragraph
   c) For Medicaid members over age 20 and CHIP members, behavioral health-related health care services that:
      d) Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder
      e) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
      f) Are furnished in the most appropriate and least restrictive setting in which services can be safely provided
      g) Are the most appropriate level or supply of service that can safely be provided
      h) Could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered
      i) Are not experimental or investigative
j) Are not primarily for the convenience of the member or provider

**Availability**

Behavioral health providers must be accessible to Members, including telephone access, 24-hours-a-day, 7 days per week in order to advise Members requiring urgent or emergency services. If the Behavioral Health Provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating providers must be arranged.

**Covered behavioral health services**

Medicaid-covered behavioral health services are not subject to the quantitative treatment limitations that apply under traditional, Fee-For-Service (FFS) Medicaid coverage. The services may be subject to the HMO’s non quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 behavioral health services, including:

- Inpatient requires prior authorization for mental health services including in Freestanding Psychiatric Facilities for children
- Outpatient mental health services
- Psychiatry services
- Counseling services for adults (age 21 and older)
- Outpatient substance use disorder treatment services, including:
  - Assessment
  - Detoxification services
  - Counseling treatment
  - Medication-assisted therapy
  - Residential substance use disorder treatment services, including detoxification services
  - Substance use disorder treatment, including room and board
- Mental Health Rehabilitative Services
- Targeted Case Management

**CHIP-covered* behavioral health services include:**

- Inpatient mental health
- Outpatient mental health
- Inpatient substance abuse
- Outpatient substance abuse

*These services are not covered for CHIP Perinates (unborn children).

**Mental Health Rehabilitative Services and Targeted Case Management**

Effective September 1, 2014, Aetna Better Health covers services for our members receiving Targeted Case Management and Mental Health Rehabilitative services in compliance with Texas Resilience and Recovery Utilization Management Guidelines.

For members with severe and persistent mental illness (SPMI) or severe emotional disturbance (SED), Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM) must be available to eligible STAR and STAR+PLUS Members.

SPMI is a condition of an adult 18 years of age or older. It is a diagnosable mental, behavioral, or emotional disorder that meets the criteria of DSM-IV-TR and that has resulted in functional impairment which
substantially interferes with or limits one or more major life activities.

SED is a condition of a child up to age 18 either currently or at any time during the past year. It is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV-TR and that has resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.

Providers of MHR Services and TCM Services must use and be trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) Case management for members who have SPMI (adult, 18 years of age or older) MHR Services and TCM Services including any limitations to these services are described in the most current TMPPM, including the Behavioral Health, Rehabilitation, and Case Management Services Handbook. We will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG) but ABH is not responsible for providing any services listed in the RRUMG that are not covered services.

Providers must submit a Prior Authorization by FAX on the Service Request Form (HHSC Uniform Managed Care Manual 15.2 Version 2.3).

Providers of MHR and TCM services must attest to ABH that they have the ability to provide either directly or through subcontract, the members with a full array of services.

Mental Health Rehabilitative Services, as well as any limitations to these services, are described in the most current Texas Medicaid Provider Procedures Manual (TMPPM), which includes the Behavioral Health, Rehabilitation, and Case Management Services Handbook. Mental Health Rehabilitative Services must be billed using appropriate procedure codes and modifiers as listed in the TMPPM. Aetna Better Health is not responsible for providing Criminal Justice Agency funded procedure codes with modifier HZ because these services are excluded from the capitation.

Crisis Intervention services receive concurrent review but not Prior Authorization, and requests for authorization for crisis services must be submitted within 24 hours of the time the services were offered. The MCO will respond within 24 hours of receipt for crisis services. The Concurrent Review FAX number is 1-855-857-9932. All other authorization requests should be faxed to Prior Authorization Fax number 1-855-841-8355. You will be notified by FAX of our decision. If the level of care requested deviates from that derived by CMBHS, you must advise us of the deviation and submit your CANS or ANSA documentation as clinical evidence for the deviation. Aetna Better Health will verify that all persons submitting these assessments are certified.

MHR Services include training and services that help the member maintain independence in the home and community, such as the following:

- Medication training and support – curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- Psychosocial rehabilitative services – social, educational, vocational, behavioral, or cognitive interventions to improve the member’s potential for social relationships, occupational or educational achievement, and living skills development
• Skills training and development – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
  — Crisis intervention – intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
  — Day program for acute needs – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting

TCM Services include:
  • Case management for members who have SED (child, 3 through 17 years of age), which includes routine and intensive case management services
  • Case Management for members who have SPMI (adult, 18 years of age or older)

MHR Services and TCM Services including any limitations to these services are described in the most current TMPPM, including the Behavioral Health, Rehabilitation, and Case Management Services Handbook. We will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG) but ABH is not responsible for providing any services listed in the RRUMG that are not covered services.

Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services can be found at Texas Resilience and Recovery Utilization Management Guidelines—Adult Services (PDF) [http://www.dshs.state.tx.us/workArea/linkit.aspx?LinkIdentifier=id&temID=8589981162](http://www.dshs.state.tx.us/workArea/linkit.aspx?LinkIdentifier=id&temID=8589981162)

Texas Resilience and Recovery Utilization Management Guidelines for Child and Adolescent Services can be found at Texas Resilience and Recovery Utilization Management Guidelines—Child and Adolescent Services (PDF) [http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979570](http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979570)

Providers of MHR Services and TCM Services must use and be trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) Case management for members who have SPMI (adult, 18 years of age or older) MHR Services and TCM Services including any limitations to these services are described in the most current TMPPM, including the Behavioral Health, Rehabilitation, and Case Management Services Handbook. We will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG) but ABH is not responsible for providing any services listed in the RRUMG that are not covered services.

Providers must follow the current Texas Resilience and Recovery Utilization Management Guidelines. For more information, you may refer to HHSC Uniformed Managed Care Manual, Chapter 15.1 version 2.0 – Mental Health Targeted Case Management and Mental Health Rehabilitative Services.

**Primary Care Provider referral**

We promote early intervention and health screening for identification of behavioral health problems and patient education. To that end, Aetna Better Health providers are expected to:
• Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem/disorder
• Treat mental health and/or substance abuse disorders within the scope of their practice
• Inform Members how and where to obtain behavioral health services
• Understand that Members may self-refer to an Aetna Better Health behavioral health care provider without a referral from the Member’s Primary Care Provider.

**Member Access to Behavioral Health Services**

**Self-Referral**
Eligible Members may self-refer to a participating behavioral health specialist by calling the Aetna Better Health behavioral health hotline listed on page 3 of this manual. Aetna Better Health network behavioral health providers can also obtain authorization for initial services online for most behavioral health services at www.aetnabetterhealth.com.

**Referral Information**
Members must obtain care from Aetna Better Health participating provider to obtain behavioral health services. Contact us on line at www.aetnabetterhealth.com or by phone at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

Providers must use DSM-IV multi-axial classifications and other assessment instruments or outcome measures required by HHSC when assessing Member for behavioral health services.

**Attention Deficit Hyperactivity Disorder (ADHD)**
Treatment of children diagnosed with ADHD, including follow-up care for children who are prescribed ADHD medication, is covered as outpatient mental health services. Reimbursement for these services will be determined according to the Provider Agreement. Covered benefits are as outlined in the TMPPM. Providers should complete follow-up of members receiving these medications including a minimum of a one month follow-up to first fill of the prescription and two subsequent OV during the next 9 months.

**Admissions to IP BH facilities as a condition of probation Court-ordered Commitment**
We cover inpatient and outpatient psychiatric services to STAR, and CHIP members who have been ordered by a court of competent jurisdiction under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, to receive the services under a court-ordered commitment to an inpatient mental health facility. Aetna Better Health:

- Will not deny, reduce or controvert the medical necessity of any court-ordered inpatient or outpatient psychiatric service for members age 20 and younger; any modification or termination of services will be presented to the court with jurisdiction over the matter for determination
- Will comply with the utilization review of chemical dependency treatment; chemical dependency treatment must conform to the standards set forth in the Texas administrative code
- Will not allow members ordered to receive treatment under the provisions of the Texas Health and Safety Code to appeal the commitment through our complaint or appeals processes

**DADS Contracted providers**

**Coordination with Non-Medicaid Managed Care Covered Services**
In addition to HMO coverage, STAR members are eligible for the services described below. Aetna Better Health and our network providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM).
• Texas Health Steps dental (including orthodontia)
• Texas Health Steps environmental lead investigation (ELI)
• Early Childhood Intervention (ECI) case management/service coordination
• Early Childhood Intervention Specialized Skills Training
• Case Management for Children and Pregnant Women
• Texas School Health and Related Services (SHARS)
• Department of Assistive and Rehabilitative Services Blind Children’s Vocational Discovery and Development Program
• Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
• DADS hospice services
• Admissions to inpatient mental health facilities as a condition of probation
• Texas Health Steps Personal Care Services for members birth through age 20
• DADS contracted providers of long-term services and supports for individuals who have intellectual or developmental disabilities
• DADS contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities
• For members who are prospectively enrolled in STAR from Medicaid FFS during an inpatient stay, hospital facility charges associated with the inpatient stay are noncapitated services except for a stay in a Chemical Dependency Treatment Facility
• Health and Human Services Commission’s Medical Transportation Program

**STAR Members who volunteer for STAR and have Intellectual or Developmental Disabilities**
DADS contracted providers of long-term services and supports, case management or service coordination services who are serving members under 21 having intellectual or developmental disabilities and are residing in the service area, are receiving SSI benefits, but not Medicare, or are enrolled in certain DADS 1915(c) waiver programs may continue to provide services to children receiving waiver services as a fee-for-service if they volunteer for STAR.


**Referrals to health-related service**
We will enlist the involvement of community organizations that may not provide CHIP Perinatal covered services but are otherwise important to the health and well-being of the members. We will make a best effort to establish relationships with these community organizations to make referrals. These organizations may include:

• Texas ECI Program
• Texas Department of Mental Health and Mental Retardation (MHMR)
• Texas Department of Health Title V Program
• Local school district special education
• Other state and local agencies and programs with jurisdiction over children’s services, including food stamps and the Women, Infants and Children program
• Texas information and referral network
• Texas Commission for the Blind
• Child-service civic and religious organizations, and consumer and advocacy groups, such as United Cerebral Palsy, that also work on behalf of the CSHCN population; CHIP Perinatal case managers can offer assistance with coordination of care for these members

**Coordination between behavioral health and physical health services**

We are committed to coordinating medical and behavioral care for Members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance abuse, dual or multiple diagnoses, mental retardation or developmental disabilities. With the member’s permission, our case management staff can facilitate coordination of care and case management related to substance abuse screening, evaluation and treatment.

Members seen in the primary care setting may present with a behavioral health condition, which the Primary Care Provider must be prepared to recognize. Primary Care Providers are encouraged to use behavioral health screening tools, treat behavioral health issues that are within their scope of practice and refer Members to behavioral health providers when appropriate.

Members seen by behavioral health providers are screened for co-existing medical issues. Behavioral health providers will refer Members with known or suspected and untreated physical health problems or disorders to their Primary Care Provider for examination and treatment, with the Member’s consent. Behavioral health providers may only provide physical health care services if they are licensed to do so.

Behavioral health providers are asked to communicate any concerns regarding the Member’s medical condition to the Primary Care Provider, with the Members consent if required, and work collaboratively on a plan of care. Information is shared between Aetna Better Health and participating behavioral health and medical providers to ensure interactions with the Member result in appropriate coordination between medical and behavioral health care.

The Primary Care Provider and behavioral health provider are asked to share pertinent history and test results in a timely manner and document review of the information received in the clinical record. Behavioral health provider must send initial and quarterly summary reports of a Member’s behavioral health status to the PCP with the Member’s consent if required.

**Medical records standards**

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals agree to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services. Detailed information on Medical Records Standards can be found later in this manual.

**Consent for disclosure of information**

An authorization to release confidential information, such as medical records regarding treatment, should be signed by the patient prior to receiving care from a behavioral health provider. In order to adhere to the continuity of care between the PCP, specialist, and/or behavioral health provider, sharing of a patient’s personal health information is necessary. This can be done using the “Consent for Disclosure of Confidential Information” form. Please refer to Appendix K for a copy of this form.
Court-Ordered Commitments
A “Court-Ordered Commitment” means a confinement of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. We are required to provide inpatient psychiatric services to Members under the age of 21, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, related to Court-Ordered Commitments to psychiatric facilities. Aetna Better Health will not deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered commitment for Members under age 21.

Coordination with the Local Mental Health Authority
Aetna Better Health will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric facility. Aetna Better Health will comply with additional behavioral health services requirements relating to coordination with the LMHA and care for special populations. Covered services will be provided to Members with Severe and Persistent Mental Illness (SPMI)/Severe Emotional Disturbance (SED) when medically necessary, whether or not they are receiving targeted case management or rehabilitation services through the LMHA.

We work with participating behavioral health care practitioners, PCPs, medical/surgical specialists, organizational providers and other community and State resources to develop relevant primary and secondary prevention programs for behavioral health. These programs may include:
- educational programs to promote prevention of substance abuse
- parenting skills training
- developmental screening for children
- ADHD screening
- postpartum depression screening
- depression screening in adults

Assessment instruments for behavioral health
In addition to the Screening tools provided in the Texas Medicaid Provider Procedures Manual at www.tmhp.com, additional tools are included as Appendix B to this manual.

Focus studies and utilization reporting requirements
We have integrated behavioral health into its Quality Assessment and Performance Improvement (QAPI) Program to ensure a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services provided to our Members. A special focus of these activities is the improvement of physical health outcomes resulting from behavioral health integration into the Member’s overall care. Aetna Better Health will routinely monitor claims, encounters, referrals and other data for patterns of potential over and underutilization, and target areas where opportunities to promote efficient and effective use of services exist.

Member Discharged From Inpatient Psychiatric Facilities
We require that all Members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Aetna Better Health providers will follow-up with Medicaid members within 24 hours and attempt to reschedule missed appointments.
**Value-added services**
Screenings for Behavioral Health issues are conducted with all members screened for Case Management beginning with the Health Risk Questionnaire (HRQ). If the HRQ reveals potential areas of concern, additional assessments are completed. Disease Management education is offered to members through verbal and written instructions. Referrals to case management are made by PCP’s and specialists, other departments within the health plan, and upon admission to an inpatient facility. Participation by the member is voluntary.

**Utilization Management reporting requirements**
Utilization trending and reporting is conducted by Medical Management on key metrics such as Average Length of Stay, Bed Days per 1000, and *Readmissions within 30 days*. Data is trended and reported by category: Medical-Surgical, NICU, ICU, Nursery, Mental Health and Maternity.

**Health and Behavior Assessment and Intervention (HBAI) services**
HHSC implemented a new benefit, Health and Behavior Assessment and Intervention (HBAI), in Texas Medicaid on April 1, 2014.

HBAI services are provided by a licensed practitioner of the healing arts (LPHA) who is co-located in the same office or building complex as the client’s primary care provider (PCP). These services are designed to identify and address the psychological, behavioral, emotional, cognitive and social factors important to prevention, treatment or management of physical health symptoms. HBAI is an adjunct to other services, and is to be used as a non-intensive means to identify specific needs, and as appropriate, the client should be referred for those additional services that would meet the client’s biopsychosocial needs.

- HBAI services may be reimbursed to the following provider types in the office and outpatient hospital setting:
  - Physician Assistant (PA)
  - Nurse Practitioner/Clinical Nurse Specialist (NP/CNS)
  - Licensed Professional Counselor/Licensed Marriage Family Therapist (LPC/LMFT)
  - Comprehensive Care Program (CCP) Social Worker
  - Physician (D.O.)
  - Physician (M.D.)
  - Physician Group (D.O.s Only)
  - Physician Group (M.D.s Only and Multispecialty)
  - Psychologist
  - Psychology Group
  - Licensed Clinical Social Worker (LCSW)
  - Federally Qualified Health Centers (FQHC)
  - Rural Health Clinic (RHC) - Freestanding/Independent
  - Rural Health Clinic (RHC) - Hospital Based

**HBAI services provided by psychologists**
HBAI services (procedure codes 96150, 96151, 96152, 96153, 96154, and 96155) may be a benefit when provided by psychologist, provisionally licensed psychologist (PLP), or licensed psychological assistant (LPA) providers who are practicing under the direct supervision of a psychologist.
Quality assessment and performance improvement

What is quality?
Quality health care means doing the right thing, at the right time, in the right way, for the right person – and having the best possible results. Although we would like to think that every health plan, doctor, hospital, and other provider gives high quality care, this is not always so. Quality varies for many reasons.

The Quality Improvement Program is tailored to the unique needs of the membership, in terms of age groups, disease categories and special risk status. Aetna Better Health complies with all State and federal requirements regarding Quality Improvement (QI). The QAPI Program is overseen by the governing board and committees whose membership broadly represents the network of participating providers and Members.

Our goals for improvement: (Excerpt: Crossing the Quality Chasm, A New Health System for the 21st Century, Institute of Medicine, 2001, National Academy of Sciences).

- **Safe** – avoiding injuries to patients from the care that is intended to help them.
- **Effective** – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding overuse and underuse)
- **Patient Centered** – providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.
- **Timely** – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

Aetna Better Health achieves these goals by developing evidence about which interventions are most effective, developing quality measures, working with frontline clinicians, health care organizations, health leaders, and through close collaborations with the HHSC Quality Division and the Institute of Child Health Policy.

Fortunately, there are scientific ways to measure health care quality. These tools have mostly been used by health professionals and nationally recognized organizations such as NCQA and AHRQ. They use measures to review and improve the quality of care provided. Quality measurement is a relatively new science and requires a large amount of resources to develop and collect information. Fully developed and tested measures are available for reporting on some of the most common conditions or processes of care.

The Chief Medical Director is directly responsible for the Quality Improvement Program. The QAPI Program is directed by a multidisciplinary committee whose Members bring a diversity of knowledge and skills to the design, oversight, and evaluation of the program.

The QI Committee and other QI sub-committees include input from Members, clinical practitioners and others who are involved in the provision of care and service to Aetna Better Health Medicaid and CHIP Members.

All aspects of Member care and satisfaction are important to us. The monitoring and evaluation of clinical care encompass all components of the delivery system and the full range of services. The delivery system includes both individual practitioners and institutional providers. The monitoring and evaluation of services includes availability, accessibility, and acceptability services delivered in the appropriate manner.
Satisfaction with the healthcare experience: Member surveys are conducted annually to further evaluate their experiences with the delivery of care and services. A third party NCQA Certified vendor reports member satisfaction via the CAHPS. Focused groups and Member Advisory Committee is another source of obtaining direct feedback on the experience of care and service. A variety of techniques are used to gather suggestions from Members in order to identify and meet their needs. These may include, but are not limited to:

- Satisfaction surveys;
- Focus groups;
- Member advisory councils;
- Member representation on QI Committees and selected QI Work Teams.

Annually, demographics and health risks of enrolled populations are accessed, and meaningful clinical issues are chosen that reflect the health needs of significant groups within that population. High risk, high volume, problem prone diagnoses, preventive health and acute and chronic conditions are monitored and evaluated.

Continuity and coordination of care is evaluated across health care settings and practitioners. Methods may include medical record review for presence of advance directives, discharge plans and signing of abnormal test results; evaluation of the referral process, case management interventions and systems for tracking and notifying practitioners of abnormal lab/radiology results.

Mechanisms are also in place to identify patterns of under-and over-utilization. Methods may include physician profiles, review of practitioner performance against practice guidelines, trending of complaint data, sentinel events and adverse outcomes and number of Member encounters per Primary Care Provider. Access and availability of care are monitored through appointment availability for preventive care, routine primary and urgent care, 24 hour access, number and geographic distribution of primary care providers and high volume specialists, and telephone service standards. For more detailed access requirements, please see the Primary Care Provider Responsibilities section of this manual.

Medicaid and CHIP Provider participation in Aetna Better Health and HHSC sponsored training programs, as well as the aforementioned issues are carefully scrutinized. We work in conjunction with its physician and facility partners to maintain a program of the highest quality. All Aetna Better Health Medicaid and CHIP network providers are required to comply with our QAPI program requirements.

Aetna Better Health strives to partner with our network providers, informing them of new initiatives and results, continuing to re-evaluate in accordance with the Plan, Do, Study, and Act improvement cycle. Physicians interested in participating with the Provider/Medical Advisory Committee should contact their Provider Relations Representative and/or the Chief Medical Officer.

**Practice Guidelines**

Clinical Practice Guidelines summarize evidence-based management and treatment options for specific diseases or conditions. They are based on scientific clinical and expert consensus information from nationally recognized sources and organizations, national disease associations, and peer-reviewed, published literature.

Practice guidelines are developed nationally and adopted locally through Medical Advisory Committees that include practicing physicians who participate in the Plan. This group also suggests topics for guideline development, based on relevance to enrolled membership, with selection of high volume, high risk, problem prone conditions as the first priority.
The Aetna Better Health Medicaid and CHIP programs have adopted the following guidelines:


- **Addiction** – American Society of Addiction Medicine Behavioral Health Checklist for ASAM Adult Patient Placement Criteria-Second Edition Revised. This guideline can be found online at: [http://www.asam.org/](http://www.asam.org/)

- **Asthma**: National Heart Lung and Blood Institute (NHLBI) Full text and a summary report of the guidelines, along with supporting material and tools can be found at [https://www.nhlbi.nih.gov/guidelines/asthma/](https://www.nhlbi.nih.gov/guidelines/asthma/)

- **Attention-Deficit/Hyperactivity Disorder** - American Academy of Pediatrics (AAP): Diagnosis, Evaluation and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in Children and Adolescents, October 2011. This guideline can be found online at [http://pediatrics.aappublications.org/content/128/5/1007.full.html](http://pediatrics.aappublications.org/content/128/5/1007.full.html)

- **Coronary Artery Disease** - American Heart Association/American College of Cardiology Foundation (AHA/ACCF) Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular disease: 2011. This guideline can be found online at [http://circ.ahajournals.org/content/124/22/2458](http://circ.ahajournals.org/content/124/22/2458)

- **Diabetes**: The current edition of the American Diabetes Association (ADA) Standards of Medical Care in Diabetes – 2014. You can find the full text of this guideline online at [http://care.diabetesjournals.org/content/37/Supplement_1/S14.full](http://care.diabetesjournals.org/content/37/Supplement_1/S14.full)

- **Treatment of Patients with Major Depressive Disorders**: American Psychiatric Association (APA) Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition. You can find the full text of this guideline at [http://psychiatryonline.org/guidelines.aspx](http://psychiatryonline.org/guidelines.aspx) The intent of the guidelines is to promote a consistent application of evidence-based treatment methodologies to reduce unnecessary practice variation. Guidelines are always included in the development of new interventions and study projects. The guidelines are provided for informational purposes and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of physicians or health care professionals, and these guidelines do not dictate or control the clinical judgment of the health care professionals caring for a Member.

**Preventive Services Guidelines**

It is widely known that providing primary prevention services, such as adult and childhood immunizations, can result in the reduction of 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. Aetna has adopted the U.S. Preventive Services Task Force Preventive Service Guidelines which can be found at: [http://www.uspreventiveservicestaskforce.org/recommendations.htm](http://www.uspreventiveservicestaskforce.org/recommendations.htm)

Centers for Disease Control and Prevention which can be found at: [http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html)

National Cancer Institute which can be found at: [http://www.cancer.gov/cancertopics/factsheet/detection/mammograms](http://www.cancer.gov/cancertopics/factsheet/detection/mammograms)

**Aetna Better Health Medicaid Pediatric Preventive Health – Texas Health Steps** Medical checkup services are covered for clients younger than age 21 when delivered in accordance with the Texas Health Steps periodicity
The periodicity schedule specifies the screening procedures recommended at each stage of the Member’s life and identifies the time period based on the Member’s age when medical checkup services are reimbursable. All the checkups listed on the periodicity schedule have been developed based on the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code; the standards in the ACIP Immunization Schedule and the DSHS Periodicity Schedule. Current schedules are available on the DSHS website: http://www.dshs.state.tx.us/immunize/default.shtm. The current edition of the Texas Health Steps periodicity schedule is also provided in Appendix C.

In acknowledgment of the practical situations that occur in the office or clinic settings, the periodicity schedule published in this manual has stressed the philosophy that the components of the Texas Health Steps medical checkup should be completed according to the individual child’s appropriate needs. If a component cannot be completed because of a medical contraindication of child’s condition, then a follow-up visit is necessary.

The required components of the Texas Health Steps checkups are described under the Texas Health Steps Section in this manual.

The screening provider is responsible for administration of immunizations. Referring children to local health departments to receive the immunizations is discouraged. For children not previously immunized, HHSC requires immunizations be given unless medically contraindicated or against parental religious beliefs.

Annual examinations for adolescents have been included in the periodicity schedule to emphasize the AAP recommendation that comprehensive checkups be performed annually. The AAP continues to emphasize the importance of separate counseling and anticipatory guidance for the child and the accompanying parent/guardian during the adolescent years. Refer to the Texas Medicaid Provider Procedures Manual – Texas Health Steps about information specific to adolescents’ medical checkups. Providers are encouraged to emphasize the educational components based on a comprehensive risk assessment.

Providers must be enrolled as Medicaid and Texas Health Steps-participating providers in order to submit claims to receive reimbursement for medical checkups. The primary responsibilities of Texas Health Steps providers are:

- to conduct medical checkups according to policies and procedures established by DSHS
- to provide clinic surroundings which will establish a positive relationship between clinic personnel, the recipient, and the recipient’s family
- to interpret medical checkup results to the recipient or the recipient’s parent, conservator, or responsible adult, during the course of the medical checkup
- to make referrals for needed follow-up diagnosis and treatment services
- to ensure a recipient under age 15 is accompanied by a parent, guardian or authorized adult at a Texas Health Steps medical checkup unless the services are provided by an exempt entity and if the exempt entity obtains written consent to the services, which has not been revoked, from the child’s parent or guardian within the one- year period prior to the date the services are provided
- encourages parental involvement in and management of the health care of the children receiving services from the exempt entity.

Texas Health Steps providers must send all Texas Health Steps newborn screens to DSHS, Bureau of Laboratories or a DSHS-certified laboratory.

Providers must include detailed identifying information for all screened newborn Members and each Member’s mother to allow HHSC to link the screens performed at the hospital with screens performed at the
two week follow-up.

**Aetna Better Health CHIP Pediatric preventive health**

We adopt clinical preventive services recommendations from federal agencies and medical professional organizations. Providers delivering well-child care to Aetna Better Health CHIP Members are encouraged to use the American Academy of Pediatrics (AAP) preventive health guidelines. We recommend fully immunizing children according to the recommendations of the AAP to help protect members from infections that can lead to serious and even life threatening complications. The AAP guidelines for screening exams and anticipatory guidance are also useful tools to help in the early identification and prevention of illness and injury from birth through adolescence. The AAP guidelines are included in Appendix C.

The recommended childhood and adolescent immunization schedule of the American Academy of Pediatrics is issued annually and available online at [www.aap.org](http://www.aap.org). These general preventive services guidelines are recommended for healthy children for the prevention and early detection of conditions and diseases. Patients with high-risk conditions are encouraged to talk with their health care provider about the guidelines to determine what is appropriate for their individual needs.

**ImmTrac**

ImmTrac, the Texas immunization registry, is a no-cost service offered by the Texas Department of State Health Services (DSHS). It is a secure and confidential registry available to all Texans. ImmTrac safely consolidates immunization records from multiple sources throughout the State. Texas law states that health care providers must report to ImmTrac all vaccines administered to a child less than 18 years of age within 30 days of administration. ImmTrac allows providers to search for immunization histories on new patients that have changed physicians or moved into a new community and provides a method for doctors to send recall and reminder notices of pending or overdue immunizations. ImmTrac is available free of charge to authorized health care providers. Further information about ImmTrac is available at [http://www.dshs.state.tx.us/immunize/immtrac/imm_provider.shtm](http://www.dshs.state.tx.us/immunize/immtrac/imm_provider.shtm)

**Aetna Better Health Medicaid adult preventive health and wellness**

An annual adult physical exam performed by the Member’s primary care provider is a benefit for Aetna Better Health’s Medicaid Members age 21 years and older. The annual physical exam is performed in addition to family planning services. This service is provided for the purpose of promoting health and preventing injury of illness. The annual examination should be age and health risk appropriate and should include all clinically indicated elements of history, physical examination, laboratory/diagnostic examinations and patient counseling that are consistent with good medical practice. We have adopted the U.S. Taskforce guidelines which are available at [http://www.ahrq.gov/clinic/pocketgd07/index.htm](http://www.ahrq.gov/clinic/pocketgd07/index.htm).

**Confidentiality**

Aetna Better Health network providers must treat all information that is obtained through the performance of health services as confidential information to the extent that confidential treatment is provided under state and federal laws, rules and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs.

Aetna Better Health network providers shall not use information obtained through the performance of Aetna Better Health in any manner except as is necessary for the proper discharge of obligations and securing of rights.
Privacy practices
Protecting our Member’s health information is one of Aetna Better Health’s top priorities. To this end, Aetna Better Health Members receive the following notification about our policy regarding the confidentiality of Member information.

This notice describes how medical information about a member may be used and disclosed and how a member can get access to this information. Please review it carefully.

Aetna Better Health privacy notice
At Aetna Better Health we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice. This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about “information” or “health information” in this notice we mean the following:
- Information about you that has been created or received by us and that relates to your health condition(s), or to the provision of health care to you, or to the payment for such health care.

How we use or share information
The following are ways we may use or share information about you:
- For Payment Purposes: We may use the information to help pay your medical bills that have been submitted to us by doctors and hospitals for payment.
- For Treatment Purposes: We may share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, we may give them access to any medical records sent to us by your doctor. Behavioral Health Information will only be shared without the member’s permission in clinically appropriate and urgent situations that would improve the member’s health outcome.
- For Health Care Operations: We may use or share your information with others to help manage your health care. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health. Behavioral Health Information will only be shared with a non-behavioral health provider with the member’s permission if required. BH information without member’s permission may only be shared in a clinically appropriate and urgent situation that would improve the member’s outcome.
- With Our Business Associates/Contractors: We may share your information with others who help us conduct our business operations. We will not share your information with these outside groups unless they agree to keep it protected.
- For the Promotion of Health Maintenance and Wellness: We may use or share your information to send you a reminder if you have an appointment with your doctor. We may also use or share your information to give you information about alternative medical treatments and programs or about health related products and services that you may be interested in. For example, we might send you information about smoking cessation or weight loss programs.

There are also state and federal laws that may require us to release your health information to others. We may be required to provide information for the following reasons:
- We may report information to state and federal agencies that regulate us such as the U.S. Department of Health and Human Services, and the Texas Health and Human Services Commission.
• We may share information for public health or disaster relief activities. For example, we may report information to the Food and Drug Administration for investigating or tracking of prescription drug and medical device problems.
• We may report information to public health agencies if we believe there is a serious health or safety threat.
• We may share information with a health Oversight agency for certain oversight activities (for example, audits, inspections, licensure and disciplinary actions).
• We may provide information to a court or administrative agency (for example, pursuant to a court order, search warrant or subpoena).
• We may report information for law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
• We may report information to a government authority regarding child abuse, neglect or domestic violence.
• We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
• We may use or share information for procurement, banking or transplantation of organs, eyes, or tissue.
• We may share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
• We may report information on job-related injuries because of requirements of your state worker compensation laws.
• We will comply with any state laws that are more restrictive regarding the permissible uses and disclosures of your health information, such as state laws relating to mental health and substance abuse records.

If none of the above reasons for using or disclosing your health information applies, we must get your written permission to use or disclose your health information. If you give us written permission and later change your mind, you may revoke your written permission at any time. However, your revocation will not affect the uses or disclosures that were made pursuant to your written permission.

What are your rights
The following are your rights with respect to your health information. If you would like to exercise the following rights, please contact Aetna Better Health at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar). You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your request, we are not required to agree to these restrictions. You have the right to ask to receive confidential communications of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.

You have the right to inspect and obtain a copy of information that we maintain about you in your designated
A “designated record set” is the set of information that includes your health information and that either (i) is enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for us or (ii) is used, in whole or in part, by or for us to make decisions about you. However, you do not have the right to access certain types of information and we may decide not to provide you with copies of the following information:

- Contained in psychotherapy notes;
- Compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and
- Subject to certain federal laws governing biological products and clinical laboratories.

In certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed. You have the right to ask us to make changes to information we maintain about you in your designated record set. These changes are known as amendments. We may require that your request be in writing and that you provide a reason for your request. We will respond to your request no later than 60 days after we receive it. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay and the date by which we will complete action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you.

If we deny your request to amend your record, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to respond to your statement. However, you have the right to request that your written request, our written denial and your statement of disagreement be included with your information for any future disclosures. You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. Please note that we are not required to provide you with an accounting of the following disclosures:

- Any disclosures that were made prior to April 14, 2003;
- Information disclosed or used for treatment, payment, and health care operations purposes;
- Information disclosed to you or pursuant to your authorization;
- Information that is incident to a use or disclosure otherwise permitted;
- Information disclosed for a facility’s directory or to persons involved in your care or other notification purposes;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies; or
- Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We may require that your request be in writing. We will act on your request for an accounting within 60 days. We may need additional time to act on your request. If so, we may take up to an additional 30 days. Your first accounting will be free. We will continue to provide you with one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.
You have a right to receive a copy of this notice upon request at any time. You can also view a copy of the notice on our web site at www.aetnabetterhealth.com. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by direct mail and post it on our website.

Exercising your rights
If you have any questions about this notice or about how we use or share information, please contact Aetna Better Health Member Services at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar). Our office is open Monday through Friday from 8 a.m. to 5 p.m. If you believe your privacy rights have been violated, you may file a complaint with us by calling 1-800-306-8612 or mail your written complaint to:

Aetna Better Health
Attention Member Advocate
PO Box 569150
Dallas, Texas 75356-9150

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint at the following address:

Office of Civil Rights – Region VI U.S. Department of Health and Human Services
1301 Young Street
Suite 1169
Dallas, Texas 75202
Phone: 214-767-4056; TTY: 214-767-8940
Fax: 214-767-0432

Please be advised: we will not take any action against you for filing a complaint.

Focus study and utilization management reporting requirements
Aetna Better Health conducts focused studies to look at the quality of care and service to our members. The QAPI Program:
1. Evaluates performance using objective quality indicators, such as HEDIS encounter data
2. Fosters data-driven decision-making
3. Recognizes that opportunities for improvement are unlimited
4. Solicits Member and Provider input on performance and Performance Improvement Projects (PIPs)
5. Evaluates clinical and non-clinical effectiveness through HEDIS rates and Member satisfaction
6. Supports programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements
7. Supports remeasurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate

Along with the QAPI Program, Aetna Better Health develops annually a QM Work Plan to track and trend progress throughout the year.

Aetna Better Health works collaboratively with HHSC’s External Quality Review Organization (EQRO) to
develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. Mid-year evaluations allow both the EQRO and the Health Plan to gauge progress with the Performance Improvement Projects (PIP) and hear recommendations for improvement. The purpose of the health care PIPs is to assess and improve processes, and thereby outcomes of care. In order for such projects to achieve real improvement in care, and for interested parties to have confidence in the reported improvements, PIPs are designed, conducted, and reported in a methodologically and systematically sound manner. s PIPs are reported in a format that demonstrates the relevance of the activity, validity of the study design, quantitative and qualitative analysis of results, barrier analysis, determination of opportunity for improvement, and strength of interventions.

Aetna Better Health Provider contracts require cooperation with the QAPI efforts. We routinely update providers on the QAPI program and PIP results/interventions as well as make information available to providers upon requests and when the Medical Directors and QM Staff visit providers’ offices.

**Informed consent**
All participating physicians and other health care professionals should understand and comply with applicable legal requirements regarding patient informed consent, and adhere to the policies of the medical community in which they practice and/or hospitals where they have admitting privileges. In general, it is the participating physician’s duty to give patients adequate information and be reasonably sure the patient understands this information before proceeding to treat the patient.

**Physician–Member communications**
Aetna Better Health providers are encouraged to discuss pertinent details regarding the diagnosis of the patient’s conditions, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment. This open communication is designed to give our Members the comfort of knowing their providers have the right and the obligation to speak freely with them.

**Primary Care Provider (Medical Home) responsibilities**
A medical home is an approach to providing comprehensive primary care and is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally sensitive. In a medical home, the Primary Care Provider works in partnership with the Member and the Member’s family to assure that all of the medical and non-medical needs of the Medical are met. Through this partnership, the Primary Care Provider can help access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the Member.

Practitioners from any of the following practice areas may act as primary care providers for Aetna Better Health Medicaid and CHIP Members: general practice, family practice; internal medicine; pediatrics; obstetrics/gynecology (Ob/Gyn); certified nurse midwives (CNM), pediatric and family advanced practice nurses and physician assistants (PA) practicing under the supervision of a physician, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) or similar community clinics; and, with approval by the Aetna Better Health Medical Director, specialists who are willing to provide the primary care services for selected Members who are chronically ill, medically complex or have other special health care needs. The Primary care provider has the following responsibilities:

- Provide for access to medical care 24-hours-a-day, 7-days-a-week
• Provide all age appropriate primary care covered services within the scope of the physician’s practice, including appropriate health education and instructions to the Member, or if the Member is a child or other dependent, to family members or primary caregivers.
  — For Members under the age of 21, the Primary Care Provider will provide well child health checkups in accordance with the American Academy of Pediatric recommendations for CHIP members and Texas Health Steps checkups in accordance with the STAR members.
  — For Members under the age of 21, the Primary Care Provider must either be enrolled as a Texas Health Steps provider or refer Members due for a Texas Health Steps checkup to a Texas Health Steps provider.
  — For adult Members over the age of 21, the Primary Care Provider provides adult health care oversight and appropriate care according to the U.S. Preventive Services Task Force.
• Provide or arrange for the provision of services to Members assigned to their panel. Covered services are detailed in the current year Texas Medicaid Provider Procedures Manual at www.tmhp.com and summarized under the “Covered Services” in this manual.
• Refer to Aetna Better Health participating specialists and other providers when services are indicated.
• Seek prior authorization from Aetna Better Health when referring to nonparticipating providers.
• Initiate the request for authorization for services that require prior approval.
• Facilitate ongoing communication between the primary care provider and specialty care providers while the Member is undergoing specialty care. Assure appropriate transfer of medical information between the primary care providers, specialty care providers, and ancillary care providers.
• Recognize the role that the family members have as primary caregivers for children and other dependents and ensure their participation in decision making.
• Assure integration of Member’s medical home needs with home and community support services.
• Provide information concerning appropriate support services (for example, WIC, ECI, etc.) within the community. In the case of children with Texas Health Steps benefits, include coordination with existing State agency approved providers and/or case managers within ECI, DARS, TCB, and the DSHS targeted case management program for high risk pregnant women and infants, where appropriate.
• Coordinate care for hospitalized Members.
  — assure that pre-admission planning occurs for the Member in all non-emergency hospital admissions.
  — assure that discharge planning is conducted for each admitted Member.
  — assure that the home and community arrangements are available prior to the hospital discharge of the Member.
• Member.
  — assist in the development of alternatives to hospitalization when medically appropriate.
• Provide timely follow-up after emergency care or hospitalization.
• Comply with requirements as outlined as the Primary Care Provider, you must provide telephone access to Members 24-hours-a-day, 7-days-a-week.

**Contract effective date**

New providers who enter into a valid contract and have been credentialed by Aetna Better Health will be assigned a network participation effective date. The provider’s effective date will be fifteen (15) business days from the date the provider was credentialed or the date a valid contract and documentation was received by Aetna Better Health, whichever is later.

For existing Aetna Better Health providers that have notified us of their request to be added as STAR participating providers, provider’s effective date will be fifteen (15) business days from the date valid
documentation was received by Aetna Better Health.

**Credentialing process**

Once an application to participate as an Aetna Better Health Medicaid or CHIP provider has been submitted, our credentialing processes are designed to evaluate the qualifications of physicians who apply for participation.

These processes assess the physician’s ability to deliver quality care and services to their patients. Our process does not discriminate against physicians or other health care professionals who serve high-risk populations or who specialize in the treatment of patients with costly conditions.

We verify licensure and other required credentials, office standards and professional competence and conduct as part of its comprehensive credentialing process. All applicants are reviewed by a credentialing committee of their peers and are notified of the outcome.

The credentials of participating providers are also re-reviewed on a periodic basis. In addition to verifying credentials, the re-credentialing process incorporates additional information related to patient complaints, results of quality reviews, utilization management, and Member satisfaction surveys.

All of the information obtained during the credentialing and re-credentialing processes is confidential. Participating Aetna Better Health providers may not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A “thing of value” means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law.

We may terminate a provider’s contract at any time for violation of this requirement.

**Availability and accessibility**

Primary Care Providers 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 Primary Care Provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating physicians must be arranged. If a member is referred to another Primary Care Provider who is not on record as a covering provider, a referral must be submitted to the Aetna Better Health Prior Authorization unit to prevent a delay in payment.

**After hours access**

The following are acceptable and unacceptable phone arrangements for contacting primary care physicians after normal business hours.

**Acceptable:**

1. Office phone is answered after hours by an answering service, in English, Spanish or other languages of the major population groups served, that can contact the Primary Care Provider or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes.

2. Office phone is answered after normal business hours by a recording in English, Spanish and other languages of the major population groups served, directing the Medical to call another number to reach
the Primary Care Provider or another designated provider. Someone must be available to answer the designated provider’s phone. Another recording is not acceptable.

3. Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the Primary Care Provider or another designated medical practitioner.

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

**Appointment Availability**
Providers are expected to adhere to the following appointment availability standards

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Waiting Times for Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>Upon Member presentation at the service delivery site</td>
</tr>
<tr>
<td>Urgent Care (Medical and Behavioral)</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Routine Medical Care</td>
<td>Within 14 days of request</td>
</tr>
<tr>
<td>Routine Behavioral Health Care</td>
<td>Within 14 days of request</td>
</tr>
<tr>
<td>Members under the age of 21, including Texas Health Steps services</td>
<td>Steps Periodicity Schedule and the American Academy of Pediatrics guidelines, but in no case later than 60 days from date of request. For newly enrolled members, appointments must be offered within ■14 days of enrollment for newborns; ■90 days for all others</td>
</tr>
<tr>
<td>Adult Preventive Health Physicals/Well-child checkups for Members over the age of 21</td>
<td>Within 90 days of request. For high-risk pregnancies or new Members in the third trimester, appointments should be offered immediately, but no later than within 9 days of request. As soon as possible for Members who are due or overdue for services in accordance the Texas Health</td>
</tr>
</tbody>
</table>

**Patient capacity**
There is no Member capacity limit for Medicaid or CHIP providers. However, we and HHSC will monitor for accessibility and quality of care. If HHSC determines that the provider is unable to provide acceptable care and access to current membership, the provider panel will be reduced through an enrollment freeze. If the quality of care for Members is jeopardized, HHSC may disenroll Members from the provider’s panel.

**Updates to contact information**
Network providers must inform both the MCO and HHSC’s administrative services contractor of any changes
to the provider’s address, telephone number, group affiliation, etc. Providers can call Provider Services at 1-
800-306-8612 Tarrant County or 1-800-248-7767 Bexar County service areas to request the Aetna
Demographic Form for Provider adds, terms, or changes. The Aetna Demographic Form can be faxed to 1-866-
510-3710 or e-mailed to TXProviderEnrollment@aetna.com.

**Provider termination from plan**

Physicians and other providers must inform Aetna Better Health in writing of their intent to terminate their
participation with us at least 90 days prior to termination from the plan. This information can be sent to:

Aetna Better Health Provider Relations
PO Box 569150
Dallas, TX 75356-9150
Fax: 1-866-510-3710

Within 15 calendar days after receipt or issuance of a termination notification, we will notify 1) all Members in
a PCP’s panel and 2) all Members who have had two or more visits with the Network Provider for home-based
or office-based care in the past 12 months and assist them in selecting new providers or coordinate the
transition of care.

**Plan initiated provider termination**

Aetna Better Health will follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating
a contract with a provider, including a Significant Traditional Provider (STP). At least 90 days before the
effective date of the proposed termination of the provider’s contract, Aetna Better Health will provide a
written explanation to the provider of the reasons for termination. Aetna Better Health may immediately
terminate a provider contract if the provider presents imminent harm to patient health, actions against a
license or practice, fraud or malfeasance.

Not later than 30 days following receipt of the termination notice, a provider may request a review of Aetna
Better Health’s proposed termination by an advisory review panel, except in a case in which there is imminent
harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must
be composed of physicians and providers, as those terms are defined in §843.306 of the Texas Insurance Code,
including at least one representative in the provider’s specialty or a similar specialty, if available, appointed to
serve on the standing quality assurance committee or utilization review committee of Aetna Better Health.
The decision of the advisory review panel must be considered by Aetna Better Health but is not binding on us.
Within 60 days following receipt of the provider’s request for review and before the effective date of the
termination, the advisory review panel must make its formal recommendation, and we must communicate our
decision to the provider. We must provide to the affected provider, on request, a copy of the recommendation
of the advisory review panel and Aetna Better Health’s determination.

Network Providers may not offer or give anything of value to an officer or employee of HHSC or the State of
Texas in violation of state law. A “thing of value” means any item of tangible or intangible property that has a
monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and
charitable contributions. The term does not include contributions to public office holders or candidates for
public office that are paid and reported in accordance with state and/or federal law. Aetna Better Health may
terminate this Network Provider contract at any time for violation of this requirement.
**Members right to select network ophthalmologist**
Aetna Better Health allows members the right to select and have access to, without a Primary Care Provider referral, a network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery.

**Member’s right to obtain medication from any network pharmacy**
All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

**Member’s right to designate an Ob/Gyn**
Aetna Better Health allows the member to pick any Ob/Gyn, whether that doctor is in the same network as the Member’s Primary Care Provider or not.

**ATTENTION FEMALE MEMBERS**
Members have the right to pick an Ob/Gyn without a referral from their Primary Care Provider. An Ob/Gyn can give the member:
- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

**Family planning**
If an Aetna Better Health Medicaid Member requests contraceptive services or family planning services, the Aetna Better Health Medicaid network providers must also provide the Member counseling and education about family planning and available family planning services. Network providers cannot require parental consent for Members who are minors to receive family planning services. Network Providers must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Aetna Better Health Medicaid Members. Members have the right to choose any Medicaid participating family planning provider whether in or out of network.

**Member information on Advance Directives**
The Patient Self-Determination Act is a federal law designed to raise public awareness of Advance Directives. An Advance Directive is a written statement, completed in advance of a serious illness, about how one would want medical decisions made if he/she is incapable of making them. The two most common forms of Advance Directives are the Living Will and the Durable Power of Attorney for Health Care.

The Social Security Act Section 1902(a)(57) and Section 1903 (m)(1)(A) requires HMOs and providers to maintain written policies for informing and providing written information to all adult Members about their rights under State and Federal law, in advance of their receiving care. These policies must contain procedures for providing written information regarding the Member’s right to refuse, withhold or withdraw medical treatment in advance.

In addition to State laws and rules, Aetna Better Health Medicaid and CHIP policies and procedures must comply with provisions contained in 42 CFR Section 434.28 and 42 CFR Section 489, Sub Part I, relating to Advance Directives for all hospitals, critical access hospitals, skilled nursing facilities, home health agencies, providers of home health care, providers of personal care services and hospices.
We will assist the provider in understanding the requirements for Advance Directives and how to follow the laws and rules written for such a purpose. Aetna Better Health Advance Directive policies address:

- The Member’s right to self-determination in making health care decisions;
- The Member’s right under the Natural Death Act (Texas Health and Safety Code Chapter 672) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life sustaining procedures in the event of a terminal condition;
- The Member’s right under Texas Health and Safety Code, Chapter 674, relating to written and non-written Out-of-Hospital Do-Not-Resuscitate Orders;
- The Member’s right to execute a Durable Power of Attorney for Health Care regarding their right to appoint an agent to make medical treatment decisions on their behalf if the Member becomes incapacitated (Civil Practice and Remedies Code, Chapter 135) and procedures for implementing a Member’s Advance Directives, including a clear and concise statement of limitations if the HMO or a participating provider cannot or will not be able to carry out a Member’s Advance Directive.

Aetna Better Health encourages you to discuss Advance Directives with your patients. The Advance Directive Notification should be completed by the patient and returned to the primary care physician so that it may be placed in their medical record. During the credentialing and recredentialing processes, we check for Advance Directives when reviewing medical records of Members over the age of 18 years old.

**Referral to specialists and health-related services**

We are committed to promoting the “medical home” and expect participating primary care providers to direct their patient’s care, including referring members to specialists as needed. A referral is a primary care provider’s request that a member’s covered services be provided by another participating provider. Because the Primary Care Provider is responsible for coordinating his/her patient’s health care, the Primary Care Provider must authorize a referral prior to the visit to a specialist.

The exceptions to the Primary Care Provider referral authorizations are:

- Services the member may access directly without a referral, such as obstetrical care of behavioral health services.
- Services that require prior authorization by the health plan (refer to Medical Management section and current Prior Authorization list)

The Primary Care Provider may authorize a referral to an in-network specialist by completing the Texas Referral/Authorization Form or any other mutually agreed upon format. The referral must include all pertinent clinical information necessary to provide continuity of care and reduce unnecessary duplication of services, such as test results and consultation reports. The referral does not need to specify the services to be performed by the specialist. Services performed in a specialist’s office that are integral to the evaluation of the problem that led to the referral to the specialist are included in the scope of the referral and will be reimbursed according to the standard claim processing guidelines. It is the provider’s responsibility to verify the member’s eligibility and benefits prior to rendering services. It is not necessary for providers to verify authorization for services that are not included on the Aetna Better Health Prior Authorization List.

To encourage communication from the specialist to the Primary Care Provider, it is recommended that the initial consultative referral be authorized for one visit. Following an initial consultation, the specialist should communicate with the referring Primary Care Provider in a timely fashion to develop an appropriate course of treatment (for example, referrals for additional services and/or follow-up care, if needed). It is recommended that referrals for additional visits be for no more than three (3) visits and/or 90 days to ensure the Primary
Care Provider and specialist communicate frequently regarding the health services provided to each member.

Additional referrals may be required if the specialist:
- Wishes to provide additional services other than the outpatient laboratory or diagnostic imaging
- Refers the member to another specialist for services and procedures that are not included in the referral
- Requires additional visits or an extension of the timeframe authorized by the Primary Care Provider.

Coordination of care is vital to assuring Member’s receive appropriate and timely care. Relevant communication between specialist and the Primary Care Provider should be maintained in both provider’s files for the member. Aetna Better Health monitors coordination of care as part of its ongoing quality and utilization management reviews.

Prior authorization is required for certain specialty types (primarily those for which there are limited benefits) and selected procedures. When prior authorization is required, the Primary Care Provider must submit the Texas Referral/Authorization form and all pertinent clinical information that supports the medical necessity of the requested services to the Aetna Better Health Prior Authorization unit for approval. The list of services requiring prior authorization by Aetna Better Health is regularly updated and posted on www.aetnabetterhealth.com.

Please refer to the Medical Management Section of this manual for information about the prior authorization.

**How to help a member find dental care**
The Dental Plan Member ID card lists the name and phone number of a Member’s Main Dental Home provider. The Member can contact the dental plan to select a different Main Dental Home provider at any time. If the Member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan’s system, and the Member is mailed a new ID card within 5 business days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker’s toll-free telephone number at 1-800-964-2777.

**PCP and behavioral health**
Members seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. PCPs are encouraged to treat behavioral health issues that are within their scope of practice and refer Members to behavioral health providers when appropriate.

**Referral to network facilities and contractors**
We contract with Quest Labs (Bexar & Tarrant) and CPL (Bexar only) to perform lab services for Aetna Better Health Medicaid and CHIP members. Each lab will have various draw sites and the Member is able to go the nearest draw site for services.

**Access to second opinion**
Aetna Better Health allows Members access to a second opinion at no additional cost to the Member.

**Responsibility to verify member eligibility and/or authorization for services**
All Members are issued an Aetna Better Health Medicaid or CHIP ID card (samples in Appendix A) at the time of enrollment with us.
Eligibility should be verified prior to rendering services through the following resources:
- Utilize the Aetna Better Health website at www.aetnabetterhealth.com
- Visit TexMedConnect on the Texas Medicaid & Healthcare Partnership (TMHP) website.
- Call the TMHP Contact Center at 1-800-925-9126.
- Call Automated Inquiry System (AIS) at 1-800-925-9126
- Through the monthly enrollment panel provided by Aetna Better Health
- Contact Aetna Better Health at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar)

Once the Aetna Better Health Medicaid or CHIP Member presents for Services:
- Confirm the patient is an Aetna Better Health Medicaid or CHIP Member.
- Upon arrival for their appointment, ask the Member to show their Aetna Better Health Medicaid ID card. If a CHIP member, ask the member to show their Aetna Better Health CHIP ID card.
- Verify Member eligibility with Aetna Better Health through the monthly enrollment panel provided by Aetna Better Health, use of the Aetna Better Health website (www.aetnabetterhealth.com) to verify eligibility.

**Continuity of care pregnant women**
Aetna Better Health allows pregnant members past the 24th week of pregnancy to remain under the care of their current Ob/Gyn through the Member’s postpartum checkup, even if the provider is out-of-network. She may select an Ob/Gyn within the network if she chooses to do so and if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

**Member moves out-of-service area**
Members who move out of the service area are responsible for obtaining a copy of their medical records from their current primary care provider to provide to their new primary care provider. Participating providers must furnish Members with copies of their medical records.

**Pre-existing condition**
Aetna Better Health does not have a pre-existing condition limitation. We are responsible for providing all covered services to each eligible Member beginning on the Member’s date of enrollment into the Aetna Better Health Medicaid or CHIP programs, regardless of any pre-existing conditions, prior diagnosis and/or receipt of any prior health services.

Coverage will be authorized for care being provided by nonparticipating providers to Members who are in an “active course of treatment” at the time of enrollment until the Member’s records, clinical information and care can be transferred to a network provider or until such time the Member is no longer enrolled in the plan. Coverage will be provided until the active course of treatment has been completed or 90 days, whichever is shorter.

Out-of-network care will be coordinated for Members who have been diagnosed and are receiving treatment for a terminal illness at the time of enrollment for up to nine months or until they are no longer enrolled in the plan.

“Active Course of Treatment” is defined as:
- A planned program of services rendered by a physician, behavioral health provider or DME provider
• Starts on the date a provider first renders a service to correct or treat the diagnosed condition, and
• Covers a defined number of services or period of treatment
• Allowing a pregnant woman to remain under the Member’s current Ob/Gyn care through the Member’s post-partum checkup even if the Ob/Gyn provider is, or becomes, out-of-network

In order to provide transitional coverage for the nonparticipating provider, the following conditions must be met. The Member must:
• Be enrolling as a new Member, and receiving ongoing treatment for a chronic or acute medical condition from a nonparticipating provider
• Have initiated an “active course of treatment” prior to the initial enrollment date.

If services are received prior to the approval of transition of benefits, the services must be approved by the Medical Director in order for coverage to be extended at the new Plan level. The Aetna Better Health Medical Management department will coordinate all necessary referrals, or any other authorizations so that the continuity of care is not disrupted.

In order for a nonparticipating provider to continue treating Plan Members during a transition period, the provider must agree to:
• Continue to provide the Members’ treatment and follow-up
• Accept Plan rates and/or fee schedules
• Share information regarding the treatment plan with the Plan
• Use the Plan network for any necessary referrals, lab work or hospitalizations.

Any exceptions will be reviewed on a case-by-case basis by the Medical Management staff in consultation with the Medical Director. All requests that do not meet the conditions for continuity of care will be forwarded to the Medical Director who will review the request on a priority basis.

**Medical record standards**

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals agree to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services.

Medical Record Criteria has been established to provide guidelines for fundamental elements of organization, documentation of diagnostic procedures, treatment, communication and storage of medical records. Performance goals related to the quality of medical record keeping practices are established and distributed on an annual basis. A copy of the established standards for medical record criteria is included in Appendix D.

Aetna Better Health shall have access to medical records, including confidential Aetna Better Health patient information, for the purpose of claims payment, assessing quality of care, including medical evaluations and audits, and performing utilization management functions. HIPAA Privacy Regulations allow for sharing of personal health information with Aetna Better Health for the purposes of making decisions around treatment, payment or health plan operations. Personal health information must be treated as confidential in accordance with the Aetna Better Health provider agreement. Personal Health Information identifies a Member; specifies the relationship of the Member with Aetna Better Health:

addresses physical or behavioral health status or condition; and specifies payment for the provision of health
care to the Member. These requirements survive the termination of the provider’s contract, regardless of the cause for termination.

As part of the agreement to participate in Texas Medicaid and CHIP, the Aetna Better Health Medicaid and/or CHIP network provider agrees to provide HHSC:

1. All information required under the Aetna Better Health provider agreement, including but not limited to the reporting requirements and other information related to the Network provider’s performance of its obligations under the contract.
2. Any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.

All information must be provided in accordance with the timelines, definitions, formats and instructions specified by HHSC. The Aetna Better Health Medicaid or CHIP network provider shall not transfer an identifiable Member record, including a patient record, to another entity or person without written consent from the Member or someone authorized to act or his or her behalf; however, the Provider understands and agrees that HHSC may ask to transfer a Member record to another agency if HHSC determines that the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the Member.

**Out-of-network referrals**

If a required service is not available within the Aetna Better Health Medicaid or CHIP network, the Member’s primary care provider may request an out-of-network referral. However, the primary care provider must obtain authorization from the Aetna Better Health Medical Management Department.

The steps for an out-of-network referral are as follows:

1. The Member’s Primary Care Provider must complete a referral request and specify the services required of the out-of-network provider including the rationale for requesting out-of-network services.
2. The Primary Care Provider can call Medical Management or fax the referral form and all pertinent clinical information to the Aetna Better Health Medical Management Department by calling 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) or faxing 1-866-835-9589 to obtain authorization.
3. The Primary Care Provider will provide authorization information to the specialist.
4. The out-of-network referral is valid for 90 days for a maximum of three visits unless otherwise authorized by the Medical Management Department. A new authorization must be obtained if the original authorization is over 60 days old or if more than two visits are required, unless additional visits have been authorized by the Medical Management Department.
5. Medical Management Department.

**Primary Care Physician panel status changes**

Follow this procedure to change the enrollment status of a primary care office. Ninety days prior written notice of a change of the panel status of a provider office is required.

1. Call or send a letter notifying us of your request.

   Aetna Better Health
   Provider Relations
   PO Box 569150
2. Indicate the status you are requesting for your office:
   “Open” status indicates your office is open and accepting new Aetna Better Health Medicaid and/or Aetna Better Health CHIP Members “Accepting current patients only” status indicates your office is not accepting new Aetna Better Health Medicaid and/or CHIP Members unless the Member is currently a patient in your practice.
   “Closed” status indicates your office is not accepting new Aetna Better Health Medicaid and/or CHIP Members as patients even if the patient is currently a patient in your practice under another type of coverage or with another health plan.

**Provider requested member transfer**

When persistent problems prevent an effective physician-patient relationship, a participating provider may ask an Aetna Better Health Medicaid or CHIP Member to leave their practice. Such requests cannot be based solely on the Member filing a grievance, an appeal, a request for a Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific provider-patient relationship be terminated:

1. The provider must send a letter informing the Member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:
   Aetna Better Health
   Provider Relations Manager
   PO Box 569150
   Dallas, TX 75356-9150

2. The provider must support continuity of care for the Member by giving sufficient notice and opportunity to make other arrangements for care.

3. Upon request, the provider shall provide resources or recommendations to the Member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

   In the case of the primary care provider, Aetna Better Health will work with the Member to inform him/her on how to select another primary care provider.

**Labs**

Except for Texas Health Steps laboratory services, which must be submitted to the DSHC lab, all providers are required to refer Members for routine laboratory and radiology services to one of these contracted lab/radiology providers. Some procedures require prior authorization. Please see the Precertification section for a comprehensive listing of these procedures. If medically necessary services are not available within the Aetna Better Health network, the Member’s Primary Care Provider must follow the out-of-network referral procedures. A primary care provider must complete the Texas Referral/Authorization Form for any non-emergency services, including diagnostic testing, surgical procedures, hospital admissions and therapy. The completed form (Appendix D) should be faxed to the Aetna Better Health Medical Management Department at 1-866-835-9589.
For Aetna Better Health Medicaid Members, requests for DME and medical supplies must be accompanied by a Home Health Services DME/Medical Supplies Physician Order Form (Title XIX). For a copy of the Title XIX Authorization Form, please refer to the current form at [www.tmhp.com/Provider_Forms/Medicaid/Home-Health-Title-XIX-Supplies-Order-Form_7-1-11.pdf](http://www.tmhp.com/Provider_Forms/Medicaid/Home-Health-Title-XIX-Supplies-Order-Form_7-1-11.pdf)

**Texas Department of Family and Protective Services (TDFPS) – Medicaid only**

Children who are served by TDFPS may transition into and out of Aetna Better Health Medicaid and CHIP more rapidly and unpredictably than the general population, as a result of placements or reunification with the family inside and out of the Service Area.

We are required to cooperate and coordinate with the TDFPS and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of TDFPS. Should a request be made, we will require its providers to:

1. Provide medical records.
2. Schedule medical and behavioral health appointments within 14 days, unless requested earlier by TDFPS.
3. Upon recognition of abuse and neglect, make the appropriate referral to TDFPS by calling toll free at 1-800-252-5400 or by using the TDFPS secure website at [www.txabusehotline.org](http://www.txabusehotline.org).

Aetna Better Health works with the TDFPS to ensure that at-risk children receive the services they need, whether or not they are in the custody of TDFPS. Providers must:

- Refer suspected cases of abuse or neglect to TDFPS
- Provide periodic written updates on treatment status of Members, as required by TDFPS

**Routine, urgent and emergent services**

*Definition of routine care*

“Routine Services” are defined as covered preventive and medically necessary health care services, which are non-emergent or non-urgent. The Member’s Primary Care Provider should perform all routine services that are within the scope of practice for his or her specialty.

*Definition of urgent care*

An “urgent” condition is defined as a health condition which is not an emergency but is severe or painful enough to cause a prudent layperson possessing the average knowledge of medicine to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours to prevent serious deterioration to his or her condition or health.

The Member may need urgent medical care while away from home. If so, the Member should call the Primary Care Provider before seeking medical care. It is the Primary Care Provider’s responsibility to decide if the Member needs any medical care services before returning home. If the Primary Care Provider agrees that the Member needs urgent care, the Primary Care Provider will approve the care. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility.

Certain conditions, such as severe vomiting, earaches, sore throats or fever are considered “urgent” outside the Aetna Better Health service areas and are covered in any of the above settings. Preventive care services
and other routine treatment for conditions such as minor colds and flu are not covered outside the Aetna Better Health service areas.

**Emergency care**

Emergency care is covered 24-hours-a-day, 7-days-a-week, anywhere in the United States. The Member’s Primary Care Provider or the admitting hospital must call the Aetna Better Health Medical Management Department to provide notification of any emergency hospital admission for an Aetna Better Health Medicaid or CHIP Member. Aetna Better Health must be notified within 24 hours of admission or by the next working day by calling 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

Once the attending physician determines the Member is stable, post-stabilization care should be coordinated by the Primary Care Provider. The Primary Care Provider should record all pertinent information regarding the emergency room and post stabilization services in the patient’s chart.

**Definition of emergency care - Medicaid**

“Emergency Medical” conditions are medical conditions manifesting themselves by acute symptoms of recent onset and sufficient severity, (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in:

- Placing the patient’s health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus or unborn child.
- Emergency Behavioral Health services

**Definition of emergency care – CHIP and CHIP Perinate newborn**

Emergency care is a covered service if it directly relates to the delivery of the unborn child until birth.

Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions. An **“Emergency Medical Condition”** is a medical condition of recent onset and severity, including, but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the child’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- placing the child’s health in serious jeopardy;
- serious impairment to bodily functions as related to the unborn child;
- serious dysfunction of any bodily organ or part that would effect the unborn child;
- serious disfigurement to the unborn child; or
- In the case of a pregnant child, serious jeopardy to the health of the fetus.

**“Emergency Behavioral Health Condition”** means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson, possessing average knowledge of medicine and health:

- requires immediate intervention and/or medical attention without which the child would present an immediate danger to the unborn child or others; or
- that renders the child incapable of controlling, knowing or understanding the consequences of his or her actions.

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“Emergency Services” and/or “Emergency Care” means health care services provided in an in-network or out-of-network hospital emergency department, free-standing emergency medical facility, or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize Emergency Medical Condition and/or Emergency Behavioral Health Conditions. Emergency Services also include, but are not limited to, any medical screening evaluation or other evaluation required by state or federal law that is necessary to determine whether an Emergency Medical Condition or an Emergency Behavioral Condition exists.

**Definition of emergency care – CHIP Perinate**

Emergency care is a covered service if it directly relates to the delivery of the unborn child until birth.

Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions. An **“Emergency Medical Condition”** is a medical condition of recent onset and severity, including, but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- placing the unborn child’s health in serious jeopardy;
- serious impairment to bodily functions as related to the unborn child;
- serious dysfunction of any bodily organ or part that would effect the unborn child;
- serious disfigurement to the unborn child; or
- In the case of a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

**“Emergency Behavioral Health Condition”** means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson, possessing average knowledge of medicine and health:

- requires immediate intervention and/or medical attention without which the mother of the unborn child would present an immediate danger to the unborn child or others; or
- that renders the mother of the unborn child incapable of controlling, knowing or understanding the consequences of her actions.

**“Emergency Services” and/or “Emergency Care”** are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or Emergency Behavioral Health Condition, including post-stabilization care services related to labor and delivery of the unborn child.

**Requirements for scheduling follow-up appointments**

Follow-up care with nonparticipating physicians or health care professionals is covered only with prior authorization from Aetna Better Health. Whether treated inside or outside the Aetna Better Health service areas, the Member must obtain a referral before any out-of-network follow-up care can be covered. Examples of follow-up care include cast removal, x-rays and clinic or emergency room revisits.

**Definition of emergency transportation**

When the Member’s condition is life-threatening and trained attendants must use special equipment, life support systems or close monitoring while en route to the nearest appropriate facility, the ambulance transport is deemed an emergency service.
**Definition of non-emergency medical transportation**

When a Member has a medical problem requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance service requires prior authorization and coordination by Aetna Better Health.

Non-emergency transport service for an Aetna Better Health Medicaid or CHIP Member with severe disabilities must be to or from a scheduled medical appointment. The Medical Transportation Program (MTP) provides transportation services to Medicaid eligible clients who have no other means of transportation by the most cost-effective means. MTP may also pay for an attendant if a Provider documents the need, the Member is a minor, or there is a language barrier. MTP can reimburse gas money if the Member has an automobile but no funds for gas. To arrange for services, please call MTP at 1-877-633-8747.

**Medicaid provider complaint and appeals**

**Provider complaints to HMO**

Definition of a “Complaint” – Any dissatisfaction, expressed by a complainant orally or in writing to Aetna Better Health, about any matter other than an Action. Complaints may include, but are not limited to, plan administration, appeal process, or Aetna Better Health employee. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the provider. Providers can file a complaint with Aetna Better Health either in writing or verbally by contacting:

Aetna Better Health
Provider Relations Department
PO Box 569150
Dallas, TX 75356-9150
**1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar)

Aetna Better Health will make resources available to assist providers in filing a complaint. If the complaint is received verbally, Aetna Better Health will send a verbal complaint form documenting the verbal complaint. Once the provider has reviewed and agrees with this documentation, the provider will return the verbal complaint form to Aetna Better Health.

Within 5 business days of receipt of a complaint by a provider, Aetna Better Health will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint. Once the complaint has been resolved, Aetna Better Health will send a response letter to the provider with the resolution of the complaint, including the process to appeal the complaint when the Provider is not satisfied with Aetna Better Health’s decision.

**Provider appeal process to HMO**

In the event that the complaint is not resolved to the satisfaction of the provider, the provider may request an appeal to the address noted above within 30 days from the date of the response letter to the complaint. If the appeal is received verbally, we will send a verbal appeal form documenting the verbal appeal. Once the provider has reviewed and agrees with this documentation, the provider will return the verbal complaint/appeal form to Aetna Better Health for processing. Aetna Better Health will send a written
acknowledgement letter within 5 business days of receipt of the written request for an appeal of the complaint decision. This acknowledgement letter will indicate that Aetna Better Health has 30 calendar days to process and respond to the appeal. Aetna Better Health will send a resolution letter indicating the final determination and criteria used to reach the final decision and notice of the provider’s right to file a complaint with HHSC.

Provider appeals can also be submitted via the secure web portal.

**Provider appeal process to HHSC**

A provider who believes that they did not receive full due process from Aetna Better Health may file a complaint with HHSC. HHSC is only responsible for management of the complaints. Appeals, hearing or dispute resolutions are the responsibility of Aetna Better Health. Providers must exhaust the complaint/appeal process with Aetna Better Health before filing a complaint with HHSC. Providers should refer to the Texas Medical Provider Procedure’s Manual for specific information on complaint requirements. Complaints should be mailed to the following address:

Texas Health and Human Services Commission
Health Plan Operations, H-320
Resolution Services
PO Box 85200
Austin, TX 78708-5200
Email: HPM_Co...@hhsc.state.tx.us

The network provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiries and to conduct investigations into provider and Member complaints.

**Medicaid member complaint and appeals**

**Member complaints to HMO**

Definition of a “Complaint” – Any dissatisfaction expressed by a complainant orally or in writing to Aetna Better Health about any matter related to Aetna Better Health other than an Action. Complaints may include, but are not limited to, dissatisfaction with plan administration; the quality of care of services provided; and aspects of interpersonal relationships such as rudeness of a provider or Aetna Better Health employee, or failure to respect the Member’s rights. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.

A Member or a Member’s designee can file a complaint with Aetna Better Health either in writing or verbally by contacting the Member Advocate at:

Aetna Better Health
Attn. Member Advocate
PO Box 569150
Dallas, TX 75356
**1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar)

The Aetna Better Health Member Advocate will be available to assist the Member or Member’s designee with
understanding and using the complaint and appeals process. If the complaint is received verbally, the Member Advocate will send a verbal complaint form documenting the verbal complaint. Once the Member or Member’s designee has reviewed and agrees with this documentation of the verbal complaint, the Member or Member’s designee must return the verbal complaint form to the Member Advocate.

Within 5 business days of receipt of a complaint by a Member or Member’s designee, the Member Advocate will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint.

Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case, but may not exceed 1 business day from receipt of the complaint. Once the complaint has been resolved, the Member Advocate will send a response letter to the Member or Member’s designee with the resolution of the complaint, including the process to appeal the decision when the Member or Member’s designee is not satisfied with Aetna Better Health’s decision.

**Member appeal process to HMO**

In the event that the complaint is not resolved to the satisfaction of the Member or Member’s designee, he/she may request an appeal through the Member Advocate at the address noted above.

If the appeal is received verbally, the Member Advocate will send a verbal complaint/appeal form documenting the verbal appeal. Once the Member or Member’s designee has reviewed and agrees with this documentation of the verbal appeal, the Member or Member’s designee will return the verbal complaint/appeal form to the Member Advocate for processing. All oral appeals received must be confirmed by a written, signed appeal by the Member or Member’s designee, unless an expedited appeal is requested.

The Member Advocate will send a written acknowledgement letter within 5 business days of receipt of the written appeal. This acknowledgement letter will indicate that the Member Advocate has 30 days to process and respond to the appeal. To ensure continuity of currently authorized services, the appeal must be filed on or before the later of 10 days following Aetna Better Health mailing of the notice of the action or the intended start date of the proposed action.

The resolution of an appeal can be extended up to fourteen (14) calendar days of the appeal if the member asks for more time, or if Aetna Better Health can show that we need more information. We can only do this if more time will help the member. We will send the member a letter indicating why we asked for more time. To ensure continuity of currently authorized services, the appeal must be filed on or before the later of 10 days following Aetna Better Health mailing of the notice of the action or the intended start date of the proposed action.

The member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the member.

The appeal will then be prepared for review by the Appeal Committee. Within 5 calendar days following the Appeal Committee meeting or sooner, the Member Advocate will submit an Appeal Response letter to the Member or Member’s designee with the Committee’s final decision of the appeal.

If the Member has utilized the HMO Complaint and Appeals process and is still not satisfied with the results,
Member adverse determination process

“Adverse determination” means a determination by Aetna Better Health that the health services furnished or proposed to be furnished to a member are not medically necessary or appropriate.

Our Medical Management Department will notify the Member or a person acting on behalf of the Member and the Member’s provider record of a determination made in a utilization review. A notice of action or adverse determination will be provided in writing in case of a denial or limited authorization of a requested service, including the denial in whole or part of payment for a service; the denial of a type or level of service; and/or the reduction, suspension or termination of a previously authorized service. Notification of an adverse determination will include:

- the action taken or proposed
- principal reasons for the action or adverse determination
- the clinical basis for the action or adverse determination
- a description or the source of the screening criteria that were utilized as guidelines in making the determination
- a description of the procedure for the appeal process, including:
  - notification of the right for the Member to appeal an action or adverse determination orally or in writing and the procedures to request an appeal
  - a statement explaining that HMO must make its decision within 30 days from the date the appeal is received by HMO, or 3 business days in the case of an expedited appeal and
  - notification of the right to request a Fair Hearing within 90 days from date of notice of Action or adverse determination.
- an explanation that Members may represent themselves, or be represented by a provider, a friend, a relative, legal counsel or another spokesperson;
- a statement that if the Member wants a HHSC Fair Hearing on the action or adverse determination, Member must make, in writing, the request for a Fair Hearing within 90 days of the date on the notice or the right to request a hearing is waived;
- a statement explaining that the hearing officer must make a final decision within 90 days from the date a Fair Hearing is requested;
- a description of the circumstances under which expedited resolution is available and how to request it;
- notification of right to an expedited Fair Hearing after exhausting the health plan’s expedited appeal process;
- notification of the right for the Member to request continuation of benefits pending resolution of the appeal and the circumstances under which the enrollee may be required to pay the costs of services;
- the date that the action or adverse determination will be taken.

Appeal of an action or other adverse determination

The Aetna Better Health Medical Management Department maintains and makes available a written
description of appeal procedures involving actions and other adverse determinations which is facilitated through the Member Advocate. All reviews of appeals involving actions and adverse determinations are conducted by Aetna Better Health staff who were not involved in the initial determination.

**Standard appeal**

A Member or person authorized to act on behalf of the Member, including the Member’s physician or health care provider with the Member’s written consent, may appeal the action or adverse determination (including denial of payment for services in whole or in part) orally or in writing. All appeals must be received within 30 days from the date of the notice of an adverse determination. When an oral appeal of adverse determination is received, a one-page verbal appeal form, documenting the verbal appeal, will be sent to Member for review and signature. The time frame in which the appeal is resolved will be based on the medical immediacy of the condition, procedure, or treatment under review, but will not exceed 30 calendar days unless an extension is requested by the Member or the Member is notified of the reason an extension would be in the Member’s best interest. Within 5 working days from receipt of the written or verbal appeal, the Member Advocate will send an acknowledgement letter. The acknowledgement letter will include:

- the date of receipt of the appeal
- a description of the appeal procedure and time frames,
- the right of the Member or authorized representative to examine the Member’s case file, including medical records and any other information, at any time before or during the appeal process
- the right of the Member to present evidence, and allegations of fact or law, in person, as well as in writing
- a list of the documents that will need to be submitted for review during the appeal process.

The Member will have 14 business days for a standard appeal to provide additional information. If the Member requests an extension, the time frame may be extended up to 14 calendar days.

If we request additional information that requires an extension of the established time frames, the Member must be provided with written notice of the delay and the reason the delay is in the Member’s best interest. The extension may be no longer than 14 calendar days. The services being received by the Member, including the benefit that is the subject of the appeal, will be continued if all of the following criteria are met:

- the Member or his or her representative files the appeal timely
- the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- the services were ordered by an authorized provider;
- the original period covered by the original authorization has not expired
- the Member requests an extension of the benefits.

At the Member’s request, Aetna Better Health will continue or reinstate the Member’s benefits while the appeal is pending, until one of the following occurs:

- the Member withdraws the appeal
- 10 days pass after Aetna Better Health mails the notice, providing the resolution of the appeal against the Member, unless the Member, within the 10-day time frame, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached
- a Fair Hearing Officer issues a hearing decision adverse to the Member
- the time period or service limits of a previously authorized service has been met. All available information will be reviewed by a Medical Director that was not involved in the original denial and is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review and provide resolution within 30 calendar days of receipt of the appeal.
**Member expedited appeal process to HMO**

The Member or Member’s designee may ask for an expedited appeal if he/she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the Member. Requests for an expedited appeal can be made verbally or in writing as indicated in the Member Complaint to HMO Process listed above.

Expedited appeals for ongoing emergencies or denial of continued hospitalizations must occur in accordance with the medical or dental immediacy of the case and not later than 1 business day after the Member or Member’s designee request for the appeal is received.

Aetna Better Health will follow up in writing within 3 business days on a decision for an expedited appeal. If the Member or Member’s designee requests an expedited appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided they will be notified that the appeal review cannot be expedited. If the Member or Member’s designee does not agree with this decision they may submit a request for a State Fair Hearing as indicated below.

The Aetna Better Health Member Advocate will be available to assist the member or member’s designee with understanding and using the complaint and appeals process.

**Member request for State Fair Hearing**

**Can a member ask for a State Fair Hearing?**

If a Member, as a member of the health plan, disagrees with the health plan’s decision, the Member has the right to ask for a fair hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member’s representative. The Member or the Member representative must ask for the fair hearing within 90 days of the date on the health plan’s letter that tells of the decision being challenged. If the Member does not ask for the fair hearing within 90 days, the Member may lose his or her right to a fair hearing. To ask for a fair hearing, the Member or the Member’s representative should either send a letter to the health plan or call:

Aetna Better Health  
Attn. Member Advocate  
P.O. Box 569150  
Dallas, TX 75356-9150  
**1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar)

If the Member asks for a fair hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the Member does not request a fair hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the Member asks for a fair hearing, the Member will get a packet of information letting the Member know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, the Member or the Member’s representative can tell why the Member needs the service the health plan denied.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.
CHIP Provider complaint and appeals

Provider complaints to HMO
Definition of a “Complaint” – Any dissatisfaction, expressed by a Complainant, orally or in writing to Aetna Better Health, with any aspect of Aetna Better Health’s operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to Medical Necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

Providers can file a complaint with Aetna Better Health either in writing or verbally by contacting:

Aetna Better Health
Provider Relations Department
PO Box 569150
Dallas, TX 75356-9150
1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar)

Aetna Better Health will make resources available to assist providers in filing a complaint. If the complaint is received verbally, Aetna Better Health will send a verbal complaint form documenting the verbal complaint. Once the provider has reviewed and agrees with this documentation of the verbal complaint, the provider will return the verbal complaint form to Aetna Better Health. If the complaint form is not returned to Aetna Better Health within 15 calendar days from date on letter, a determination will be made based on the available information. Within 5 business days of receipt of a complaint by a Provider, Aetna Better Health will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint.

Once the complaint has been resolved, Aetna Better Health will send a response letter to the provider with the resolution of the complaint, including the process to appeal the complaint when the provider is not satisfied with Aetna Better Health decision. Aetna Better Health will appoint members to a Complaint Review Panel to advise Aetna Better Health on the resolution of a disputed decision on a complaint. Members of the Complaint Review Panel may not have been previously involved in the disputed decision. Aetna Better Health will notify the provider of the time and date of the Complaint Review Panel meeting. At least 5 days prior to the Complaint Review Panel meeting, Aetna Better Health will provide the Provider documentation to be presented to the Panel by Aetna Better Health staff. Aetna Better Health will send a resolution letter indicating the final determination and criteria used to reach the final decision and notice of the Provider’s right to file a complaint with the Texas Department of Insurance (TDI).

Provider appeal process to HMO
In the event that the complaint is not resolved to the satisfaction of the provider, the provider may request an appeal to the address noted above. If the appeal is received verbally, Aetna Better Health will send a verbal appeal form documenting the verbal appeal. Once the provider has reviewed and agrees with this documentation of the verbal appeal, the provider will return the verbal appeal form to Aetna Better Health for processing.
Aetna Better Health will send a written acknowledgement letter within 5 business days of receipt of the written request for an appeal of the complaint decision. This acknowledgement letter will indicate that Aetna Better Health has 30 calendar days to process and respond to the appeal.

The provider can also submit an appeal via the secure web portal.

**Provider complaint process to the State**
A provider who believes that they did not receive full due process from Aetna Better Health, may file a complaint with TDI by calling toll free **1-800-252-3439** or in writing at:

Texas Department of Insurance  
PO Box 149104  
Austin, Texas 78714-9104

The network provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into provider and Member complaints.

**CHIP member complaint and appeals**

**Member complaints to HMO**
Definition of a “Complaint” – Any dissatisfaction expressed by a complainant orally or in writing to Aetna Better Health with any aspect of the Aetna Better Health’s operations, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions expressed by a complainant. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member. CHIP Members, or a CHIP Member’s designee, can file a complaint with Aetna Better Health either in writing or verbally by contacting the Member Advocate at:

Aetna Better Health Attention:  
Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150  
**1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar)

If the complaint is received verbally, the Member Advocate will send a verbal complaint form documenting the verbal complaint. Once the Member or Member’s designee has reviewed and agrees with this documentation of the verbal complaint, the Member or Member’s designee will return the verbal complaint form to the Member Advocate. If the complaint form is not returned to the Member Advocate within 15 calendar days from date on letter, a determination will be made based on information available. Within 5 business days of receipt of a complaint by a Member or Member’s designee, the Member Advocate will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint. Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case, but may not exceed 1 business day from receipt of the complaint. Once the complaint has been resolved, the Member Advocate will send a response
letter to the Member or Member’s designee with the resolution of the complaint, including the process to appeal the decision when the Member or Member’s designee is not satisfied with Aetna Better Health’s decision.

**Member appeal process to HMO**

In the event that the complaint is not resolved to the satisfaction of the Member, the Member or Member’s designee may request an appeal through the Member Advocate at the address noted above. If the appeal is received verbally, the Member Advocate will send a verbal appeal form documenting the verbal appeal. Once the Member or Member’s designee has reviewed and agrees with this documentation of the verbal appeal, the Member or Member’s designee will return the verbal appeal form to the Member Advocate for processing. All oral appeals received must be confirmed by a written, signed appeal by the Member or Member’s designee, unless an expedited appeal is requested. The Member Advocate will send a written acknowledgement letter within 5 business days of receipt of the written appeal. This acknowledgement letter will indicate that the Member Advocate has 30 calendar days to process and respond to the appeal. The appeal will then be prepared for review by the Appeal Committee. Five (5) calendar days following the Appeal Committee meeting or sooner, the Member Advocate will submit an Appeal Response letter to the Member or Member’s designee with the final decision of the appeal.

If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll free to **1-800-252-3439**. If you would like to make your request in writing send it to:

Texas Department of Insurance  
Consumer Protection  
PO Box 149091  
Austin, TX 78714-9091

If you can get on the internet, you can send your complaint in an email to http://www.tdi.texas.gov/consumer/complfrm.html

**Member expedited appeal process to HMO**

The Member or Member’s designee may ask for an expedited appeal if he/she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the Member. Requests for an Expedited Appeal can be made verbally or in writing as indicated in the Member Complaint to HMO Process listed above. Expedited appeals for emergency care denials and denials of continued hospital stays will be reviewed by a Medical Director that was not involved in the original denial and is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review. The time frame in which the appeal is completed will be based on the medical immediacy of the condition, procedure, or treatment, but will not exceed 1 working day from the date all information necessary to complete the appeal is received. If the Member or Member’s designee requests an expedited appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided they will be notified that the appeal review cannot be expedited. If the Member or Member’s designee does not agree with this decision they may submit a request for an Independent Review Organization as described below. Members may also file a complaint to the TDI by calling **1-800-252-3439** or writing to:

Texas Department of Insurance  
Consumer Protection
Member adverse determination appeal process to HMO

A Member, a person acting on behalf of the Member, or the Member’s physician or health care provider may appeal an adverse determination orally or in writing. Any complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of the adverse determination. Within 5 working days from receipt of the appeal, an acknowledgement letter will be sent to the appealing party. The acknowledgement letter will include: the date of receipt of the appeal; a description of the appeal procedure and time frames; a list of the documents, such as new, previously unknown information, further reasonable documentation related to the case but not previously received or medical records that will need to be submitted for review during the appeal process. The provider will have 5 business days to submit the additional information requested; and a one-page appeal form, if the appeal is oral. As soon as practical, but in no case later than 30 calendar days of receipt of the appeal, all available information will be reviewed by a physician who was not involved in making the initial adverse determination and a written notification of the appeal determination will be sent to the appealing party. If the appeal is denied, the written notification to the Member, Member’s designee, and Member’s provider shall include a clear and concise statement that includes: the clinical basis for the appeal’s denial; the specialty of the physician making the denial; the right of the appealing party to seek review of the denial by an independent review organization and the procedures for obtaining that review; the right to an immediate appeal to an independent review organization in circumstances involving a condition that is life-threatening to the member; the right of the health care provider to set forth in writing, within 10 working days of the appeal denial, good cause for having a particular type of specialty provider review the case.

Independent Review (IRO) process

The Member or Member’s designee may seek a review of Aetna Better Health’s denial of an appeal of an adverse determination by an independent review organization assigned to the appeal in accordance with TIC Article 21.58C. The Member or Member’s designee must complete the “Request for IRO Review” form and return to Aetna Better Health within 15 days from receipt of Aetna Better Health’s decision. An Independent Review Organization (IRO) is an organization that has no connection to Aetna Better Health or with health care providers that were previously in your treatment or decisions made by Aetna Better Health about services that have not been provided.

Once Aetna Better Health receives the completed form, we will notify TDI of the Member’s request for an IRO review. The standard time frame for the IRO process should take no longer than 20 calendar days from the date the completed form and all necessary information is received by the IRO. If the Member has an emergency health condition, the IRO process should take no longer than 8 calendar days from the date the completed form and all necessary information was received by the IRO.

Medicaid Managed Care Member Eligibility

Enrollment eligibility determination

HHSC identifies persons with Medicaid who are eligible for participation in the Aetna Better Health plan. Eligible individuals must reside in one of the counties in the Bexar or Tarrant Service Areas. Eligibility is determined using the following criteria:
<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>TANF (formerly AFDC)</td>
<td>Individuals age 21 and over who are eligible for the TANF Program.</td>
</tr>
<tr>
<td>TANF Children</td>
<td>Individuals under age 21 who are eligible for the TANF Program.</td>
</tr>
<tr>
<td>Pregnant Women - MAO</td>
<td>Medical Assistance Only (MAO) pregnant women whose families’ income is below 185% of the Federal Poverty Limits.</td>
</tr>
<tr>
<td>Newborn (MAO)</td>
<td>Children under age 1 (one) year born to Medicaid-eligible mothers.</td>
</tr>
</tbody>
</table>
| Expansion Children (MAO) | Children under age 18, ineligible for TANF because of the applied income of their stepparents or grandparents.  
  • Children under age 1 whose families’ income is below 185% Federal Poverty Limit.  
  • Children age 1 – 5 whose families’ income is at or below 133% of Federal Poverty Limit.  
  Children under age 19, born before October 1, 1983, whose families’ income is below the TANF income limit. |
| Federal Mandate Children (MAO) | Children under age 19, born on or after October 1, 1983, whose families’ income is below 100% Federal Poverty Limit. |
| CHIP                 | Children under age 19, born on or after October 1, 1983, whose families’ income is between the medically needy standards unit and 100% Federal Poverty Limit. |

**Verifying eligibility**

Providers are responsible for requesting and verifying current Medicaid eligibility information about the member for the month that services are being rendered. If members have lost their identification or forgotten to bring it to appointments, providers may verify member eligibility through the Automated Inquiry System (AIS), or by calling 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

**Verifying member Medicaid eligibility**

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient’s eligibility for the date of service prior to services being rendered. There are several ways to do this:

- Swipe the patient’s Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call the Your Texas Benefits provider helpline at 1-855-827-3747.
- Call Provider Services at the patient’s medical or dental plan.

**Important:** Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling 1-855-827-3748. Medicaid members also can go online to order new cards or print temporary cards.

If the member gets Medicare, Medicare is responsible for most primary, acute, and behavioral health services; therefore, the Primary Care Provider’s name, address, and telephone number are not listed on the Member’s ID card. The member receives long-term services and support through Aetna Better Health.
**Your Texas benefits ID card**

As of August 2011, the Texas Health and Human Services Commission (HHSC) began issuing a new Medicaid ID card to Texas Medicaid clients. HHSC is introducing a new system that uses digital technology to streamline the process of verifying a person’s Medicaid eligibility and accessing their Medicaid health history. The two main elements of the system are:

- The Your Texas Benefits Medicaid card, which replaces the Medicaid ID letter (Form 3087) clients have been getting in the mail every month.
- An online website where Medicaid providers can get up-to-date information on a patient’s eligibility and history of services and treatments paid by Medicaid.

Medicaid providers should be prepared to verify a person’s Medicaid eligibility with the new card. The front of the card shows the person’s unique Medicaid ID number. That same number is embedded in a magnetic strip on the back of the card, accessible with a basic swipe-style card reader. With the card, providers have a choice of ways to verify the person’s Medicaid eligibility:

- Enter the person’s Medicaid ID number at the new, secure Medicaid eligibility verification website, [www.YourTexasBenefitsCard.com](http://www.YourTexasBenefitsCard.com).
  - Visit TexMedConnect on the Texas Medicaid & Healthcare Partnership (TMHP) website.
  - Call the TMHP Contact Center at 1-800-925-9126.
  - Call Automated Inquiry System (AIS) at 1-800-925-9126.

If the member accesses care at a Federally Qualified Health Clinic (FQHC), they will continue to receive the 3087 Form.

**Temporary ID Card (Form 1027-A)**

A Member may have a temporary Medicaid ID (Form 1027-A) which will include the plan indicator. This is issued prior to receipt of the Form 3087.

**Aetna Better Health Medicaid ID card**

We will issue a Member ID card to the Member within five (5) days of receiving notice of enrollment of the Member into the Aetna Better Health Medicaid program. The ID card will include at a minimum the following: Member’s name; Member’s Medicaid number; primary care provider’s name and telephone number; primary care provider effective date; plan eligibility effective date; the 24-hour, 7-day per week Member Services eligibility telephone number; the toll-free number for behavioral health and vision services; and directions on what to do in an emergency.

Copies of the Aetna Better Health Medicaid ID card are included in Appendix A to this manual. Call Aetna Better Health Providers may also verify eligibility through the Aetna Better Health website ([www.aetnabetterhealth.com](http://www.aetnabetterhealth.com)), or by calling Aetna Better Health Member Services department at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

**For Primary Care Providers — member listing**

Each primary care provider office will receive a panel report each month listing eligible Members who have selected that provider as their primary care provider.
Medicaid Managed Care benefits and Aetna Better Health Medicaid value-added services

Medicaid recipients have the following additional benefits under Medicaid Managed Care or STAR

“Spell of illness” limitation removed

Members of the Aetna Better Health Medicaid program are not limited by the “spell of illness” limitation, which is specified in the current Texas Medicaid Provider Procedures Manual. The annual limit of $200,000 on inpatient services does not apply for Medicaid Members.

Unlimited prescription

All Aetna Better Health adult Medicaid Members are entitled to an unlimited medically necessary prescriptions and not limited to three (3) prescriptions, which is specified in the current Texas Medicaid Provider Procedures Manual.

We also offer the following value added services to Aetna Better Health Medicaid Members:

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<th>Value Added Services</th>
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<td>You can talk to a nurse 24 hours a day, 7 days a week. The nurse can help you with questions or help you decide what to do about your health needs. Call your doctor first with any questions or concerns about your health care needs. Please call the toll-free nurse line number on your ID card.</td>
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<tr>
<td>Extra Help Getting a ride – Bus Pass</td>
<td>Need help getting to your Doctor’s appointment we can provide you with a Day Bus Pass. Please call us at the toll-free number on your ID card for additional assistance.</td>
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<tr>
<td>Contact Lenses Program</td>
<td>Aetna Better Health offers a benefit for contact lenses, including a fitting exam, with additional benefits to be applied towards the purchase of contact lenses to correct vision for members 12-18 years old. Please call Superior Vision at 1-800-879-6901.</td>
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<tr>
<td>CVS Discount Card</td>
<td>Aetna Better Health offers a 20% discount card for CVS products limited to one per household. This can be utilized to assist in the cost of over the counter medications or medical supplies. Please call us at the toll-free number on your ID card to find a provider near you.</td>
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<tr>
<td>Program</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Vital Savings by Aetna (SM) - Discount Program</strong></td>
<td>This program provides discounts on dental services for STAR members over age 21. To get a list of providers participating in this program, please call us at the toll-free number on your ID card. You will get a packet in the mail with a Vital Savings ID card. You will need to show your Vital Savings ID card when you go to a participating dentist office. You will pay a discounted fee at the time of service directly to the dentist. <strong>You will have to pay for all services or products but will get a discount from providers who have contracted with the discount medical plan organization (Aetna Life Insurance Company).</strong></td>
</tr>
<tr>
<td><strong>Health and Wellness Discount Program</strong></td>
<td>Aetna Better Health’s Vital Savings discount program also offers STAR members 21 and older access to fitness club memberships and exercise equipment through GlobalFit and alternative health care services and supplies (chiropractic, acupuncture, nutritional counseling, vitamins, and supplements. To get a list of providers participating in this program, please call us at the toll-free number on your ID card.</td>
</tr>
<tr>
<td><strong>Sports Physical Exams</strong></td>
<td>Members 19 years and younger can get one sports physical exam per year. This exam is different than the Texas Health Steps checkup, and includes specific sports related exams.</td>
</tr>
<tr>
<td><strong>Short Term Phone Help</strong></td>
<td>Cell phones with 150 minutes per month! Get a cell phone, minutes and unlimited texting with SafeLink, all at no cost. We want you to be safe and keep well. Now you can stay connected with those who care about you. Call your doctor, your family and your friends. Call them anytime, 24 hours a day! Visit <a href="http://www.safelink.com">www.safelink.com</a> or call 1-877-631-2550 to sign up.</td>
</tr>
<tr>
<td><strong>Smoking Good Cessation Program</strong></td>
<td>Do you want help quitting tobacco? This is a program for our members age 12 years or older who would like help to quit tobacco. The program includes an assessment and counseling. Members 18 years of age and older can receive nicotine replacement products with a prescription from your primary care provider. If you buy a nicotine replacement product, please call us at the toll-free number on your ID card to find out where to send your receipt(s).</td>
</tr>
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<td><strong>Weight Management Program - Nutrition</strong></td>
<td>Aetna Better Health offers weight management programs, including family counseling with a nutritionist/dietician for non-pregnant members 12-19 years old. Please call us at the toll-free number on your ID card to find a provider near you.</td>
</tr>
<tr>
<td><strong>Extra Help for Pregnant Women</strong></td>
<td>We provide services to help women stay healthy at all times, especially during pregnancy. If you are pregnant and a member, please call us to enroll in our maternity care program. Our program will help you stay healthy throughout your pregnancy and get the health care services you need. Please call us at the toll-free number on your ID card to enroll.</td>
</tr>
<tr>
<td><strong>PROMISE Program for you and your baby</strong></td>
<td>Our special prenatal program offers a package of diapers, baby wipes and gift bag ($50 value) at no cost when a pregnant member completes 10 prenatal and one postpartum visit to her doctor. The program helps you and your baby stay healthy. You will need to call us at the toll-free number on your ID card to claim your package.</td>
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<td><strong>Asthma Package Program</strong></td>
<td>Members with an asthma diagnosis receive 1 allergy protector pillow cover and 1 peak flow meter and OptiChamber each year upon enrollment into the case management program. A care manager will be assigned and will confirm that member has asthma before the items are mailed. Please call us at the toll-free number on your ID card for more information.</td>
</tr>
<tr>
<td><strong>Asthma Program</strong></td>
<td>If you have asthma, the case management department will provide new members with a $10 gift card if asthma is confirmed when completing a Health Risk Questionnaire and member completes an office visit with their assigned PCP within 30 days of enrollment to the health plan. Please call us at the toll-free number on your ID card for more information.</td>
</tr>
<tr>
<td><strong>Well Child Exam - Bicycle Helmet Ages 3-6</strong></td>
<td>If your child has a well-child exam within 30 days of their birthday can get a Bicycle Helmet. Please call us at the toll-free number on your ID card to claim your Bicycle Helmet.</td>
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<tr>
<td><strong>Well Child Exam - $10.00 gift card Ages 12-18</strong></td>
<td>If your child has a well-child exam within 30 days of their birthday they can get a $10.00 gift card. Please call us at the toll-free number on your ID card to claim your gift card.</td>
</tr>
<tr>
<td><strong>Behavior Health - $10.00 gift card</strong></td>
<td>Members who complete a follow-up visit with their provider within 7 days of discharge from a hospital stay can get a $10.00 gift card. Please call us at the toll-free number on your ID card to claim your gift card.</td>
</tr>
</tbody>
</table>

**Vital Savings™**

Vital Savings is a discount program offered to Aetna Better Health Medicaid members who are 21 years of age and older and all pregnant Aetna Better Health Medicaid members. Eligible members receive discounts on:

- dental services from participating dental providers. Discounted dental services include, but are not limited to: routine checkups, cleanings, fillings, extractions, crowns/root canals, and orthodontia.
- fees for alternative health care such as chiropractic, acupuncture, nutritional counseling
- fitness services such as fitness club memberships and exercise equipment; and
- over the counter medications, vitamins and supplements and supplies

To obtain service discounts, members simply present their Vital Savings ID card when they visit a participating provider’s office, and they pay the discounted fee at time of service directly to the participating provider.

Members will be mailed an information packet and Vital Savings ID card. Members can call Vital Savings at 1-888-238-4825 for more information on these discounts.
Informed Health Line
This 24-hours-a-day, 7-days-a-week service enables all Medicaid members to have ready telephonic access to clinical support from experienced Registered Nurses. The nurses will be available through a toll-free telephone number at 1-800-556-1555. We will provide TTY service for the hearing and speech-impaired and foreign language translation for non-English speaking members.

The Registered Nurses will provide Medicaid members with current, easy to understand information on a variety of health topics including prevention strategies, self-care skills, wellness, chronic conditions, and complex medical situations. Supported by the Healthwise® Knowledgebase (a computerized database of over 1,900 of the most common health problems) and an array of other online and desk references, the Registered Nurses will help Medicaid members understand health issues, provide information on treatment options, review specific questions to ask their PCP and other providers and provide research analyses of treatments and diagnostic procedures. The Registered Nurses will support patient/provider interaction by encouraging members to give a clear medical history and information to providers and to ask clarifying questions. Through IHL members will also have 24-hour access to an audio health library with information on more than 2,000 topics, available in both English and Spanish.

Sports physicals
Aetna Better Health offers one sports physicals every 12 months to any Aetna Better Health Medicaid member 19 years or younger. Sports Physicals may be billed in conjunction with any other office visit (99201-99205, 99211-99215, 99381-99385, 99391-99395). The code for the completion of the form (99080) should be billed with diagnosis code V70.3 in addition to other procedure codes used for the visit.

When a Sports Physical is the only reason for the visit, the provider should use CPT code 97005 (athletic physical) and diagnosis code V70.3. Do not use 99080, as this code is inclusive of the completion of the form.

Enhanced vision services/elective contact lenses
All Aetna Better Health Medicaid members over the age of 12 may elect to receive medically necessary contact lenses in lieu of eyeglasses, up to a $100 retail allowance (allowance applicable toward the contact lenses and associated professional services). This benefit includes a fitting exam with additional benefits to be applied toward the purchase of contact lenses to correct vision. There is a 20% discount available for non-disposable lenses.

The benefit will be tracked using the following CPT codes
Contact Lens Evaluation – S0592
Contact Lenses (Supplies) – v2500-v2599

Weight management
Nutritional counseling and therapy for non-pregnant adolescents between the ages of 12 and 19 years old who are obese ( >85th percentile BMI for age and gender) will be covered. The member’s primary care provider may prescribe outpatient individual, group or family nutrition intervention and refer an eligible member to a program provided by an Aetna Better Health Medicaid participating facility or licensed dieticians. Providers should bill appropriate obesity diagnoses codes:

Indications: diagnoses codes for overweight/obesity 278.00, 278.01, 287.02 with secondary code for BMI greater than 85th percentile (ages under 20) v85.53 or v85.54. Visits: 97802, 97803, 97804 or G0270, G0271 or
**Smoking cessation**
A benefit of $300 per year is available to any Aetna Better Health Medicaid member over the age of 12 years old who requires assistance to stop smoking. The benefit may be used for assessment and counseling, smoking cessation programs or nicotine replacement therapy. Members must submit receipts for reimbursement. If the member is under 18 years of age, receipts for nicotine replacement must be accompanied by a prescription from the member’s Primary Care Provider.

This program will provide members with the tools and support required to assist them to stop smoking and lead healthier lives.

The benefit will be tracked using the following CPT codes
Indication: diagnoses codes for tobacco use disorder 305.1 or 649.0 (in pregnancy) Counseling: 99406 or 99407 Nicotine Replacement: S4990, S4991 or S4995

**Behavioral health**

**Partial Hospitalization/Extended Day Treatment**
Available for Medicaid members under age 21. Structured and medically supervised alternative to, or a step down from, inpatient care. Day, evening and/or night treatment programs are provided to patients at least four (4) hours/day and at least three (3) days/week. Amount, duration and scope are based on medical necessity.

The benefit will be tracked using the following codes
Revenue Code: 912 or 913
HCPC code: H0035 (MH) or H2036 (SA)

**Intensive Outpatient Treatment/Day Treatment (IOP)**
Available for Medicaid members over age 21. At least two (2) hours/day and three (3) days/week of planned, structured services used as an alternative to or step down from more restrictive levels of care. Amount, duration and scope are based on medical necessity.

The benefit will be tracked using the following codes
Revenue code: 905 (MH) or 906 (SA) HCPC code: H0015 (SA) or S9480 (MH)

**Residential**
Available for Medicaid members over age 21. Medically monitored diagnostic and therapeutic behavioral health services for members with long-term or severe mental or substance-related disorders that require 24 hour intermediate or non-acute levels of care for services that are not available through existing community programs. Amount, duration and scope are based on medical necessity.

The benefit will be tracked using the following codes
Revenue code: 1001 (MH) or 1002 (SA) HCPC code: H0017, H0018, H0019 (not MH or SA specific)
CHIP Member eligibility and Aetna Better Health value-added benefits

**Eligibility determination by HHSC**
HHSC identifies recipients who are eligible for Aetna Better Health CHIP participation. Recipients deemed eligible for CHIP Services will have 12 months of continuous coverage. Eligible individuals must reside in one of the counties in the Bexar or Tarrant Service Area.

**Verifying eligibility**
Every Aetna Better Health CHIP Member should have an Aetna Better Health CHIP ID card. The provider should request the Member’s plan ID card each time the Member presents for services. A copy of the Aetna Better Health CHIP ID card is included in Appendix A in this manual.

**Aetna Better Health CHIP ID card**
Aetna Better Health CHIP will issue a Member ID card to the Member within 5 days after receiving notice of enrollment of the Member into the Aetna Better Health CHIP plan. The ID card will include at a minimum the following:

- Member’s name
- Member’s CHIP number
- Primary Care Provider’s name and telephone number
- Primary Care Provider effective date
- Program eligibility effective and term dates
- The 24-hour, 7-days-per-week member eligibility telephone number
- The toll-free number for behavioral health and vision services
- Directions for what to do in an emergency

A copy of the Aetna Better Health CHIP ID card is included in Appendix A in this manual.

Providers may also verify eligibility through the secure web portal, or by calling Aetna Better Health Member Services at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

For Pharmacy Eligibility, refer to the Pharmacy section of the manual.

**Pregnant teens**
Providers should contact Aetna Better Health immediately when they have identified a CHIP member who is pregnant by calling Member Services at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

**Enrollment**
HHSC, in coordination with their Enrollment Broker, administers the enrollment process for CHIP eligibles.

Some applicants may have a 90-day waiting period if they had insurance coverage prior to enrollment. The Enrollment Broker initiates the enrollment process by sending the CHIP eligible an enrollment packet. It is at that time the Member selects a health plan and a primary care provider.

All enrollments into Aetna Better Health CHIP must occur only through the Enrollment Broker. Enrollment counselors can be reached at **1-800-647-6558**.

**“Spell of illness” limitation removed**
Members of the Aetna Better Health CHIP program are not limited by the “spell of illness” limitation, which is specified in the current Texas Medicaid Provider Procedures Manual.
Disenrollment
We will take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors. We will notify a Member of our decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member, we will notify the Member of the availability of the complaint/appeal process. We cannot request a disenrollment based on adverse change in the Member’s health status or utilization of services that are medically necessary for treatment of a Member’s condition. Providers cannot take retaliatory action against a member who is disenrolled from Aetna Better Health.

CHIP Managed Care benefits and Aetna Better Health CHIP value-added services
CHIP recipients have the following additional benefits under the CHIP Managed Care program.

<table>
<thead>
<tr>
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<td>Program</td>
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<td>Asthma Program</td>
<td>If you have asthma, the case management department will provide new members with a $10 gift card if asthma is confirmed when completing a Health Risk Questionnaire and member completes an office visit with their assigned PCP within 30 days of enrollment to the health plan. Please call us at the toll-free number on your ID card for more information.</td>
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<td>Well Child Exam - Bicycle Helmet Ages 3-6</td>
<td>If your child has a well-child exam within 30 days of their birthday can get a Bicycle Helmet. Please call us at the toll-free number on your ID card to claim your Bicycle Helmet.</td>
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www.safelink.com or call 1-877-631-2550 to sign up.
**Well Child Exam - $10.00 gift card Ages 12-18**  
If your child has a well-child exam within 30 days of their birthday they can get a $10.00 gift card. Please call us at the toll-free number on your ID card to claim your gift card.

**Behavior Health - $10.00 gift card**  
Members who complete a follow-up visit with their provider within 7 days of discharge from a hospital stay can get a $10.00 gift card. Please call us at the toll-free number on your ID card to claim your gift card.

**Informed Health® Line**  
This 24-hours-a-day, 7-days-a-week service enables all CHIP members to have ready telephonic access to clinical support from experienced Registered Nurses. The nurses will be available through a toll-free telephone number at **1-800-556-1555**. We will provide TTY service for the hearing and speech-impaired and foreign language translation for non-English speaking members.

The Registered Nurses will provide CHIP members with current, easy to understand information on a variety of health topics including prevention strategies, self-care skills, wellness, chronic conditions, and complex medical situations. Supported by the Healthwise® Knowledgebase (a computerized database of over 1,900 of the most common health problems) and an array of other online and desk references, the Registered Nurses will help CHIP members understand health issues, provide information on treatment options, review specific questions to ask their PCP and other providers and provide research analyses of treatments and diagnostic procedures. The Registered Nurses will support patient/provider interaction by encouraging members to give a clear medical history and information to providers and to ask clarifying questions. Through IHL members will also have 24-hour access to an audio health library with information on more than 2,000 topics, available in both English and Spanish.

**Sports physicals**  
Aetna Better Health offers one sports physicals every 12 months to any Aetna Better Health CHIP member. Sports Physicals may be billed in conjunction with any other office visit (99201-99205, 99211-99215, 99381-99385, 99391-99395). The code for the completion of the form (99080) should be billed with diagnosis code V70.3 in addition to other procedure codes used for the visit. When a Sports Physical is the only reason for the visit, the provider should use CPT code 97005 (athletic physical) and diagnosis code V70.3. Do not use 99080, as this code is inclusive of the completion of the form.

**Enhanced vision services/elective contact lenses**  
All Aetna Better Health CHIP members over the age of 12 may elect to receive medically necessary contact lenses in lieu of eyeglasses, up to a $100 retail allowance (allowance applicable toward the contact lenses and associated professional services). This benefit includes a fitting exam with additional benefits to be applied toward the purchase of contact lenses to correct vision. There is a 20% discount available for non-disposable lenses.

The benefit will be tracked using the following CPT codes  
Contact Lens Evaluation – S0592  
Contact Lenses (Supplies) – v2500-v2599
**Weight management**

Nutritional counseling and therapy for non-pregnant adolescents between the ages of 12 and 19 years old who are obese ( >95th percentile BMI for age and gender) will be covered. The member’s primary care provider may prescribe outpatient individual, group or family nutrition intervention and refer an eligible member to a program provided by an Aetna Better Health CHIP participating facility or licensed dieticians. Providers should bill appropriate obesity diagnoses codes (278.0 or 278.01) and procedure codes for nutritional assessment and therapy (97802 – 97804) or nutritional counseling (S9470).

**Smoking cessation**

An additional benefit of $200 per year is available to any Aetna Better Health CHIP member over the age of 12 years old who requires assistance to stop smoking. The benefit may be used for assessment and counseling, smoking cessation programs or nicotine replacement therapy. Members must submit receipts for reimbursement; if the member is under 18 years of age, receipts for nicotine replacement must be accompanied by a prescription from the member’s Primary Care Provider.

This program will provide members with the tools and support required to assist them to stop smoking and lead healthier lives.

The benefit will be tracked using the following CPT codes

Indication: diagnoses codes for tobacco use disorder 305.1 or 649.0 (in pregnancy) Counseling: 99406 or 99407, Nicotine Replacement: S4990, S4991 or S4995

**CHIP Perinate and CHIP Perinate Newborn covered services**

“CHIP Perinatal” describes when HHSC contracts with Health Maintenance Organizations to provide, arrange for, and coordinate covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn members.

“CHIP Perinate” is a pregnant female CHIP Perinatal beneficiary who is identified before giving birth and is enrolled to receive covered services from Aetna Better Health pursuant to the terms of the CHIP Perinatal Contract.

“CHIP Perinate Newborn” means a CHIP Perinate who has been born alive.

Aetna Better Health CHIP Perinate and Aetna Better Health CHIP Perinate Newborn members will need to meet the same income guideline requirements as indicated previously in the CHIP section, however, the 90 day waiting period and program cost-sharing requirements will not apply to these members. Once the Aetna Better Health CHIP Perinate member is enrolled, eligibility remains continuous for 12 months. Eligibility for the Aetna Better Health CHIP Perinate member will end at the end of the month of the CHIP Perinate Newborn’s birth. Any time remaining in the first 12 months of continuous eligibility will be transferred to the CHIP Perinate Newborn. Eligibility will be continuous for the CHIP Perinate Newborn member for the remainder of the 12 months.

CHIP Perinate members will be linked to any current CHIP Program member case and are required to be enrolled in the CHIP Health Plan through the CHIP enrollment period.

A CHIP Perinate (unborn child who lives in a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC’s enrollment broker.
A CHIP Perinate mother in a family with an income at or below 185% of the FPL may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under 185% of the FPL will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC’s enrollment broker.

A CHIP Perinate will continue to receive coverage through the CHIP Program as a “CHIP Perinate Newborn” if born to a family with an income above 185% to 200% FPL and the birth is reported to HHSC’s enrollment broker.

A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

**Specialty care provider responsibilities**

Care by specialists will be provided after a referral has been made by the Member’s Primary Care Provider. It is the responsibility of the specialist’s office to ensure that the Member has a valid referral prior to rendering services. Aetna Better Health Medicaid and CHIP network specialists must:

- Be licensed to practice in the State of Texas
- Have admitting privileges at an Aetna Better Health participating hospital
- Obtain a referral from the member’s Primary Care Provider. Or, for services on the prior authorization list, approval from the Aetna Better Health Medical Management Department before rendering services
- Assure that the consultation report and recommendations are sent to the Primary Care Provider and communicate with the Primary Care Provider regarding the Member’s status and course of treatment
- Inform the Member and/or family of the diagnostic, treatment and follow-up recommendations in consultation with the Primary Care Provider (if appropriate)
- Provide Members/families with appropriate health education in the management of the Member’s special needs.

**Responsibility to verify member eligibility**

All Members have an Aetna Better Health Medicaid or CHIP ID card. Eligibility should be verified prior to rendering services via:

- Utilizing our website at www.aetnabetterhealth.com
- Contacting Aetna Better Health at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

All Members must be referred by their Primary Care Provider for specialist services other than for behavioral health, Ob/Gyn, vision services, or plan specific benefits (for example, ECI, family planning, etc.).

When an Aetna Better Health Medicaid or CHIP Member Presents For Services:

- Confirm Member eligibility with Aetna Better Health at [www.aetnabetterhealth.com](http://www.aetnabetterhealth.com)
- Contacting Aetna Better Health at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).
- Upon arrival for their appointment, verify the Aetna Better Health Medicaid and their Your Texas Benefits Medicaid Card
- If a CHIP Member, ask him/her to present his/her Aetna Better Health CHIP ID card.
**Specialists as primary care provider**

A specialty physician may assume the responsibilities of a primary care provider as a primary care provider under specific circumstances, such as in the case of a Member with a disability or chronic/complex condition. By allowing a specialist to act as a primary care provider, Members are able to draw upon the most appropriate care to meet their needs. In this capacity, the specialist is required to fulfill all of the responsibilities of a primary care provider.

Specialists who would like to be the Primary Care Provider for an Aetna Better Health Medicaid or CHIP member should contact the Medical Management Department for further information and to complete the request form. A determination will be made within 30 calendar days from the date the request is received. Member and provider requests for a specialist to be a primary care provider will be reviewed by Medical Director and approved if the specialist agrees to coordinate all of the member’s care and meets other criteria for participation as a primary care provider. The effective date of the designation of the specialist as the primary care provider may not be applied retroactively.

If this request is denied, an enrollee may appeal the decision through the HMO’s established complaint and appeal process. Please refer to the complaint and appeal section for more information. If the request for special consideration of a non-primary care physician specialist to act as a primary care physician is approved, the HMO may not reduce the amount of compensation owed to the original primary care physician for services provider before the date of new designation.

If medically necessary covered services are not available through network physicians or providers, the HMO on request of a network physician or provider and within a reasonable time shall allow referral to a non-network physician or provider and fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate. "Within a reasonable time" means with the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation. An HMO must provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral.

**Accessibility and availability standards**

Providers are expected to adhere to the following appointment and availability standards:

<table>
<thead>
<tr>
<th>Level of care</th>
<th>Waiting times for appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>Upon Member presentation at the service delivery site</td>
</tr>
<tr>
<td>Urgent Care Appointments</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Routine Specialty Care - Medical</td>
<td>Within 14 days of request</td>
</tr>
<tr>
<td>Routine Specialty Care – Behavioral Health</td>
<td>Within 14 days of request</td>
</tr>
<tr>
<td>Prenatal Care/ First Visit</td>
<td>Within 14 days of request</td>
</tr>
</tbody>
</table>

For high-risk pregnancies or new Members in the third trimester, appointments should be offered immediately, but no later than 5 days of request.
Ob/Gyn services accessed without a referral

Aetna Better Health does limit the Member’s selection of an Ob/Gyn to the Aetna Better Health Medicaid or CHIP network. Female patients have direct access to gynecologists and infertility specialists. If a member needs further care by a specialist or specialty care on the prior authorization list, the Primary Care Provider or the Ob/Gyn must initiate the referral through the Aetna Better Health Medical Management Department. Please contact us at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

CHIP Perinatal provider responsibilities

As a CHIP Perinate provider, the assigned medical professional is responsible for providing the needed care for the CHIP Perinate member related to prenatal visits and labor with delivery of the eligible unborn child. CHIP Perinatal providers can include a Physician, Physician’s Assistant, or Advanced Practice Nurse who is contracted with Aetna Better Health to provide Covered Health Services to an unborn child and who is responsible for providing initial and primary care, maintaining the continuity of care and initiating referrals for care.

When enrolling in Aetna Better Health CHIP Perinate, each member will pick a perinatal provider who participates in Aetna Better Health CHIP Perinate. The perinatal provider will provide covered services for the member and arrange for any required prior authorization from Aetna Better Health. To learn more please see the Referrals section of this manual.

Participating providers will abide by Aetna Better Health’s policies regarding preventive care and health education to members during each office visit and will document such services in the member’s medical records.

As the Perinatal provider you must provide primary prenatal care services and continuity of care to members who are enrolled with or assigned to you. Perinatal Care Services are all services that are considered medically necessary according to the definition found previously in relation to the Covered Benefits for the CHIP Perinate member. All services must be provided in compliance with generally accepted medical standards for the community in which services are rendered.

As the Perinatal provider, you must insure integration of member’s medical home needs with home and community resources which provide medical nutritional, behavioral, educational and outreach services available to members.

As the Perinatal provider, you must call the emergency room with relevant information about the member when necessary.

As the Perinatal provider, you must provide or arrange for follow-up care after emergency or inpatient care.

Medicaid Managed Care member 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 your 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. 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.

5. 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.

6. 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.

7. 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.

8. 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. 

9. 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**

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program. 
   b. Ask questions if you don’t understand your rights. 
   c. Learn what choices of health plans are available in your area. 

2. 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. 

3. 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. 

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

**CHIP Managed Care member 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 decide 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.

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.

1. You must try to follow healthy habits, such as encouraging your child to exercise, staying away from tobacco
products and eating a healthy diet.
2. You must become involved in the doctor’s decisions about your child’s treatments.
3. 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.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan’s complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. 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.
7. If your child has CHIP, you are responsible for paying your doctor and other providers copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP by health care providers, other members, or health plans.
9. Talk to your child’s provider about all of your child’s medications.

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

CHIP Perinatal Member 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.

**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](http://www.hhs.gov/ocr).

**Fraud and abuse program**

**Fraud and abuse**
Aetna Better Health has an aggressive, proactive fraud and abuse program that complies with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. A Special Investigations Unit (SIU) is a key element of the program. This SIU detects, investigates and reports any suspected or confirmed cases of fraud, abuse or waste to the Office of Inspector General (OIG). During the investigation process, the confidentiality of the patient and or people referring the potential fraud and abuse case is maintained.

Aetna Better Health uses a variety of mechanisms to detect potential fraud or abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as providers and Members, shares the responsibility to detect and report fraud. Review mechanisms includes audits, review of provider service patterns, hotline reporting, claim review, data validation and data analysis.

**FRAUD INFORMATION**

**REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR CLIENT**
MEDICAID MANAGED CARE AND CHIP
Do you want to report Waste, Abuse, or Fraud?
Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren’t given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else’s Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

**To report waste, abuse or fraud, choose one of the following:**

- Call the OIG Hotline at 1-800-436-6184;
- Visit [https://oig.hhsc.state.tx.us/](https://oig.hhsc.state.tx.us/) Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
- You can report directly to your health plan:
  - Aetna Better Health
  - PO Box 569150
  - Dallas, TX 75356-9150
  - 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

**To report waste, abuse or fraud, gather as much information as possible.**

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened

- When reporting about someone who gets benefits, include:
  - The person’s name
  - The person’s date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse, or fraud

**Investigation of fraud/abuse**
The SIU Coordinator conducts a preliminary investigation within 15 working days of identification of a potential fraud or abuse case. This investigation includes information from previous investigations, a review of Provider Relations educational/visitation logs, provider profile reports, individual provider paid or denied claims and encounter reporting. The SIU Coordinator also reviews the provider’s prior payment history. Provider must supply copies of the complete medical records and encounter data within 20 working days from the date of the written request. If records are not received by the specified due date, the SIU Coordinator will cease investigative efforts and submit the information to HHSC-Office of Inspector General (OIG).

**Medical record review**
After the initial investigation is conducted and it has been determined that possible fraud exists, a sample of 50 Members or 15% of the provider’s claims will be requested within 15 working days of making the
determination. Within 15 working days of selecting the sample, the SIU requests medical records and encounter data from the provider or Member in question and reviews the medical records and encounter data within 45 working days of receipt, to validate the sufficiency of data and ensure accuracy of encounter data. An evaluation of the need to review any additional medical records is also be assessed.

**Reporting member and provider fraud and abuse to the Office of Inspector General (OIG)**

Once the detection is made, the SIU investigates the case to include any supporting elements needed to complete this investigation and may convene, if necessary, the Fraud and Abuse Committee to review. Feedback from the Committee is incorporated into the completion of the investigation. The SIU reviews the case for completeness and accuracy and is accountable for reporting all information to the Office of Inspector General (OIG) within 15 working days of making the determination on the fraud or abuse case via the HHSC-Office of Inspector General (OIG) fraud referral form.

**Expedited referrals**

All cases involving the following situations will initiate an expedited referral to the Office of Inspector General (OIG).

- Suspected harm or death to patients
- Loss, destruction, or alteration of valuable evidence
- Potential for significant monetary loss that may not be recoverable
- Hindrance of investigation or criminal prosecution of alleged offense

**Member, provider and staff education**

Members are encouraged to report suspected fraud and abuse through the Fraud and Abuse hotline. The Member Handbook, provided to Members upon enrollment, is the primary communication vehicle for Members of the Aetna Better Health fraud and abuse plan. Periodic articles on fraud and abuse are also published in Member newsletters. During orientations, the Provider Relations staff provides an overview of the fraud and abuse plan to newly contracted providers identifying their responsibility to report all cases of suspected fraud or abuse. Periodic articles regarding fraud and abuse are also published in the provider newsletters.

Annual mandatory fraud and abuse training is provided to all Aetna Better Health staff. The training incorporates the fraud and abuse plan, detailed information about the function of the SIU, detection of fraud and abuse, investigation procedures, including the identification of violations to the state and federal False Claims Acts, and Whistleblower Protection Provisions, as well as reporting all suspected cases to the SIU. Aetna Better Health also offers an online fraud training course that will help our internal staff to understand the obligations concerning detection and prevention of health care fraud and to instruct proper handling of transactions once health care fraud is suspected. Examples of Member fraud or abuse including ID card fraud, ER abuse, and prescription drug abuse, are illustrated. Examples of provider fraud such as upcoding, billing for services not provided, and submitting false encounter data are also presented.

**Reporting waste, abuse and fraud by a provider or client**

If you suspect a person who receives benefits or a provider (doctor, dentist, counselor, etc.) has committed waste, abuse, or fraud, you have a responsibility and a right to report it.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ and pick “Click Here to Report Waste, Abuse, and Fraud” to complete
the online form; or

You can also report directly to Aetna Better Health any providers or clients you suspect of waste, abuse or fraud:

Aetna Better Health
Attention: SIU Coordinator PO Box 569150
Dallas, TX 75356-9150
1-888-761-5440

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened

- When reporting about someone who receives benefits include:
  - The person’s name
  - The person’s date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse, or fraud.

**HHSC regulatory requirements for fraud and abuse**
The Aetna Better Health Medicaid or CHIP network provider agrees to provide the following entities or their designees with prompt, reasonable and adequate access to the network provider agreement and any records, books, documents, and papers that are related to the network provider agreement and/or the network provider’s performance of its responsibilities under this contract:

a) HHSC and MCO Program personnel from HHSC
b) U.S. Department of Health and Human Services
c) Office of Inspector General and/or the Texas Medicaid Fraud Control Unit
d) An independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC
e) State or federal law enforcement agency
f) Special or general investigation committee of the Texas Legislature
g) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

The Aetna Better Health Medicaid or CHIP network provider must provide access wherever it maintains such records, books, documents and papers.

The network provider must provide such access in reasonable comfort and provide any furnishings, equipment and other conveniences deemed reasonably necessary to fulfill the purposes described herein.

Requests for access may be for, but are not limited to, the following purposes:

1. examination
2. audit
3. investigation
4. contract administration
5. the making of copies, excerpts, or transcripts, or
6. any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.

The Aetna Better Health Medicaid or CHIP network provider understands and agrees that the acceptance of funds under the Medicaid or CHIP contract acts as acceptance of the authority of the State Auditor’s Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. The Aetna Better Health Medicaid or CHIP network provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested.

The Aetna Better Health Medicaid or CHIP network provider understands and agrees to the following:
1. HHSC Office of Inspector General (OIG) and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of network providers and their employees, agents, contractors, and patients;
2. Requests for information from such entities must be complied with, in the form and language requested
3. Network providers and their employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the network provider’s own expense
4. Compliance with these requirements will be at the Aetna Better Health network provider’s own expense.

The Aetna Better Health Medicaid or CHIP network provider understands and agrees to the following:
1. Network providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the Medicaid and/or CHIP Programs, as applicable;
2. Network providers must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;
3. Network providers must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General’s Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;
4. If the network provider places required records in another legal entity’s records, such as a hospital, the network provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
5. Network providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by the MCO or a Member to the HHSC Office of Inspector General.

**State and federal false claims acts and whistleblower protections**
Aetna Better Health is also responsible for investigating and reporting fraud or abuse related to the filing of false claims against the United States Government or failure of an MCO to provide services required under contract with the state of Texas, enrollment/marketing violations or wrongful denials of claims. This information is detailed in the following locations:

- Title 31 United States Code (USC), Subtitle III, Chapter 37, Subchapter III, Section 3729 – 3733 (Federal
Aetna Better Health staff, contracted providers, entities or agents are protected from retaliation from Aetna Better Health in the event that they report suspected filing of false or fraudulent claims against the Government by Aetna Better Health. In 1986, congress added anti-retaliation protections to the False claims Act. These Provisions are contained in 31 USC Section 3730(h) and state that:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of his employer or others in furtherance of and action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

Additional information on the False Claims Acts and Whistleblower Protections can be found in the Aetna Better Health Fraud and Abuse Plan on the Aetna Better Health website (www.aetnabetterhealth.com) or in the federal and state statute listed above. You may also contact Aetna Better Health Provider Relations for further information.

**Encounter data, billing and claims administration**
Network providers must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid Program.

**Mailing address**
Providers can mail paper claims to Aetna Better Health at the following address:

Aetna Better Health  
Attn: Claims Department  
PO Box 60938  
Phoenix, AZ 85082

Any changes to the location of where to send Aetna Better Health Medicaid or CHIP claims will be provided within 30 days of the effective date of the change. If it is not possible to give 30 days notice prior to a change in claims processing entities, the filing will be extended by 30 days. All Medicaid and CHIP Claims need to be billed with the Medicaid or CHIP member’s ID in box 1A of the CMS 1500 or box 60A on the UB-04 (previously called UB-92) claim forms. This complete number can be found on the Member’s Aetna Better Health Medicaid or CHIP ID card. This will allow Medicaid and CHIP claims to be routed to Aetna Better Health for correct claims processing.

**Appropriate forms**
The claim forms providers use to submit claims to Aetna Better Health have changed to accommodate the National Provider Identifier (NPI). The approved claim forms are the CMS 1500 and the CMS 1450. Allowable billing methods include paper or electronic billing. Forms CMS 1500 and CMS 1450 are explained below.

**CMS-1500 Professional Claim Forms**
Providers must use the revised CMS-1500 (version 08/05) claim form to file or re-file claims. The table below provides HHSC Managed Care Organization paper claim filing requirements. The fields indicated below are specific to the NPI Implementation.

<table>
<thead>
<tr>
<th>Field</th>
<th>Definition</th>
<th>Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 c</td>
<td>Insurance Plan or Program Name</td>
<td>Enter the benefit code, if applicable, for the billing or performing provider.</td>
<td>Benefit code, if applicable</td>
</tr>
<tr>
<td>17</td>
<td>Referring Provider or Other Source</td>
<td>Name of the professional who referred or ordered the service(s) or supply(s) on the claim.</td>
<td>NPI</td>
</tr>
<tr>
<td>17a</td>
<td>Other ID#</td>
<td>The Other ID number of the referring provider, ordering provider, or other source should be reported in 17a.</td>
<td>NPI or Atypical</td>
</tr>
<tr>
<td>17b</td>
<td>NPI</td>
<td>Enter the NPI of the referring provider, ordering provider, or other source.</td>
<td>NPI</td>
</tr>
<tr>
<td>24j</td>
<td>Rendering Provider ID# (Performing)</td>
<td>The individual rendering the service should be reported in 24j. Enter the TPI in the shaded area of the field. Enter the NPI in unshaded area of the field</td>
<td>TPI is shaded field and NPI in unshaded area</td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Information</td>
<td>Enter the name, address, city, state, and ZIP code of the location where the services were rendered.</td>
<td>Enter facility information when applicable</td>
</tr>
<tr>
<td>Field</td>
<td>Definition</td>
<td>Description</td>
<td>Requirement</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>32a</td>
<td>NPI</td>
<td>Enter the NPI of the service facility location.</td>
<td>NPI</td>
</tr>
<tr>
<td>32b</td>
<td>Other ID#</td>
<td>Enter the non-NPI ID number of the service facility. This refers to the payer-assigned unique identifier of the facility.</td>
<td>TPI</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info and Ph. No.</td>
<td>Enter the provider’s or supplier’s billing name, address, ZIP code, and telephone number.</td>
<td>The billing provider’s information is required.</td>
</tr>
<tr>
<td>33a</td>
<td>NPI</td>
<td>Enter the NPI of the billing provider.</td>
<td>NPI</td>
</tr>
<tr>
<td>33b</td>
<td>Other ID#</td>
<td>Enter the non-NPI ID number of the service facility. This refers to the payer-assigned unique identifier of the facility.</td>
<td>TPI required</td>
</tr>
</tbody>
</table>

**UB-04 Institutional claim form**

Providers must use the UB-04 CMS-1450 claim form to submit or resubmit claims, including appeals. The table below provides HHSC Managed Care Organizations paper claim filing requirements. The fields indicated in the table below are specific to the NPI Implementation.

<table>
<thead>
<tr>
<th>Field</th>
<th>Definition</th>
<th>Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>NPI</td>
<td>Enter the NPI of the billing provider.</td>
<td>NPI</td>
</tr>
<tr>
<td>57a</td>
<td>Other ID#</td>
<td>Enter the non-NPI ID number of the billing provider.</td>
<td>TPI (optional)</td>
</tr>
<tr>
<td>73</td>
<td>Benefit Code</td>
<td>Enter the benefit code, if applicable, for the billing provider.</td>
<td>Benefit code, if applicable (optional)</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider</td>
<td>Attending provider name and identifiers (including NPI): Required when claim/encounter contains any services other than nonscheduled transportation services. The attending provider is the individual who has overall responsibility for the patient’s medical care and treatment reported in this claim/encounter.</td>
<td>NPI required. TPI in field to the right of Qualifier box, if applicable</td>
</tr>
<tr>
<td>77</td>
<td>Operating Provider</td>
<td>Operating provider name and identifiers (including NPI): Required when a surgical procedure code is listed on the claim. The name and ID number of the individual with the primary responsibility for performing the surgical procedure(s).</td>
<td>NPI required. TPI in field to the right of Qualifier box, if applicable</td>
</tr>
</tbody>
</table>
**Claim submission**

Providers shall submit itemized statements on CMS-1500 or UB-04 claim forms with current HCPC, ICD-9, or CPT-4 coding. Hospitals should submit all claims on a UB-04 claim form for services provided to Aetna Better Health Medicaid and CHIP Members.

- Electronic claims should be submitted to Aetna Better Health using payer ID 38692. Claims billed using payer ID 38692 will come directly to the Medicaid/CHIP claim system.
- CMS-1500s can be submitted in the standard NSF 2.0 format and the UB-04s can be submitted in the standard ANSI format. Emdeon can also accept electronic claims in the MCDS and HCDS formats. Please contact Emdeon customer service for more information at 1-800-735-8254.

Providers can verify the status of a claim via the web portal.

**Emergency services claims**

Payment for emergency services is made based on the “Prudent Layperson” standard. Utilization of the emergency department for routine follow-up services such as suture removal, dressing change or well-person checkups is not appropriate. Claims for routine services provided in the emergency room will be denied.

Aetna Better Health does not require prior authorization for emergency services and does not limit what
constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The attending emergency physician or the provider actually treating the Member is responsible for determining when the Member is stable. Post-stabilization care provided to maintain, improve, or resolve the Member's stabilized condition is subject to prior authorization and notification requirements. We require notice of inpatient admission on the next business days following a non-elective admission.

Services are covered for the period of time it takes for us to make a determination, including times Medical Management cannot be contacted, does not respond to a request for approval within an hour, or a Medical Director is not available for consultation when medical necessity is questioned by the Medical Management staff.

The Aetna Better Health’s Medical Management Department has staff available by toll-free telephone at least 40 hours per week during normal business hours, Monday through Friday, except for State approved holidays. The phone system is capable of accepting and recording messages for incoming phone calls during non-business hours and the Medical Management staff responds to such calls the next business day in most cases and no later than 2 working days.

In the event a provider requests post stabilization care subsequent to emergency treatment when Medical Management staff is available, notification will occur within a time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from request. In such circumstances, notification shall be provided verbally to the treating physician or health care provider. In any instance where a service authorization request or authorization of service in an amount, duration or scope less than that requested is questioned, the health care provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the patient with the clinical basis for the decision with a physician prior to the issuance of a determination.

At least 2 documented attempts at consultation between the Medical Director and the treating physician will be made prior to an adverse determination. Benefits may be continued for the period of time it takes an appeal of the adverse determination to be resolved, both at the health plan appeal level and the external review by a Fair Hearing officer or an Independent Review Organization (IRO).

No copayments for Medicaid Managed Care members
There are no copayments due for Aetna Better Health Medicaid Members for covered services.

Billing Medicaid members
Except as specifically indicated in the Medicaid benefit descriptions, a provider may not bill or require payment from Members for Medicaid covered services. Providers may not bill, or take recourse against Members for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the STAR Program. For more information, please refer to Section 1.4.9 of the Texas Medicaid Provider Procedures Manual found at www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html.

Cost sharing schedule for Aetna Better Health CHIP members
The chart below is the complete cost sharing table for all CHIP eligible members depending on their income level. Copayments for medical services or prescription drugs are paid to the health care provider at the time of service. No copayments are paid for well-child and well-baby services, preventive services or pregnancy-related assistance. No copayments are required for CHIP Members who are Native Americans or Alaskan Natives.
The Aetna Better Health CHIP ID card lists the copayments that apply to each family’s situation. Aetna Better Health CHIP members should present their ID card when they receive physician or emergency room services or have a prescription filled.

**No copayments for CHIP Perinate and/or CHIP Perinate Newborn members**
There are no copayments due for Aetna Better Health CHIP Perinate or CHIP Perinate Newborn Members for covered services.

**CHIP cost sharing caps**
Members receive a guide from the CHIP Enrollment Broker when they enroll in the CHIP program. Included in the guide is a tear-out form that can be used to track CHIP expenses. To ensure that members do not exceed their cost-sharing limit, guardians must keep track of CHIP-related expenses on the form. The enrollment packet welcome letter tells the Member exactly what their cost-sharing cap is, based on family income. Members may contact the CHIP Helpline at 1-800-647-6558 to verify their annual limit.

When members reach their annual cap, they may send the form to CHIP Enrollment Broker and CHIP Services will notify Aetna Better Health of this information and we will issue a new Member ID card. This new card will show that no copayments are due when the Member receives services.

**Billing CHIP members**
Except as specifically indicated in the CHIP benefit descriptions, a provider may not bill or require payment, other than a copay, from Members for CHIP covered services. Providers may not bill, or take recourse against Members for denied or reduced claims for services that are within the amount, duration and scope of benefits of Texas CHIP. Aetna Better Health CHIP Providers are responsible for collecting at the time of service any applicable CHIP copayments in accordance with CHIP cost-sharing limitations.

Aetna Better Health CHIP Providers shall not charge:

1. Copayments or deductibles to CHIP Members of Native Americans or Alaskan Natives.
2. Copayments or deductibles to a CHIP Member with an ID card that indicates the Member has met his or her cost-sharing obligation for the balance of their term of coverage.
3. Copayments for well-child and well-baby services, preventive services, or pregnancy-related assistance.

Copayments are the only amounts that Aetna Better Health CHIP Providers may collect from CHIP Members, except for costs associated with unauthorized non-emergency services provided to a Member by out-of-network providers for non-covered services. We will initiate and maintain any action necessary to stop an Aetna Better Health provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member above an allowable copayment or deductible, excluding payment for services not covered by CHIP.

<table>
<thead>
<tr>
<th>CHIP cost-sharing</th>
<th>Effective through February 28, 2011</th>
<th>Effective March 1, 2011-February 29, 2012</th>
<th>Effective March 1, 2012**</th>
</tr>
</thead>
</table>

163
<table>
<thead>
<tr>
<th>Enrollment fees (for 12-month enrollment period):</th>
<th>Charge</th>
<th>Charge</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 150% of FPL*</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHIP cost-sharing</th>
<th>Effective through February 28, 2011</th>
<th>Effective March 1, 2011-February 29, 2012</th>
<th>Effective March 1, 2012**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 150% up to and including 185% of FPL</td>
<td>$35</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>Above 185% up to and including 200% of FPL</td>
<td>$50</td>
<td>$50</td>
<td>$50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Co-pays (per visit):</th>
<th>Charge</th>
<th>Charge</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 100% of FPL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$3</td>
<td>$3</td>
<td>$3</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$3</td>
<td>$3</td>
<td>$3</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$3</td>
<td>$3</td>
<td>$3</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient</td>
<td>$10</td>
<td>$10</td>
<td>$15</td>
</tr>
<tr>
<td>Cost-sharing Cap</td>
<td>1.25% (of family’s income)***</td>
<td>1.25% (of family’s income)***</td>
<td>5% (of family’s income)***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Above 100% up to and including 150% FPL</th>
<th>Charge</th>
<th>Charge</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>$5</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$5</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$5</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient (per admission)</td>
<td>$25</td>
<td>$25</td>
<td>$35</td>
</tr>
<tr>
<td>Cost-sharing Cap</td>
<td>1.25% (of family’s income)***</td>
<td>1.25% (of family’s income)***</td>
<td>5% (of family’s income)***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Above 150% up to and including 185% FPL</th>
<th>Charge</th>
<th>Charge</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>$7</td>
<td>$12</td>
<td>$20</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$50</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$5</td>
<td>$8</td>
<td>$10</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$20</td>
<td>$25</td>
<td>$35</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient (per admission)</td>
<td>$50</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>Cost-sharing Cap</td>
<td>2.5% (of family’s income)***</td>
<td>2.5% (of family’s income)***</td>
<td>5% (of family’s income)***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Above 185% up to and including 200% FPL</th>
<th>Charge</th>
<th>Charge</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>$10</td>
<td>$16</td>
<td>$25</td>
</tr>
</tbody>
</table>
The network provider understands and agrees that the MCO has the sole responsibility for payment of Covered Services rendered pursuant to this network provider contract, and that HHSC is not liable or responsible for such payment.

**Private pay agreement / member acknowledgment**
If an Aetna Better Health Medicaid or CHIP Member decides to go to a provider that is not within the Aetna Better Health Medicaid or CHIP network or chooses to get services that have not been authorized or are not a covered benefit, the Member must document his/her choice by signing the Private Pay Agreement (Appendix I) and the Member Acknowledgement form (Appendix J).

If a claim is not received by Aetna Better Health within 95 days, the claim will be denied unless excepted from the claims filing deadline. For more information, refer to the Texas Medicaid Provider Procedures Manual, Section 6.1.3, “Claims Filing Deadlines,” which includes exceptions for inpatient facility claims, claims by newly-enrolled Medicaid providers, claims by out-of-state providers, and other exceptions www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html

Participating providers shall be paid by us, no later than 30 working days after receipt of a completed “clean” claim for covered services. A clean claim is one that is accurate, complete (that is, includes all information necessary to determine Aetna Better Health liability), not a claim on appeal, and not contested (that is, not reasonably believed to be fraudulent and not subject to a necessary release, consent or assignment). Aetna
Better Health will indicate to participating providers within 30 days of receipt if claims received by Aetna Better Health, are not clean claims.

**Hospital facility claims for Aetna Better Health CHIP Perinate and CHIP Perinate Newborns**

**Clients at or below 185% of Federal Poverty Level:**
Hospital facility charges related to an Aetna Better Health CHIP Perinate member’s labor with delivery, and the initial hospital admission of an Aetna Better Health CHIP Perinate Newborn member is covered by Emergency Medicaid. Hospitals will need to work with these members to apply for Emergency Medicaid upon presentation to the hospital for services. These claims will be billed to Texas Medicaid and Healthcare Partnership (TMHP) through the TMHP normal billing processes. Please contact TMHP at 1-800-925-9126 or visit their website at www.tmhp.com for details their billing process.

Any hospital services rendered to Aetna Better Health CHIP Perinate Newborn members after the original newborn hospital discharge will not be considered for reimbursement under Emergency Medicaid, but can be covered under CHIP (see the CHIP Perinate Newborn scope of benefits). Hospitals should urge mothers to apply for “regular” Medicaid for the newborn only if the child has a medical condition that is not considered normal for a newborn.

**Clients with income above 185-200% of Federal Poverty Level:**
Hospital facility charges related to labor with delivery for an Aetna Better Health CHIP Perinate and the initial hospital admission of an Aetna Better Health CHIP Perinate Newborn should be mailed to:

Aetna Better Health  
Attn: Claims Department  
PO Box 60938  
Phoenix, AZ 85082

Electronic submission can be performed by submitting EDI claims to Payor ID 38692 to Emdeon. Providers can contact Emdeon at 1-800-735-8254 for assistance. Required formats are CMS 1500 –NSF (National Standard Format 2.0) and UB-04 (previously known as UB-92) –ANSI. Providers have 95 days from date of service to submit claims for services. Authorization numbers must be included on CMS 1500 field # 23 and UB-04 field # 63. Aetna Better Health CHIP Perinate and Aetna Better Health CHIP Perinate Newborn are obligated to pay all clean claims within 30 days of receipt.

**FQHC/RHC reimbursement**

**FQHCs**

<table>
<thead>
<tr>
<th>Type of Service</th>
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<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Services</td>
<td>T1015 (CMS 1450)</td>
<td>Encounter rate</td>
</tr>
<tr>
<td>THSteps</td>
<td>CPT (CMS 1500)</td>
<td>Encounter rate</td>
</tr>
<tr>
<td>Family Planning</td>
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<tr>
<td>Vision</td>
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<td>Behavioral Health</td>
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**RHCs**

**STAR**

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**CHIP**

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<td>Encounter rate</td>
</tr>
</tbody>
</table>

Additional Items:
- Co-pay as appropriate to CHIP plans will apply to T1015 codes
- Follow-up visits after well child exam billed with 99211 and a well diagnosis code of V20.2, V20.31, or V20.32 will be denied.
- FQHCs and RHCs will be instructed to bill their NPI in both billing and rendering fields on the claim for STAR and CHIP.

**Claims for vaccines**

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid procedure code must be submitted with the appropriate “administration with counseling” procedure code(s) (procedure codes 90460 and 90461) or the most appropriate “administration without counseling” procedure code (procedure code 90471, 90472, 90473, or 90474). If an “administration with counseling” procedure code is submitted with an “administration without counseling” procedure code for the same vaccine or toxoid, the administration of the vaccine or toxoid will be denied.

**Immunization administration without counseling**

Procedure codes 90471, 90472, 90473, and 90474 are a benefit for immunizations administered to the following:
- Clients who are 19 years of age and older
- Clients of any age who do not require counseling

Providers must no longer include modifiers U2 or U3 when submitting claims for procedure codes 90471, 90472, 90473, or 90474. Providers will no longer receive an increased rate for additional state-defined components.
For the initial “without counseling” vaccine or toxoid administration that is submitted on the claim, procedure code 90471 must be submitted if an injection is administered, or procedure code 90473 must be submitted if the administration is oral or nasal. Only one initial “without counseling” procedure code may be reimbursed on the claim. All subsequent “without counseling” vaccine or toxoid administrations must be submitted using procedure code 90472 or 90474 depending on the route of administration.

**Clean claim requirements**

The following are clean claim submission requirements as specified by TDI:

Clean Claim Elements: Aetna Better Health Medicaid and CHIP Services will adhere to the elements of a clean claim as described in Texas Administrative Code Title 28, Part 1, Chapter 21, Subchapter T, Rule § 21.2803. The necessary elements are:

Required data elements. CMS has developed claim forms which provide much of the information needed to process claims. Two of these forms, HCFA 1500 and UB-82/HCFA, and their successor forms, have been identified by Insurance Code Article 21.52C as required for the submission of certain claims. The terms in paragraphs (1) and (2) of this subsection are based upon the terms used by CMS on successor forms CMS-1500 and UB-92 CMS-1450 claim forms. The parenthetical information following each term refers to the applicable CMS claim form, and the field number to which that term corresponds on the CMS claim form.

(1) Required form and data elements for physicians or noninstitutional providers for claims filed or re-filed on or after the later of July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for Medicare claims. The CMS-1500 (08/05) and the data elements described in this paragraph are required for claims filed or re-filed by physicians or noninstitutional providers on or after the later of these two dates: July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for Medicare claims. The CMS-1500 (08/05) must be completed in accordance with the special instructions applicable to the data element as described by this paragraph for clean claims filed by physicians and noninstitutional providers. Further, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05), a physician or noninstitutional provider may submit claims on form CMS-1500 (08/05) prior to the mandatory use date described in this paragraph, subject to the required data elements set forth in this paragraph.

(A) subscriber’s/patient’s plan ID number (CMS-1500 (08/05), field 1a) is required; (B) patient’s name (CMS-1500 (08/05), field 2) is required;

(C) patient’s date of birth and gender (CMS-1500 (08/05), field 3) is required;

(D) subscriber’s name (CMS-1500 (08/05), field 4) is required, if shown on the patient’s ID card; (E) patient’s address (street or P.O. Box, city, state, ZIP) (CMS-1500 (08/05), field 5) is required;

(F) patient’s relationship to subscriber (CMS-1500 (08/05), field 6) is required;

(G) subscriber’s address (street or P.O. Box, city, state, ZIP) (CMS-1500 (08/05), field 7) is required, but physician or provider may enter “same” if the subscriber’s address is the same as the patient’s address required by subparagraph (E) of this paragraph;

(H) other insured’s or enrollee’s name (CMS-1500 (08/05), field 9) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (1)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(I) other insured’s or enrollee’s policy/group number (CMS-1500 (08/05), field 9a) is required if the patient is
covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (1)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element; (J) other insured’s or enrollee’s date of birth (CMS-1500 (08/05), field 9b) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (1)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element; (K) other insured’s or enrollee’s plan name (employer, school, etc.) (CMS-1500 (08/05), field 9c) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (1)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element; (L) other insured’s or enrollee’s HMO or insurer name (CMS-1500 (08/05), field 9d) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (1)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element. If the field is required and the physician or provider is a facility-based radiologist, pathologist, or anesthesiologist with no direct patient contact, the physician or provider must either enter the information or enter “NA” (not available) if the information is unknown; (M) whether patient’s condition is related to employment, auto accident, or other accident (CMS-1500 (08/05), field 10) is required, but facility-based radiologists, pathologists, or anesthesiologists shall enter “N” if the answer is “No” or if the information is not available; (N) if the claim is a duplicate claim, a “D” is required; if the claim is a corrected claim, a “C” is required (CMS-1500 (08/05), field 10d); (O) subscriber’s policy number (CMS-1500 (08/05), field 11) is required; (P) HMO or insurance company name (CMS-1500 (08/05), field 11c) is required; (Q) disclosure of any other health benefit plans (CMS-1500 (08/05), field 11d) is required; (i) if answered “yes,” then:
(1) data elements specified in paragraph
(1)(H) - (L) of this subsection are required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete the data elements in paragraph (1)(H) - (L) of this subsection;
(ii) the data element specified in paragraph (1)(II) of this subsection is required when submitting claims to secondary payor HMOs or preferred provider carriers; (ii) if answered “no,” the data elements specified in paragraph (1)(H) - (L) of this subsection are not required if the physician or provider has on file a document signed within the past 12 months by the patient or authorized person stating that there is no other health care coverage; although the submission of the signed document is not a required data element, the physician or provider shall submit a copy of the signed document to the HMO or preferred provider carrier upon request;
(R) patient’s or authorized person’s signature or notation that the signature is on file with the physician or provider (CMS-1500 (08/05), field 12) is required;
(S) subscriber’s or authorized person’s signature or notation that the signature is on file with the physician or provider (CMS-1500 (08/05), field 13) is required;
(T) date of injury (CMS-1500 (08/05), field 14) is required if due to an accident;
(U) when applicable, the physician or provider shall enter the name of the referring primary care physician, specialty physician, hospital, or other source (CMS-1500 (08/05), field 17); however, if there is no referral, the physician or provider shall enter “Self-referral” or “None”;
(V) if there is a referring physician noted in CMS-1500 (08/05), field 17, the physician or provider shall enter the ID Number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (08/05), field 17a);
(W) for claims filed or re-filed on or after May 23, 2008, if there is a referring physician noted in CMS-1500 (08/05), field 17, the physician or provider shall enter the NPI number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (08/05), field 17b) if the referring physician is eligible for an NPI number;
(X) narrative description of procedure (CMS-1500 (08/05), field 19) is required when a physician or provider uses an unlisted or not classified procedure code or an NDC code for drugs;
(Y) for diagnosis codes or nature of illness or injury (CMS-1500 (08/05), field 21), up to four diagnosis codes may be entered, but at least one is required (primary diagnosis must be entered first);
(Z) verification number (CMS-1500 (08/05), field 23) is required if services have been verified pursuant to §19.1724 of this title (relating to Verification). If no verification has been provided, a prior authorization number (CMS 1500 (08/05), field 23b) is required; (AA) date(s) of service (CMS-1500 (08/05), field 24) is required;
(BB) place of service code(s) (CMS-1500 (08/05), field 24B) is required; (CC) procedure/modifier code (CMS-1500 (08/05), field 24D) is required; (DD) diagnosis code by specific service (CMS- 500 (08/05), field 24E) is required with the first code linked to the applicable diagnosis code for that service in field 21;
(EE) charge for each listed service (CMS-1500 (08/05), field 24F) is required; (FF) number of days or units (CMS-1500 (08/05), field 24G) is required;
(GG) for claims filed or re-filed on or after May 23, 2008, the NPI number of the rendering physician or provider (CMS-1500 (08/05), field 24i, unshaded portion) is required if the rendering provider is not the billing provider listed in CMS-1500 (08/05), field 33, and if the rendering physician or provider is eligible for an NPI number;
(HH) physician’s or provider’s federal tax ID number (CMS-1500 (08/05), field 25) is required;
(H) whether assignment was accepted (CMS-1500 (08/05), field 27) is required if assignment under Medicare has been accepted;
(JJ) total charge (CMS-1500 (08/05), field 28) is required;
(KK) amount paid (CMS-1500 (08/05), field 29) is required if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber or by a primary plan in accordance with paragraph (1)(P) of this subsection and as required by subsection (d) of this section;
(LL) signature of physician or provider or notation that the signature is on file with the HMO or preferred provider carrier (CMS-1500 (08/05), field 31) is required;
(MM) name and address of facility where services rendered (if other than home) (CMS-1500 (08/05), field 32) is required;
(NN) for claims filed or re-filed on or after May 23, 2008, the NPI number of facility where services are rendered (other than home) is required (CMS-1500 (08/05), field 32a) if the facility is eligible for an NPI; (OO) physician’s or provider’s billing name, address and telephone number (CMS-1500 (08/05), field 33) is required;
(PP) for claims filed or re-filed on or after May 23, 2008, the NPI number of billing provider (CMS-1500 (08/05),
(2) Required form and data elements for physicians or noninstitutional providers for claims filed or re-filed before the later of July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for Medicare claims. The CMS-1500 (12/90) and the data elements described in this paragraph are required for claims filed or re-filed by physicians or noninstitutional providers before the later of these two dates: July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for Medicare claims. The CMS-1500 (12/90) must be completed in accordance with the special instructions applicable to the data element as described in this paragraph for clean claims filed by physicians and noninstitutional providers. However, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05), a physician or noninstitutional provider may submit claims on form CMS-1500 (08/05) prior to the subsection (b)(1) mandatory use date, subject to the subsection (b)(1) required data elements.

(A) subscriber’s/patient’s plan ID number (CMS-1500 (12/90), field 1a) is required; (B) patient’s name (CMS-1500 (12/90), field 2) is required;
(C) patient’s date of birth and gender (CMS-1500 (12/90), field 3) is required;
(D) subscriber’s name (CMS-1500 (12/90), field 4) is required, if shown on the patient’s ID card; (E) patient’s address (street or P.O. Box, city, state, ZIP) (CMS-1500 (12/90), field 5) is required;
(F) patient’s relationship to subscriber (CMS-1500 (12/90), field 6) is required;
(G) subscriber’s address (street or P.O. Box, city, state, ZIP) (CMS-1500 (12/90), field 7) is required, but physician or provider may enter “same” if the subscriber’s address is the same as the patient’s address required by subparagraph (E) of this paragraph;
(H) other insured’s or enrollee’s name (CMS-1500 (12/90), field 9) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;
(I) other insured’s or enrollee’s policy/group number (CMS-1500 (12/90), field 9a) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;
(J) other insured’s or enrollee’s date of birth (CMS-1500 (12/90), field 9b) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;
(K) other insured’s or enrollee’s plan name (employer, school, etc.) (CMS-1500 (12/90), field 9c) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but
unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element. If the field is required and the physician or provider is a facility based radiologist, pathologist or anesthesiologist with no direct patient contact, the physician or provider must either enter the information or enter “NA” (not available) if the information is unknown;
(L) other insured’s or enrollee’s HMO or insurer name (CMS-1500 (12/90), field 9d) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, “disclosure of any other health benefit plans,” is answered “yes,” this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;
(M) whether patient’s condition is related to employment, auto accident, or other accident (CMS-1500 (12/90, field 10) is required, but facility-based radiologists, pathologists, or anesthesiologists shall enter “N” if the answer is “No” or if the information is not available;
(N) if the claim is a duplicate claim, a “D” is required; if the claim is a corrected claim, a “C” is required (CMS-1500 (12/90), field 10d);
(O) subscriber’s policy number (CMS-1500 (12/90), field 11) is required;
(P) HMO or insurance company name (CMS-1500 (12/90), field 11c) is required;
(Q) disclosure of any other health benefit plans (CMS-1500 (12/90), field 11d) is required; if answered “yes”, then:
(I) data elements specified in paragraph (2)(H) - (L) of this subsection are required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete the data elements in paragraph (2)(H) - (L) of this subsection; (II) the data element specified in paragraph (2)(II) of this subsection is required when submitting claims to secondary payor HMOs or preferred provider carriers; (iii) if answered “no”, the data elements specified in paragraph (2)(H) - (L) of this subsection are not required if the physician or provider has on file a document signed within the past 12 months by the patient or authorized person stating that there is no other health care coverage; although the submission of the signed document is not a required data element, the physician or provider shall submit a copy of the signed document to the HMO or preferred provider carrier upon request;
(R) patient’s or authorized person’s signature or notation that the signature is on file with the physician or provider (CMS-1500 (12/90), field 12) is required;
(S) subscriber’s or authorized person’s signature or notation that the signature is on file with the physician or provider (CMS-1500 (12/90), field 13) is required;
(T) date of injury (CMS-1500 (12/90), field 14) is required, if due to an accident;
(U) when applicable, the physician or provider shall enter the name of the referring primary care physician, specialty physician, hospital, or other source (CMS-1500 (12/90 field 17); however, if there is no referral, the physician or provider shall enter “Self-referral” or “None”;
(V) the physician or provider shall enter the ID Number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (12/90), field 17a); however, if there is no referral, the physician or provider shall enter “Self-referral” or “None”;
(W) narrative description of procedure (CMS-1500 (12/90), field 19) is required when a physician or provider uses an unlisted or not classified procedure code or an NDC code for drugs;
(X) for diagnosis codes or nature of illness or injury (CMS-1500 (12/90), field 21), up to four diagnosis codes may be entered, but at least one is required (primary diagnosis must be entered first);
(Y) verification number (CMS-1500 (12/90), field 23) is required if services have been verified pursuant to §19.1724 of this title (relating to Verification). If no verification has been provided, a prior authorization number (CMS-1500 (12/90), field 23) is required when prior authorization is required and granted;
(Z) date(s) of service (CMS-1500 (12/90), field 24A) is required;

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(AA) place of service code(s) (CMS-1500 (12/90), field 24B) is required; (BB) procedure/modifier code (CMS-
1500 (12/90), field 24D) is required;
(CC) diagnosis code by specific service (CMS-1500 (12/90), field 24E) is required with the first code linked to
the applicable diagnosis code for that service in field 21;
(DD) charge for each listed service (CMS-1500 (12/90), field 24F) is required; (EE) number of days or units
(CMS-1500 (12/90), field 24G) is required;
(FF) physician’s or provider’s federal tax ID number (CMS-1500 (12/90), field 25) is required;
(GG) whether assignment was accepted (CMS-1500 (12/90), field 27) is required if assignment under Medicare
has been accepted;
(HH) total charge (CMS-1500 (12/90), field 28) is required;
(ll) amount paid (CMS-1500 (12/90), field 29) is required if an amount has been paid to the physician or
provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber or by a
primary plan in accordance with paragraph (2)(P) of this subsection and as required by subsection (d) of this
section;
(JJ) signature of physician or provider or notation that the signature is on file with the HMO or preferred
provider carrier (CMS-1500 (12/90), field 31) is required;
(KK) name and address of facility where services rendered (if other than home or office) (CMS-1500 (12/90),
field 32) is required; and (LL) physician’s or provider’s billing name, address, and telephone number is
required, and the provider number (CMS-1500 (12/90), field 33) is required if the HMO or preferred provider
carrier required provider numbers and gave notice of that requirement to physicians and providers prior to
June 17, 2003. (3) Required form and data elements for institutional providers for claims filed or re-filed on or
after July 18, 2007. The UB-04 CMS-1450 and the data elements described in this paragraph are required for
claims filed or re-filed by institutional providers on or after July 18, 2007. The UB-04 CMS-1450 must be
completed in accordance with the special instructions applicable to the data elements as described by this
paragraph for clean claims filed by institutional providers. Further, upon notification that an HMO or preferred
provider carrier is prepared to accept claims filed or re-filed on form UB-04 CMS-1450, an institutional
provider may submit claims on UB-04 CMS-1450 prior to the mandatory use date described in this paragraph,
subject to the required data elements set forth in this paragraph.
(A) provider’s name, address, and telephone number (UB-04, field 1) is required; (B) patient control number
(UB-04, field 3a) is required;
(C) type of bill code (UB-04, field 4) is required and shall include a “7” in the fourth position if the claim is a
corrected claim;
(D) provider’s federal tax ID number (UB-04, field 5) is required;
(E) statement period (beginning and ending date of claim period) (UB-04, field 6) is required; (F) patient’s
name (UB-04, field 8a) is required;
(G) patient’s address (UB-04, field 9a - 9e) is required; (H) patient’s date of birth (UB-04, field 10) is required;
(I) patient’s gender (UB-04, field 11) is required;
(J) date of admission (UB-04, field 12) is required for admissions, observation stays, and emergency room care;
(K) admission hour (UB-04, field 13) is required for admissions, observation stays, and emergency room care;
(L) type of admission (e.g., emergency, urgent, elective, newborn) (UB-04, field 14) is required for admissions;
(M) source of admission code (UB-04, field 15) is required;
(N) discharge hour (UB-04, field 16) is required for admissions, outpatient surgeries, or observation stays; (O)
patient-status-at-discharge code (UB-04, field 17) is required for admissions, observation stays, and
emergency room care;
(P) condition codes (UB-04, fields 18 - 28) are required if the CMS UB-04 manual contains a condition code
appropriate to the patient’s condition; 64
(Q) occurrence codes and dates (UB-04, fields 31 - 34) are required if the CMS UB-04 manual contains an
occurrence code appropriate to the patient’s condition;
(R) occurrence span codes and from and through dates (UB-04, fields 35 and 36) are required if the CMS UB-04 manual contains an occurrence span code appropriate to the patient’s condition;
(S) value code and amounts (UB-04, fields 39 - 41) are required for inpatient admissions. If no value codes are applicable to the inpatient admission, the provider may enter value code 01;
(T) revenue code (UB-04, field 42) is required;
(U) revenue description (UB-04, field 43) is required;
(V) HCPCS/Rates (UB-04, field 44) are required if Medicare is a primary or secondary payor; (W) service date (UB-04, field 45) is required if the claim is for outpatient services;
(X) date bill submitted (UB-04, field 45, line 23) is required; (Y) units of service (UB-04, field 46) are required;
(Z) total charge (UB-04, field 47) is required;
(AA) HMO or preferred provider carrier name (UB-04, field 50) is required;
(BB) prior payments-payor (UB-04, field 54) are required if payments have been made to the physician or provider by a primary plan as required by subsection (d) of this section;
(CC) for claims filed or re-filed on or after May 23, 2008, the NPI number of the billing provider (UB-04, field 56) is required if the billing provider is eligible for an NPI number;
(DD) other provider number (UB-04, field 57) is required if the HMO or preferred provider carrier, prior to June 17, 2003, required provider numbers and gave notice of that requirement to physicians and providers;
(EE) subscriber’s name (UB-04, field 58) is required if shown on the patient’s ID card; (FF) patient’s relationship to subscriber (UB-04, field 59) is required;
(GG) patient’s/subscriber’s certificate number, health claim number, ID number (UB-04, field 60) is required if shown on the patient’s ID card;
(HH) insurance group number (UB-04, field 62) is required if a group number is shown on the patient’s ID card;
(II) verification number (UB-04, field 63) is required if services have been verified pursuant to §19.1724 of this title. If no verification has been provided, treatment authorization codes (UB-04, field 63) are required when authorization is required and granted;
(JJ) principal diagnosis code (UB-04, field 67) is required;
(KK) diagnoses codes other than principal diagnosis code (UB-04, fields 67A - 67Q) are required if there are diagnoses other than the principal diagnosis;
(LL) admitting diagnosis code (UB-04, field 69) is required;
(MM) principal procedure code (UB-04, field 74) is required if the patient has undergone an inpatient or outpatient surgical procedure;
(NN) other procedure codes (UB-04, fields 74 - 74e) are required as an extension of subparagraph (MM) of this paragraph if additional surgical procedures were performed;
(OO) attending physician NPI number (UB-04, field 76) is required on or after May 23, 2008, if attending physician is eligible for an NPI number; and
(PP) attending physician ID (UB-04, field 76, qualifier portion) is required. (4) Required form and data elements for institutional providers for claims filed or re-filed before July 18, 2007. The UB-92 CMS-1450 and the data elements described in this paragraph are required for claims filed or re-filed by institutional providers before July 18, 2007. The UB-92 CMS-1450 must be completed in accordance with the special instructions applicable to the data element as described in this paragraph for clean claims filed by institutional providers. However, upon notification that an HMO or preferred provider carrier will accept claims filed or refilled on form UB-04 CMS-1450, an institutional provider may submit claims on form UB-04 CMS-1450 prior to the subsection (b)(3) mandatory use date, subject to the subsection (b)(3) required data elements. (A) provider’s name, address and telephone number (UB-92, field 1) is required; (B) patient control number (UB-92, field 3) is required;
(C) type of bill code (UB-92, field 4) is required and shall include a “7” in the third position if the claim is a corrected claim;
(D) provider’s federal tax ID number (UB-92, field 5) is required;
(E) statement period (beginning and ending date of claim period) (UB-92, field 6) is required; (F) covered days (UB-92, field 7) is required if Medicare is a primary or secondary payor;

(G) noncovered days (UB-92, field 8) is required if Medicare is a primary or secondary payor; (H) coinsurance days (UB-92, field 9) is required if Medicare is a primary or secondary payor;

(I) lifetime reserve days (UB-92, field 10) is required if Medicare is a primary or secondary payor and the patient was an inpatient;

(J) patient’s name (UB-92, field 12) is required; (K) patient’s address (UB-92, field 13) is required;

(L) patient’s date of birth (UB-92, field 14) is required; (M) patient’s gender (UB-92, field 15) is required;

(N) patient’s marital status (UB-92, field 16) is required;

(O) date of admission (UB-92, field 17) is required for admissions, observation stays, and emergency room care;

(P) admission hour (UB-92, field 18) is required for admissions, observation stays, and emergency room care;

(Q) type of admission (e.g., emergency, urgent, elective, newborn) (UB-92, field 19) is required for admissions;

(R) source of admission code (UB-92, field 20) is required;

(S) discharge hour (UB-92, field 21) is required for admissions, outpatient surgeries, or observation stays; (T) patient-status-at-discharge code (UB-92, field 22) is required for admissions, observation stays, and emergency room care;

(U) condition codes (UB-92, fields 24 - 30) are required if the CMS UB-92 manual contains a condition code appropriate to the patient’s condition;

(V) occurrence codes and dates (UB-92, fields 32 - 35) are required if the CMS UB-92 manual contains an occurrence code appropriate to the patient’s condition;

(W) occurrence span code, from and through dates (UB-92, field 36), are required if the CMS UB-92 manual contains an occurrence span code appropriate to the patient’s condition;

(X) value code and amounts (UB-92, fields 39-41) are required for inpatient admissions. If no value codes are applicable to the inpatient admission, the provider may enter value code 01;

(Y) revenue code (UB-92, field 42) is required;

(Z) revenue description (UB-92, field 43) is required;

(AA) HCPCS/Rates (UB-92, field 44) are required if Medicare is a primary or secondary payor; (BB) Service date (UB-92, field 45) is required if the claim is for outpatient services;

(CC) units of service (UB-92, field 46) are required; (DD) total charge (UB-92, field 47) is required;

(EE) HMO or preferred provider carrier name (UB-92, field 50) is required;

(FF) provider number (UB-92, field 51) is required if the HMO or preferred provider carrier, prior to June 17, 2003, required provider numbers and gave notice of that requirement to physicians and providers.

(GG) prior payments-payor and patient (UB-92, field 54) are required if payments have been made to the physician or provider by the patient or another payor or subscriber, on behalf of the patient or subscriber, or by a primary plan as required by subsection (d) of this section;

(HH) subscriber’s name (UB-92, field 58) is required if shown on the patient’s ID card; (II) patient’s relationship to subscriber (UB-92, field 59) is required;

(JJ) patient’s/subscriber’s certificate number, health claim number, ID number (UB-92, field 60) is required if shown on the patient’s ID card;

(KK) insurance group number (UB-92, field 62) is required if a group number is shown on the patient’s ID card;

(LL) verification number (UB-92, field 63) is required if services have been verified pursuant to §19.1724 of this title. If no verification has been provided, treatment authorization codes (UB-92, field 63) are required when authorization is required and granted;

(MM) principal diagnosis code (UB-92, field 67) is required;

(NN) diagnoses codes other than principal diagnosis code (UB-92, fields 68 - 75) are required if there are diagnoses other than the principal diagnosis;

(OO) admitting diagnosis code (UB-92, field 76) is required;
(PP) procedure coding methods used (UB-92, field 79) is required if the CMS UB-92 manual indicates a procedural coding method appropriate to the patient’s condition;
(QQ) principal procedure code (UB-92, field 80) is required if the patient has undergone an inpatient or outpatient surgical procedure;
(RR) other procedure codes (UB-92, field 81) are required as an extension of subparagraph (QQ) of this paragraph if additional surgical procedures were performed;
(SS) attending physician ID (UB-92, field 82) is required;
(TT) signature of provider representative, electronic signature or notation that the signature is on file with the HMO or preferred provider carrier (UB-92, field 85) is required; and (UU) date bill submitted (UB-92, field 86) is required.

Disclosure of Necessary Attachments:
Aetna Better Health will not require an attachment as described in Texas Administrative Code Title 28, Part 1, Chapter 21, Subchapter T, Rule § 21.2803 unless it has given the physician or provider at least 90 calendar days notice prior to requiring the attachment. The notice will be contained in a revision to the Provider Manual. (Texas Administrative Code Title 28, Part 1, Chapter 21, Subchapter T, Rule § 21.2804) Disclosure of Additional Clean Claim Elements: Should Aetna Better Health determine that it needs to require additional elements for clean claims, these additional elements will be communicated to the physician or provider in a revision to the Provider Manual at least 90 calendar days prior to requiring the additional elements as elements of a clean claim. (Texas Administrative Code Title 28, Part 1, Chapter 21, Subchapter T, Rule § 21.2805.) Disclosure of Revision of Data Elements, Attachments, or Additional Clean Claim Elements: Should Aetna Better Health determine that it needs to revise its requirements for data elements, attachments or additional clean claim elements, it will provide at least 90 calendar days notice to the physician or provider.

**National coding and transaction**
Standards HIPAA requires that the American Medical Association’s (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided based on the code’s description. Providers must pay special attention to the standards CPT descriptions for the Evaluation and Management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the Medical.

**Special billing newborns**
It may take several weeks to process the newborn’s Member ID card once the newborn is enrolled. In the interim, use the mother’s ID card when administering care to the newborn. If after 31 days the newborn still has not received an ID card, please contact Aetna Better Health Member Services at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar).

For primary care providers:
If your office provided routine newborn hospital care, submit your bill electronically or on a CMS-1500 form to Aetna Better Health. If a referral is necessary or a newborn not yet appearing on the primary office list, use the mother’s Member ID number.

Inpatient admission prior to enrollment:
For CHIP Members hospitalized on the date of enrollment, Aetna Better Health is responsible for payment of physician and non-hospital charges from the date of eligibility with Aetna Better Health. For Medicaid members who become eligible with Aetna Better Health while inpatient, Aetna Better Health is only responsible for the professional charges associated with the hospital stay. Payment of physician charges should be submitted to previous STAR health plan member was enrolled in. To find out more information about a Medicaid member’s enrollment, call STAR Help Line at 1-800-964-2777.

Special billing for compounded medications
Aetna Better Health will cover compounds if:
- All ingredients are processed by the pharmacy
- The products are on the plan’s formulary
- Prior authorization must be obtained for all formulary products indicated as non-preferred on the Preferred Drug List. Please refer to page 3 of this manual for the Pharmacy Prior Authorization phone number

Pharmacy billing
Pharmacy providers are required to submit their electronic claims for payment within 90 days. Participating pharmacy providers must be paid by our Pharmacy Benefits Manager, CVS Caremark, no later than 18 working days after receipt of a completed “clean” claim for covered services. CVS Caremark pays pharmacies in accordance with Texas prompt pay regulations. Aetna Better Health Pharmacy Benefit Manager performance guarantee’s all clean claims are paid within 18 days, while submitted clean paper claims will be paid within 21 days.

Coordination of benefits (Dual coverage)
If an Aetna Better Health Medicaid or CHIP Member has insurance other than Medicaid or CHIP, the other insurance becomes the primary carrier and claims should be submitted to that primary carrier first. When you receive the primary carrier’s explanation of benefits (EOB), you can then file the claim with the EOB attached to Aetna Better Health. Aetna Better Health’s authorization procedures must be followed to receive payment. Only those services listed in the benefit schedule are available for reimbursement. Since the State’s CHIP Program is designed for children who do not have access to other health insurance, we ask that you notify us if an Aetna Better Health CHIP member has private health insurance. Please contact Aetna Better Health at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) to report this information which we will then forward to the State.

Providers must submit claims within 95 days of the rendering of service, or within 95 days of the primary carrier’s EOB in the Coordination of Benefits (COB) case. The network provider understands and agrees that it may not interfere with or place any liens upon the state’s right or the Aetna Better Health’s right, acting as the State’s agent, to recovery from third party resources.

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**

**Enrollment**

HHSC, in coordination with their Enrollment Broker, administers the enrollment process for Medicaid-eligibles. The Enrollment Broker initiates the enrollment process by sending the Medicaid-eligible person an enrollment packet. It is at that time the Medicaid-eligible person picks a health plan and a primary care provider. All enrollments into Aetna Better Health Medicaid must occur only through the Enrollment Broker. The enrollment counselors can be reached at **1-800-964-2777**.

**Newborn process**

Newborns of current Aetna Better Health Medicaid Members are automatically covered by Aetna Better
Health Medicaid for the first 90 days of life. However, it is the responsibility of the Member to notify HHSC to add the newborn in the STAR program to continue benefits. Aetna Better Health Medicaid will assign the newborn an internal “proxy ID” in order to expedite the payment of claims and systematically track the newborn. Once the newborn is enrolled with the STAR program, the “proxy ID” will be updated with the State-assigned Medicaid ID.

Practitioners and facility providers can report information about each child born to a mother eligible for Medicaid. To report this information, Federally Qualified Health Centers (including FQHCs with birthing centers), hospitals, and birthing centers should complete the “Hospital Report” (Newborn Child or Children) HHSC (Form 7484) and submit it to DADS Data Control within five days of the child’s birth.

For more detailed information on Newborn Services, please refer to Section 2.3.2.3 in the Physician section of the Texas Medicaid Provider Procedures Manual found at www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html.

Automatic reenrollment
Members who are disenrolled because they are temporarily ineligible for Medicaid will be automatically reenrolled into their previously selected health plan and primary care provider. Temporary loss of eligibility is defined as a loss of eligibility for a period of six months or less. When Aetna Better Health informs Members of their rights and responsibilities, they will also inform them of the automatic reenrollment process including the option to change health plans after reenrollment. This information is given to the Member in the Member Handbook.

Disenrollment
Aetna Better Health has a limited right to request a Member be disenrolled from the Plan without the Member’s consent. Request to disenroll a Member from the Plan will require medical documentation from the Member’s primary care provider or documentation that indicates sufficiently compelling circumstances that merits disenrollment. HHSC must approve and will make the final decision on any request by Aetna Better Health for disenrollment of a Member for cause.

- We will take reasonable measures to correct a Member’s behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.
- If all reasonable measures fail to remedy the problem, Aetna Better Health will notify the Member of the decision to recommend disenrollment to HHSC. The notice will include the process available to the Member to file an appeal or request a Fair Hearing.
- We cannot request a disenrollment based on adverse change in the Member’s health status or utilization of services that are medically necessary for treatment of a Member’s condition.
- Additionally, a provider cannot take retaliatory action against a Member who is disenrolled from Aetna Better Health Medicaid.

Changing Managed Care health plans
Medicaid Members can change health plans by calling the Texas STAR Program Helpline at 1-800-964-2777. Members can change plans as often they want, but not more than once a month. If a Member is in the hospital, a residential Substance Use Disorder (SUD) treatment facility, or residential detoxification facility for SUD, the Member will not be able to change health plans until he/she has been discharged. Exceptions to this rule include members retroactively enrolled in STAR as a pregnant woman or newborn and all Medicaid
eligible newborns.

If a Member calls to change health plans on or before the 15th of the month, the change will take place on the 1st day of the next month. If they call after the 15th of the month, the change will take place the 1st day of the 2nd month after that. For example:

- If a request for plan change is made on or before April 15, the change will take place May 1st.
- If a request for plan change is made after April 15, the change will take place on June 1.

**CHIP Member enrollment and disenrollment**

**Enrollment application**

Parents and guardians can apply telephonically for CHIP coverage by contacting CHIP at **1-800-647-6558**. Applicants can ask for a blank form or CHIP will print completed applications based on phone information and mail to the requesting party for signature and return. Applicants can download and complete application forms from the internet at [www.chipmedicaid.com](http://www.chipmedicaid.com). Once enrolled, the CHIP eligibility remains continuous for 12 months. Eligibility determination is the responsibility of the HHSC Administrative Services Contractor.

**Enrollment process**

Eligibility determination notices are sent to families determined eligible based on completed applications. The enrollment packet mailed to families contains:

- Explanation of CHIP benefits
- Comparison table showing value-added services by health plan
- A place to indicate a child with special health care needs
- A place to indicate whether a medical support order is applicable
- How to pick a health plan, primary care provider, and the choice to pick a specialist as Primary Care Provider
- Provider directories
- Cost-sharing information specific to the income level of the family and payment coupon book for families with net income over 150% Federal Poverty Level
- Simple form to track cost-sharing expenses relative to caps
- Information concerning the grievances and appeals process

Reminder notices are sent 14 days after enrollment packages are mailed to members. Concurrent notice is sent to the Community Based Organization (CBO) when there is a record of past involvement with the family. A follow-up letter is mailed 14 days after the reminder notices. Families who are unresponsive to the two follow-up attempts are timed out after 60 days.

Post-enrollment letters are sent as temporary evidence of coverage, pending receipt of the health plan ID card. Enrollment letters will contain the following information:

- Member ID numbers
- First date of coverage
- Health plan and Primary Care Provider sections
- Applicable co-payments

**Re-enrollment**

At the beginning of the tenth month of coverage, the Administrative Services Contractor will send a notice
to the family outlining the next steps for renewal for continuation of coverage. The Administrative Services Contractor will also send a notice to the Health Plan regarding its members and to a community based outreach organization providing follow-up assistance in the members’ areas. To promote continuity of care for children eligible for re-enrollment, the HMO can ease re-enrollment through reminders to members and other appropriate means. Failure of the family to respond to the Administrative Services Contractor’s renewal notices will result in disenrollment from the plan and from CHIP.

**Disenrollment**

For those members who are disenrolled because they are no longer eligible for CHIP, the HMO will receive from the Administrative Services Contractor notice informing the HMO that the members’ coverage will end on a particular date. Disenrollment due to loss of eligibility includes, but is not limited to; “aging-out” when a child turns 19, failure to re-enroll at the conclusion of the 12-month eligibility period, change in health insurance status, failure to meet monthly cost–sharing obligation, death of the child, child permanently moves out of the state, and data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP.

Aetna Better Health has a limited right to ask for a member be disenrolled from the Plan without the member’s consent. Aetna Better Health’s request to disenroll a member from the Plan will require medical documentation from the member’s Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merits disenrollment. HHSC must approve and will make the final decision on any request by Aetna Better Health for disenrollment of a member for cause.

Aetna Better Health will make sure that punitive action is not taken in retaliation against a member who requests an appeal or a provider who requests an expedited resolution or supports a member’s appeal.

- We will take reasonable measures to correct a member’s behavior before asking for disenrollment.
- Reasonable measures can include providing education and counseling regarding the offensive acts or behaviors.
- If all reasonable measures fail to remedy the problem, Aetna Better Health will inform the member of the decision to recommend disenrollment to HHSC.
- We cannot ask for a disenrollment based on adverse change in the member’s health status or utilization of services that are medically necessary for treatment of a member’s condition.
- Additionally, a provider cannot take retaliatory action against a member who is disenrolled from Aetna Better Health.

**Changing Managed Care health plans**

Members are allowed to make health plan changes under the following circumstances:

- For any reason within the 90 days of enrollment in CHIP and once thereafter;
- For cause at any time;
- If the client moves to a different service area; and
- During the annual re-enrollment period.

HHSC must approve and will make the final decision on any request by members to change health plans.
CHIP Perinatal member enrollment and disenrollment

**Newborn process**

- When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member’s health plan if those health plans are different. All members of the household must remain in the same health plan until the later of: 1) the end of the CHIP Perinatal member’s enrollment period; or 2) the end of the traditional CHIP member’s enrollment period. Copayments, cost-sharing and enrollment fees still apply to children enrolled in the CHIP Program.

- In the 10th month of the CHIP Perinate Newborn’s coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn’s and the CHIP members’ information. Once the child’s CHIP Perinatal coverage expires, the child will be added to his or her siblings’ existing CHIP case.

**Changing Managed Care health plans**

- A CHIP Perinate (unborn child) who lives in a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC’s enrollment broker.
  
  — A CHIP Perinate mother in a family with an income at or below 185% of the FPL may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under 185% of the FPL will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC’s enrollment broker.

- A CHIP Perinate will continue to receive coverage through the CHIP Program as a “CHIP Perinate Newborn” if born to a family with an income above 185% to 200% FPL and the birth is reported to HHSC’s enrollment broker.

- A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

- CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

- When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member’s health plan if the plan is different. All members of the household must remain in the same health plan until the later of: 1) the end of the CHIP Perinatal member’s enrollment period; or 2) the end of the traditional CHIP members’ enrollment period. In the 10th month of the CHIP Perinate Newborn’s coverage, the family will receive a CHIP renewal form, which will be prepopulated to include the CHIP Perinate Newborn’s and the CHIP members’ information. Once the child’s CHIP Perinatal coverage expires, the child will be added to his or her siblings’ existing CHIP case.

- CHIP Perinatal Members may request to change health plans under the following circumstances:
  
  - For any reason within the 90 days of enrollment in CHIP Perinatal;
  - If the Member moves to a different service delivery area; and
For cause at any time.

Disenrollment
HHSC must approve and will make the final decision on any request for disenrollment of a member for cause.

A provider cannot take retaliatory action against a member who is disenrolled from Aetna Better Health CHIP Perinate or Aetna Better Health CHIP Perinate Newborn.

Medical Management
Aetna Better Health’s Medical Management model emphasizes case management, disease management, discharge planning and targeted concurrent review. The Medical Management staff is accessible through a toll-free telephone number 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, State-approved holidays and after normal business hours will be returned on the next business day.

The Aetna Better Health Medical Management Unit 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. 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.

Medical Management has adopted screening criteria and established review procedures which are periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians and other health care providers. Utilization review decisions are made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case. In addition to the Texas Medicaid Provider Procedures Manual, Aetna Better Health 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 Medical Management staff also utilizes Aetna Better Health Clinical Policy Bulletins (CPBs) as supplemental guidelines in determining the safety, effectiveness and medical necessity of selected medical technologies. Screening criteria is used to determine only whether to approve the requested service. Flexibility may be utilized when applying screening criteria in determining utilization review decisions for Members with special health care needs. This may involve Members who have a disability, acute condition or a life-threatening illness. Cases that cannot be approved by a nurse reviewer are referred to a Medical Director to determine medical necessity.

In any instance where a service authorization request or authorization of service in an amount, duration or scope less than that requested is questioned, the health care provider who ordered the services shall be afforded an opportunity to discuss the plan of treatment for the patient with the clinical basis for the decision with a physician 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.

Aetna Better Health does not require prior authorization for emergency services and does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The attending emergency physician or the provider actually treating the Member is responsible for determining when the
Member is stable.

Post-stabilization care provided to maintain, improve or resolve the Member’s stabilized condition is subject to prior authorization and notification requirements, but is covered for the period of time it takes for Aetna Better Health to make a determination, including times the Plan cannot be contacted, does not respond to a request for approval within one hour, or a Medical Director is not available for consultation when medical necessity is questioned by the Medical Management staff.

**Utilization Management**

The Aetna Better Health Medical Management Department is responsible for maintaining a system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of health services provided, being provided, or proposed to be provided to members.

**Prior authorization**

Prior Authorization is the prospective review of the medical necessity and appropriateness of the selected health services. The prior authorization list is reviewed and revised periodically to ensure only those services that are medical management issues are subject to review by the health plan and approved before the services are eligible for reimbursement.

The process for requesting services on the prior authorization list:

- Complete the Texas Universal Authorization Form.
- Fax to Aetna Better Health Prior Authorization Unit at 1-866-835-958.
- Include any pertinent clinical information that supports the medical necessity of the request, such as a Title XIX form, test results, information about failed conservative treatment
- Allow at least 3 business days for a response if medically appropriate. Urgent requests for medically non-urgent services will be handled within the timeframes for a routine request
- Respond to requests for additional information timely. The turnaround time begins when all information necessary to make determination is received.

Medical Management staff will review the information submitted for medical necessity, verify eligibility and benefits for the member and issue a determination. Approvals will be communicated to the requesting provider. Adverse determinations will be communicated to the requesting provider immediately followed by a written notice of the determination and appeal rights. For the most up to date Prior Authorization list, please refer to our website.

**Concurrent review**

Concurrent Review is the ongoing review of the medical necessity and appropriateness of previously authorized health services. This includes extensions of outpatient services and review of hospitalized members.

**Maternity management program**

Members who become eligible for Medicaid due to pregnancy, as well as any Medicaid or CHIP member who becomes pregnant while on the Plan, receive educational materials and telephone interventions encouraging them to seek early prenatal care, attend all scheduled prenatal visits and make healthy lifestyle choices to succeed in a healthy birth outcome. Assessment and questionnaires are conducted to identify members who may be at risk for complications related to their pregnancy. In addition to the traditional Medicaid obstetrical benefits, including genetic services from full-service genetic providers, we provide case management for high-
risk pregnancies. Care Management staff initiate contact with these members as soon as they are identified to provide coaching, education and other services to help the member and her providers in developing a case management service plan. Care Managers follow up with the member to assess compliance with their plan of care and monitor for early signs of complications. Providers are encouraged to refer their OB patients to the Care Management Department as soon as the pregnancy is confirmed to facilitate care coordination and minimize delays in payment. To refer an OB patient, please call the Aetna Better Health Member Services Department at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

**Newborn (NB) and sonogram process**

**Newborn process:**
- Authorization must be requested for any NB after day 4 of stay
- DRG hospitals must meet the acute level of care

**Sonogram process:**
- No limitation on number of sonograms performed as long as medically necessary
- Does not require an authorization.

**CHIP Perinate**
- Can get one sonogram per pregnancy
- Must be high risk diagnosis with supporting clinical documentation for more.
- Information must be submitted and approved prior to the second sonogram being performed.
- Please complete the Texas referral authorization form and fax to 1-866-835-9589.

**OB process:**
- No authorization required for OB global days. (2 day uncomplicated Vaginal Delivery & 4 day uncomplicated C-section)
- Anything outside of the OB global must be authorized.
- If the DRG is a higher DRG upon submission of claim, provider must follow the current appeal process for any denied claims.
- Resubmit for review and payment based on documented medical necessity.

**Transplants**
Members that require organ/tissue transplants that include bone marrow, peripheral stem cell, heart, lung, liver, kidney and combined heart/lung receive case management services to facilitate continuity and coordination of care among the providers who care for the member. Transplants must be performed in an institution that is certified by Texas Medicaid and participates in the Aetna Better Health Medicaid and CHIP programs. Prior authorization for transplant services is required and exceptions to any provisions defined in the Texas Medicaid Provider Procedures manual must be approved by the Medical Director. To request case management services for an Aetna Better Health member who is a potential transplant recipient, call the Aetna Better Health Member Services Department.

**Disease Management**
The conditions currently targeted for Aetna Better Health Disease Management are asthma, diabetes and depression. Members receive disease management education, coaching and other services that include welcome letters, action plans and access to disease management nurses through a toll-free telephone number. Care Management Staff proactively perform or facilitate assessments and questionnaires and
develop a service plan based on the Member’s understanding of their condition, need for equipment, supplies, referral for specialty care or other special considerations due to co-morbidities— including behavioral health and substance abuse.

Our goal is to provide comprehensive integrated care management services that holistically address the needs of members with chronic conditions. Members that might benefit from disease management are identified and enrolled in a program based on screening and evaluation procedures for early detection. Members may also enroll in the disease management programs through self-referral or upon the recommendation of a physician or other health care provider. The components of the disease management programs include:

- Patient self-management education
- Provider education
- Evidence-based models and minimum standards of care
- Standardized protocols and participation criteria
- Physician-directed or physician supervised care
- Interventions that address continuum of care
- Mechanisms to modify or change interventions that are not proven effective
- Mechanisms to monitor the impact of the disease management program over time, including both the clinical and the financial impact

Many of the complications and acute episodes associated with chronic diseases and conditions can be avoided or slowed by prevention, education, early detection, self-care and appropriate interaction. Our disease management programs focus on improving members' understanding of their illnesses and the impacts that these illnesses have on their lifestyles, as well as helping providers to deliver high-quality care based on opportunities to improve the health status of chronically ill individuals. Our staff work with members to enhance their ability to work with their physicians to take control of (and manage) their chronic conditions. Providers receive regular feedback on the members that are enrolled in the disease management programs, that includes information concerning member adherence to a service plan. Alerts are issued when differences between recommended prevention and treatment and actual care received by Members enrolled in a disease management program are identified.

To refer a patient for disease management, please call the Aetna Better Health Member Services Department at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

**Case management services**

Case management is “a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes” (Case Management Society of America). Aetna Better Health attempts to assist in the efficient utilization of medical resources for Members with special health care needs, including highly complex chronic and catastrophic cases to improve access to quality care and avoid unnecessary medical costs.

Members who might benefit from case management are identified for case management through utilization management activities, health risk assessments and screening of administrative data. Treating providers may refer Members for Case Management services by contacting the Aetna Better Health Medical Management Department. Members may also self-refer for case management.

The multidisciplinary Medical Management staff includes designated Case Managers for high-cost catastrophic cases, high-risk OB, pediatric, adult, premature infant, behavioral health and Members with Special Health
Care Needs.

The Medical Management staff use screening tools and guidelines to identify Members with catastrophic, complicated or complex conditions as soon as possible after becoming Aetna Better Health Medicaid and CHIP Members. Members are assigned to a Case Manager as soon as they are identified for assessment and development of a case management plan. Case management plans are based on the Member’s medical and behavioral health care needs. Templates for condition-specific case management plans are customized with Member specific goals in cooperation with the Member, the Member’s family, the Primary Care Provider and other practitioners involved in the care of the Member. The plan includes goals and objectives with targeted interventions to meet those goals and objectives.

Reassessment is done regularly to determine progress and the plan is modified when acute needs are identified and then periodically as the Member moves through the continuum of care. Once the stated goals and objectives are met, the Member is discharged from case management. The Case Manager takes a proactive approach to managing the health of the Member and providing Members with health promotion information and assistance based on individual Member conditions. Results have shown that personalized case management planning with regular follow-up is the most effective method of managing cost and improving outcomes.

Members with special health care needs

Members with Special Health Care Needs are those Members who have or are at risk for a chronic or complex physical, mental, emotional, behavioral or developmental disorder and who also require health and related services of a type or amount beyond that required by the general population. These conditions are expected to last at least 12 months or longer (or have sequelae that last at least 12 months or longer) and require ongoing treatment and or monitoring. Aetna Better Health provides the following services for Members with Special Health Care Needs or needs other than the general population.

General transportation and ambulance – Medicaid only

General transportation

What is MTP?

MTP is an HHSC program that helps with non-emergency transportation to healthcare appointments for eligible Medicaid clients who have no other transportation options. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?

- Passes or tickets for transportation such as mass transit within and between cities
- Air travel
- Taxi, wheelchair van, and other transportation
- Mileage reimbursement for enrolled individual transportation participant (ITP). The enrolled ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals at a contracted vendor (such as a hospital cafeteria)
- Lodging at a contracted hotel and motel
- Attendant services (responsible party such as a parent/guardian, etc., who accompanies the client to a healthcare service)
How to get a ride?

If the member lives in the counties of Collin, Dallas, Denton, Ellis, Hood, Hunt, Johnson, Kaufman, Navarro, Parker, Rockwall, Tarrant, and Wise:

Call LogistiCare
Phone reservations: **1-855-687-3255**
Phone Ride Help Line: **1-877-564-9834**
Hours: LogistiCare takes requests for routine transportation by phone Monday through Friday from 8:00 a.m. to 5:00 p.m. Routine transportation should be scheduled 48 hours (2 business days) before your appointment.

If you live in the counties of Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller and Wharton:

Call MTM
Phone reservations: **1-855-687-4786**
Where’s My Ride: **1-888-513-0706**
Hours: 7am to 6pm, Monday-Friday / Call **1-855-MTP-HSTN** or **1-855-687-4786** at least 48 hours before your visit. If it’s less than 48 hours until your appointment and it’s not urgent, MTM might ask you to set up your visit at a different date and time.

If the member lives in any other county:

Call MTP
Phone reservations: **1-877-633-8742**
All requests for transportation services should be made within 2-5 days of your appointment. Exceptions may be authorized in the event of an emergency.

Ambulance transportation
Medicaid reimburses for emergency and non-emergency transports for those clients that meet the severely disabled criteria. Severely disabled means that “the clients’ physical condition limits mobility and requires the client to be bed-confined at all times or unable to sit unassisted at all times, or requires continuous life support systems (including oxygen or IV infusion) or monitoring of unusual physical or chemical restraint.” All non-emergency transports require prior authorization. Emergency transports do not require prior authorization. For more information regarding ambulance services and/or limitations, please refer to Section 8.2.5 of the Texas Medicaid Provider Procedures Manual found at www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html.

Interpreter/translation services
Aetna Better Health provides language interpretation services to translate multiple languages. We do this through a language line which may be accessed by calling our Member Services line and our Member Services Staff will then contact the language line as a third party conversation. For persons who are deaf or hearing impaired, please call TTY line at **1-800-735-2989** and ask them to call the Member Services Line.

Aetna Better Health also maintains a current list of interpreters who remain available to provide interpreter services. We will arrange, with 72-hour notice, to have someone that speaks the Member’s language meet the
patient at the provider’s office when they come for their appointment. For Members in need of a sign language interpreter, Aetna Better Health will provide an approved interpreter from the American Sign Language Association. Interpreter services will be paid for by Aetna Better Health. Trained interpreters must be used when technical, medical, or treatment information is to be discussed. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality or confidentiality is critical unless specifically requested by the Member.

**HMO/provider coordination**

Aetna Better Health will comply with the HHSC standards regarding care for persons with disabilities or chronic and complex conditions. We will provide information, education and training programs to Members, families, primary care providers, specialty physicians, and Community Agencies about the care and treatment available within Aetna Better Health for Members with disabilities or chronic or complex conditions. Specialists may function as a primary care provider for treatment of Members with chronic/complex conditions when approved by Aetna Better Health.

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of ethnicity, sex, age, religion, color, mental or physical disability, national origin, marital status, sexual orientation, or health status (including, but not limited to, chronic communicable diseases such as AIDS or HIV positive status). All participating physicians and health care professionals may also have an obligation under the Federal Americans with Disabilities Act to provide physical access to their offices and reasonable accommodations for patients and employees with disabilities.

For each person with disabilities or chronic or complex conditions, the Primary Care Provider is required to develop a plan of care that meets the special preventive, primary acute care and specialty care needs of the Member. The plan must be based on:

- Health needs
- Specialist recommendations
- Periodic reassessment of the Member’s functional status and service delivery needs.

The Primary Care Provider must maintain an initial plan of care in the medical records of persons with disabilities or chronic or complex conditions and that plan must be updated as often as the Member’s needs change, but at least annually.

Aetna Better Health will ensure the members with special health care needs have adequate access to primary care providers and specialists skilled in treating persons with disabilities or chronic or complex conditions. Case Management services are available to assist members with special health care needs, their families and health care providers to facilitate access to care, continuity and coordination of services.

**Reading/grade level consideration**

Adhering to the policies and procedures set by HHSC, any literature that is published for informational use by Aetna Better Health Medicaid or CHIP Members needs to be written at or below a 6th grade reading level and in English and Spanish. This will help to enhance the communication between the population, providers and Aetna Better Health.

**Cultural sensitivity**

It is critical that Aetna Better Health and its participating providers be sensitive to the vast cultural differences that span the Texas Medicaid and CHIP population. To that end, it is critical that we, as partners, develop a
culturally competent system of care – one that acknowledges and incorporates at all levels the importance of
culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural
differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique
needs (Cross et al 1989).

Texas Medicaid and CHIP recipients will vary in language and culture (for example, customs, religion,
backgrounds, etc). Our goal is to effectively serve Members of all cultures, races, ethnic backgrounds and
religions in a manner that recognizes values, affirms and respects the worth of the individuals and protects
and preserves the dignity of each. We must operate at a level in which cultural knowledge is high and policies
and practices are in place that produces positive results and satisfaction from the viewpoint of the culturally
diverse Member.

Aetna Better Health maintains a cultural competency plan which is available upon request to Aetna Better
Health.

Insurance requirements, laws, rules and regulations

Insurance
An Aetna Better Health Medicaid or CHIP Network Provider shall maintain, during the term of the network
provider contract, Professional Liability Insurance of $100,000 per occurrence and $300,000 in the aggregate,
or the limits required by the hospital at which network provider has admitting privileges.

NOTE: Community-based Long Term Care providers are exempt from this requirement as long as their
licensure does not require the professional liability insurance. This provision will not apply if the network
provider is a state or federal unit of government that is required to comply with, and is subject to, the
provisions of the Texas and/or Federal Tort Claims Act.

An Aetna Better Health Medicaid or CHIP network provider shall maintain, during the term of the network
provider contract:

1. Worker’s Compensation coverage in the amounts required by Texas law
2. Comprehensive Liability Insurance including Bodily Injury Coverage of $100,000 per occurrence and
   Comprehensive Liability Insurance including Property Damage Coverage of $25,000 per occurrence.

Laws, rules and regulations
The Aetna Better Health Medicaid or CHIP Network Provider understands and agrees that it is subject to all
state and federal laws, rules, regulations and waivers that apply to the network provider Contract, the
Medicaid and/or CHIP Program and all persons or entities receiving state and federal funds. The network
provider understands and agrees that any violation by a provider of a state or federal law relating to the
delivery of services pursuant to this network provider contract, or any violation of the HHSC/MCO contract
could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or
federal law.

The network provider understands and agrees that the following laws, rules, and regulations, and all
amendments or modifications thereto, apply to the network provider contract:

1. Environmental protection laws:
   a) Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free
      workplace and promoting the non-use of all tobacco products
c) Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, “Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans”)
d) State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State

e) Implementation Plans under §176(c) of the Clean Air Act and

2. State and federal anti-discrimination laws:
   a) Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352)
   b) Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112)
   c) Americans with Disabilities Act of 1990 (Public Law 101-336) and d. Title 40, Texas Administrative Code, Chapter 73.

3. The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 et seq.) regarding employment verification and retention of verification forms and

**Liability**

In the event the Aetna Better Health becomes insolvent or ceases operations, the network provider understands and agrees that its sole recourse against Aetna Better Health will be through Aetna’s bankruptcy, conservatorship or receivership estate. The network provider understands and agrees that the Aetna Better Health’s Members may not be held liable for the Aetna’s debts in the event of the entity’s insolvency. The network provider understands and agrees that HHSC does not assume liability for the actions of, or judgments rendered against, Aetna, its employees, agents or subcontractors. Further, the network provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to the network provider by Aetna Better Health or any judgment rendered against Aetna. HHSC’s liability to the network provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.).

**Marketing**

The Aetna Better Health Medicaid or CHIP network provider agrees to comply with HHSC’s marketing policies and procedures, as set forth in the HHSC/MCO Managed Care Contract (which includes HHSC’s Uniform Managed Care Manual).

The network provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain network providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

**Professional conduct**

While performing the services described in the network provider contract, the network provider agrees to:

1. Comply with applicable state laws, rules and regulations and HHSC’s requests regarding personal and professional conduct generally applicable to the service locations and 2. otherwise conduct themselves in a businesslike and professional manner.
Conclusion
We are pleased to partner with Medicaid and/or CHIP network providers to coordinate covered services for STAR and CHIP Members. Members who take an active part in their health care begin with effective and appropriate communication, in large part given by the provider. We appreciate you taking the time to review the Aetna Better Health Medicaid and CHIP Program requirements presented in this manual.

Should you have questions, please contact Aetna Better Health Provider Relations at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).
Appendix A – Sample ID cards

*Your Texas Medicaid ID card, form 3087 and plan ID cards*

<table>
<thead>
<tr>
<th>Medicaid ID Card</th>
<th>Health plan / Plan de salud</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member name:</strong></td>
<td><strong>Your plan</strong></td>
</tr>
<tr>
<td>John Doe</td>
<td>1-800-####-####</td>
</tr>
<tr>
<td><strong>Member ID (Medicaid ID):</strong></td>
<td></td>
</tr>
<tr>
<td>123456789</td>
<td></td>
</tr>
<tr>
<td><strong>Issuer ID:</strong></td>
<td><strong>Date card sent:</strong></td>
</tr>
<tr>
<td>(80840)</td>
<td>10/01/2011</td>
</tr>
<tr>
<td><strong>XXXXXXX</strong></td>
<td></td>
</tr>
<tr>
<td><strong>RxBIN:</strong></td>
<td></td>
</tr>
<tr>
<td>001111</td>
<td></td>
</tr>
<tr>
<td><strong>RxPCN:</strong></td>
<td></td>
</tr>
<tr>
<td>ADV</td>
<td></td>
</tr>
<tr>
<td><strong>RxGRP:</strong></td>
<td></td>
</tr>
<tr>
<td>RX1234</td>
<td></td>
</tr>
</tbody>
</table>
Form 3087 and plan ID card

<table>
<thead>
<tr>
<th>ID #</th>
<th>Name</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Eligibility Date</th>
<th>Type</th>
<th>Medicare #</th>
</tr>
</thead>
<tbody>
<tr>
<td>765432198</td>
<td>JOHN DOE</td>
<td>04-30-1990</td>
<td>M</td>
<td>04-30-2003</td>
<td>P</td>
<td></td>
</tr>
</tbody>
</table>

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1 de enero de 2006, usted tendrá los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

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### Back of 3087 ID form

**FOR THE CLIENT:** About your Medicaid ID Form

This is your Medicaid identification form. A new Medicaid identification form will be mailed to you each month. Take your most recent Medicaid identification form with you when you visit your doctor or receive services from any of your health care providers. This form helps health care providers know which services you can receive.

If you receive a letter from HRSC stating that the Medicaid program will no longer pay for certain health services your provider thinks you need, this letter will tell you about your right to ask for a due process hearing to appeal the denial of services. The letter will tell you who to call and listen address where you can write to request a hearing.

**NOTE:** If you accept Medicaid benefits or services or supplies, the HRSC has the right to receive payment for those services or supplies from other insurance companies and other third-party sources, up to the amount paid by Medicaid.

<table>
<thead>
<tr>
<th>Question</th>
<th>Contact</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who can I call for help finding or connecting a doctor, dentist, care...</td>
<td>Texas Healthsteps</td>
<td>1-877-467-4371</td>
</tr>
<tr>
<td>Who can I call to find out which services are paid by Medicaid or if I...</td>
<td>Texas-wide Medicaid helpline</td>
<td>1-800-355-6867</td>
</tr>
<tr>
<td>Who can I call to get my Medicaid provider?</td>
<td>Medical Transportation</td>
<td>1-877-403-6747</td>
</tr>
<tr>
<td>Who can I call if I have questions or problems with my health plan, or ...</td>
<td>STARLINK, Medicaid Managed Care</td>
<td>1-866-666-4888</td>
</tr>
<tr>
<td>Who can I call about my Medicaid benefits?</td>
<td>Texaswide Medicaid helpline</td>
<td>1-800-355-4851</td>
</tr>
<tr>
<td>Are you receiving help paying my medical bills and needing assistance ...</td>
<td>STARLINK, Medicaid Managed Care</td>
<td>1-866-666-4888</td>
</tr>
<tr>
<td>Who can I call to find out about nursing home care, adult day care, or ...</td>
<td>Texaswide Medicaid helpline</td>
<td>1-800-355-4851</td>
</tr>
<tr>
<td>Who can I call to tell me about how my other insurance affects my ...</td>
<td>Texas Medicaid Healthcare Partnership Third</td>
<td>1-888-865-7707</td>
</tr>
<tr>
<td>To whom do I report Medicaid fraud, waste, or abuse?</td>
<td>Office of Inspector General</td>
<td>1-800-435-8103</td>
</tr>
<tr>
<td>Who can I call about getting help to pay my private insurance premiums?</td>
<td>Health Insurance Premium Program hotline</td>
<td>1-877-467-4680</td>
</tr>
<tr>
<td>Who can I call if I receive Supplemental Security Income (SSI) and I need to change my address?</td>
<td>Social Security Administration</td>
<td>1-800-772-1213</td>
</tr>
<tr>
<td>Who can I call if I have questions about my Medicare Rx Prescription Program?</td>
<td>Medicare</td>
<td>1-888-MEDEX99 (1-888-633-9999)</td>
</tr>
<tr>
<td>Who can I call to use TDD/TTY for hearing impairment?</td>
<td>Texas Relay</td>
<td>1-800-735-2989</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Contact</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Quién puede llamar si necesita ayuda para encontrar o conectarse con un ...</td>
<td>Planes Sanos de Texas</td>
<td>1-877-467-4377</td>
</tr>
<tr>
<td>¿Quién puede llamar para recibir información sobre qué servicios paga ...</td>
<td>Líneas Estadía de Ayuda de Medicaid</td>
<td>1-800-288-0957</td>
</tr>
<tr>
<td>¿Quién puede llamar a mí proveedor de Medicaid?</td>
<td>Transport médicos</td>
<td>1-877-637-0747</td>
</tr>
<tr>
<td>¿Quién puede ayudar si tengo preguntas o problemas con mi plan de salud y ...</td>
<td>STARLINK, Medicaid Managed Care</td>
<td>1-866-666-4888</td>
</tr>
<tr>
<td>¿Quién puede informar sobre cómo recibir beneficiarios de Medicaid. Tomo ...</td>
<td>Líneas Directas del Cliente de Texas Medica ...</td>
<td>1-800-339-0657</td>
</tr>
<tr>
<td>¿Quién puede recibir ayuda para pagar mis cuentas médicas y recibir informa ...</td>
<td>Líneas Directas del Cliente de Departamento ...</td>
<td>1-800-465-9858</td>
</tr>
<tr>
<td>¿Quién puede decirme cómo puedo recibir el seguro médico de Medicaid?</td>
<td>Líneas Directas de Recursos para Personas ...</td>
<td>1-800-646-7307</td>
</tr>
<tr>
<td>¿Quién puede decirme cómo puedo recibir el seguro médico de Medicaid?</td>
<td>Líneas Directas del Programa de Prima ...</td>
<td>1-800-445-0463</td>
</tr>
<tr>
<td>¿Qué puedo hacer si necesito ayuda para pagar mis primas de seguro privado?</td>
<td>Líneas Directas de Seguro Social</td>
<td>1-800-772-1213</td>
</tr>
<tr>
<td>¿Qué puedo hacer si tengo preguntas sobre mi Programa de Medicamentos con ...</td>
<td>Medicare</td>
<td>1-800-MEDEX99 (1-888-633-9999)</td>
</tr>
<tr>
<td>¿Qué puedo hacer si tengo preguntas sobre mi Programa de Medicamentos con ...</td>
<td>Texas Relay</td>
<td>1-800-735-2989</td>
</tr>
</tbody>
</table>

Form H3487/Page 203-2007
Aetna Better Health plan ID cards
Medicaid ID card

Member Name: Medicaid ID:

Date of Birth:

PCP:

Effective Date:

PCP Telephone:

Carry this card with you and present it at time of service.

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

For additional information regarding emergency services, please refer to your member handbook.

Mailing address:

Claims Processing Center
P.O. Box 60003
Phoenix, AZ 85082
Member ID: 31602

Member Services / Servicios para Miembros: 1-800-386-8612
Behavioral Health / Salud Mental: 1-888-386-8612
24 hours/7 days per week/365 days of the year

Interpretation Line / Línea de Interpretación: 1-800-596-8555

Member Services for Members of Health Plan:

Member Services Tel: 1-888-774-3977

Pharmacy Coverage

Member Services

1-800-386-8612

Member ID:

Effective Date:

PCP:

Telephone:

Member Name:

Medicaid ID:

Member Services / Servicios para Miembros: 1-800-386-8612
Behavioral Health / Salud Mental: 1-888-386-8612
24 hours/7 days per week/365 days of the year

Interpretation Line / Línea de Interpretación: 1-800-596-8555

Member Services Tel: 1-888-774-3977

En caso de urgencia, llame a 911 o vaya a la sala de urgencias más cercana. Después de la atención médica, llame al PCP de su hijo dentro de 24 horas tan pronto como sea posible.

Para más información sobre servicios de emergencia, ver instrucciones en el manual para miembros.

Enviel la reclamación a esta dirección:

Claims Processing Center
P.O. Box 60003
Phoenix, AZ 85082
Member ID: 31602

In caso de urgencia, llame al 911.

En caso de una emergencia, por favor llame al 911.
MEMBER NAME:
MEMBER ID:
EFF. DATE:
PCP:
PCP EFFECTIVE DATE:
Doctor’s Office Visit:
Emergency Room:
Hospital Inpatient:
Prescription Generic Drugs:
Hospital Outpatient:
Prescription Brand Drugs:

No copayments apply for well child or well baby immunization visits.

Directions for What to Do In An Emergency
In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

For additional information regarding emergency services, please refer to your member handbook.

Mail claims to this address:
Claims Processing Center
P.O. Box 64633
Phoenix, AZ 85062
Payor ID: 30662

Member Services / Servicios para Miembros: 1-800-245-5300
Behavioral Health/Salud Mental: 1-800-245-5300
24 hours / 7 days per week

Internal Health Line / Línea de salud interna: 1-800-556-1555
Block Vision of Texas, Inc. / Servicios de Visión: 1-800-873-0361
Relay Texas TTY: 1-800-735-2969

MEMBER NUMEBRE:
MEMBER ID:
EFECTIVO:
PCP:
PCP TELE:
FECHA DE EFEKTICIDAD CON EL PCP:
Visita Oficina del Doctor:
Salas de emergencia:
Medicamentos genéricos de receta:
Co-pagos no se aplican para análisis de sangre o de niño visitas para vacunas.

En caso de una emergencia, por favor llame al 911.

Para mas información sobre servicios de emergencia, acérquese a Manual para Miembros.
CHIP Perinate Newborn ID card

MEMBER NAME:
MEMBER ID:
EFF. DATE:

Co-pays do not apply.

Directions for What to Do In An Emergency
In case of emergency call 911 or go to the closest emergency room.

For additional information regarding emergency services, please refer to your member handbook.

Mail claims to this address:
Claims Processing Center
P.O. Box 60993
Phoenix, AZ 85082
Payor ID: 30092

Co-pagos no se aplican.

Instrucciones en caso de emergencia:
En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana.

Para más información sobre servicios de emergencia, averíe reftarse el Manual para Miembros.

Envié reclamaciones a este dirección:
Claims Processing Center
P.O. Box 60993
Phoenix, AZ 85082
Payor ID: 30092
CHIP Perinate ID card (<185% FPL)

Co-pays do not apply. Health Care Services are limited to the care of the unborn child.

Directions for What to Do In An Emergency

In case of emergency call 911 or go to the closest emergency room.

For additional information regarding emergency services, please refer to your Aetna Better Health member handbook.

Professional/Other Services Billing
Claim Processing Center
P.O. Box 198900
Phoenix, AZ 85019
Payor ID: 38692

Hospital Facility Billing
THP-Aetna Claim Administrator
12205-A Nita Trace Plwy
Austin, TX 78727

Member Services / Servicios para Miembros: 1-888-245-5388
24 hours / 7 days per week / 24 horas del dia / 7 dias de la semana

Internet Health Line / Linea de salud internet: 1-888-245-5388
Relay Texas TTY: 1-800-735-2999

MEMBER NAME: MEMBER NOMBRE:
MEMBER ID: MEMBER ID:
EFF. DATE: EFFECTIVO:

Los servicios de la asistencia médica son limitados al cuidado del niño no nacido aún.
Co-pays do not apply. Health Care Services are limited to the care of the unborn child.

In case of an emergency, please call 911.

Directions for What to Do in an Emergency

In case of emergency call 911 or go to the closest emergency room.

For additional information regarding emergency services, please refer to your member handbook.

Professional & Other Services Billing
Claims Processing Center
P.O. Box 680213
Phoenix, AZ 85062
Payor ID: 26462

CHIP Perinate ID card (+186% FPL)
Appendix B – Behavioral health screening tools

Mental Health
An emergency mental health referral for evaluation and/or treatment must always be made when suicidal thoughts, threats, or behaviors and/or homicidal thoughts, threats, or behaviors are identified during a mental health screening. Whenever an urgent mental health crisis is suspected, every effort must be made to secure a prompt mental health evaluation and any medically necessary treatment for the client. A clinician conducting the mental health screen that has the appropriate training and credentials to conduct the mental health evaluation and provide treatment may choose to provide the mental health services or refer the client to another appropriate clinician. Clinicians who do not have these qualifications must refer clients to a qualified mental health specialist for such care.

BEHAVIORAL HEALTH CLINICAL DECISION MAKING TOOLS

LOCUS AND CALOCUS
Aetna Better Health uses a bio-psycho-social clinical model to evaluate the individual needs of each member. The model incorporates utilization management decision-making criteria that fully integrates all co-occurring disorders into a single criteria set consistent with current best practices that recognize the importance of identifying and treating co-occurring disorders. Aetna Better Health has adopted the Level of Care Utilization System (LOCUS) as the clinical guidelines for making decisions regarding medical necessity. LOCUS was developed for adults by the American Association of Community Psychiatrists (AACP). For children and adolescents ages 6 to 18, Aetna Better Health uses the Child and Adolescent Level of Care Utilization System (CALOCUS), which was developed by the Work Group on Systems of Care of the American Academy of Child and Adolescent Psychiatry (AACAP). It incorporates developmental, family, and community systems of care perspectives. Developmental status determines the cut-off between LOCUS and CALOCUS.

LOCUS/CALOCUS assesses member needs based on level of functioning, rather than diagnosis and psychiatric risk alone. Aetna Better Health looks beyond acuity and dangerousness to assess member needs and to allocate resources based on six evaluation dimensions:

1) Risk of harm to self or others, including potential for victimization or accidental harm.
2) Functional status in terms of the ability to function in all age-appropriate roles, as well as basic daily activities of daily living.
3) Co-morbidity in terms of the co-existence of disorders across four domains: Psychiatric, Substance Abuse, Medical, and Development Disability or Delay (CALOCUS only).
4) Recovery environment in terms of strengths/weaknesses of the family, neighborhood and community (including services). This dimension has two subscales:
   a) Environmental Stress
   b) Environmental Support.
5) Treatment history in terms of a history of successful use of treatment.
   a) LOCUS identifies the adult’s extent of recovery in response to prior treatment.
   b) CALOCUS identifies the child’s innate or constitutional emotional strength and capacity for successful adaptation [resiliency] as well as treatment history.
6) Engagement.
   a) LOCUS identifies the patient’s degree of engagement.
   b) CALOCUS identifies the child and family's acceptance and engagement in treatment.
      i) Scale A -- Child/Adolescent
This comprehensive clinical model offers members individualized services that are seamlessly integrated. LOCUS/CALOCUS assesses service needs and matches them to the clinically appropriate level of care, where *level of care* refers to intensity of services, not to bricks-and-mortar programs. This permits a broad range of treatment options that:

- Is adaptable to the available continuum in each service area;
- Allows ofr variations in practice patterns and resources among communities and agencies;
- Recognizes traditional services, as well as newer forms of care.

Each level of care has required features, including clinical services, support services, crisis stabilization and prevention services, and the care environment

**The table below describes the seven levels of care:**

**LEVELS OF CARE**

<table>
<thead>
<tr>
<th>Level</th>
<th>CALOCUS</th>
<th>LOCUS</th>
<th>TRADITIONAL SETTINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Basic Services</td>
<td>Prevention and Health Maintenance</td>
<td>Package of prevention and health maintenance services assumed to be available to the community</td>
</tr>
<tr>
<td>1</td>
<td>Recovery Maintenance and Health Management</td>
<td>Recovery Maintenance and Health Management</td>
<td>Maintenance services after more intensive services (e.g., brief crisis counseling, traditional outpatient supportive services, medication maintenance)</td>
</tr>
<tr>
<td>2</td>
<td>Outpatient Services</td>
<td>Low Intensity Community Based Services</td>
<td>Traditional outpatient treatment once/week visits</td>
</tr>
<tr>
<td>3</td>
<td>Intensive Outpatient Services</td>
<td>High Intensity Community Based Services</td>
<td>IOP: From 2 visits/week up to few hours for 3 days per week; includes multiple services (e.g. big brother, church services, mental health services) necessitating coordination (case management).</td>
</tr>
<tr>
<td>4</td>
<td>Intensive Integrated Service Without 24-Hour Medical Monitoring</td>
<td>Medically Monitored Non-Residential Services</td>
<td>C&amp;A: Wraparound plan required, increased formal supports (respite, homemaking services or paid mentors); can include day treatment or partial hospitalization; active case management is essential Adult: Acute PHP or ACT</td>
</tr>
<tr>
<td>5</td>
<td>Non-Secure, 24-Hour, Medically Monitored Services</td>
<td>Medically Monitored Residential Services</td>
<td>C&amp;A: Group home, foster care or a residential facility, can also be provided by tightly knit wraparound services Adult: Community-based residential services [nursing home, RTC]</td>
</tr>
<tr>
<td>6</td>
<td>Secure, 24-Hour, Medically Managed Services</td>
<td>Medically Managed Residential Services</td>
<td>C&amp;A: Inpatient psychiatric settings or highly programmed residential facilities; if security needs can be met through the wrap-around process, could also be provided in a community setting. Case management essential. Time at</td>
</tr>
</tbody>
</table>
LOCUS/CALOCUS has application beyond utilization management decisions. Each member has a quantitative profile that changes over the course of his/her treatment. Different profiles suggest different treatment planning requirements to address the issues that are driving the placement decision. As members progress through treatment the changing profile will reflect clinical progress and highlight the need for specific resources in the service delivery system. Finally, LOCUS/CALOCUS is useful as a way of monitoring treatment effectiveness.

**Texas Commission on Alcohol and Drug Abuse (TCADA) Standards for Alcohol and Drug Use Disorders**

As mandated by the state, Aetna Better Health’s Level of Care (LOC) Medical Necessity determinations rely on The Standards for Reasonable Cost Control & Utilization Review for CD Treatment Centers (formerly TCADA) criteria for members treated for chemical dependency in the state of Texas. The Standards set forth criteria that include length of stay for treatment. However, these recommended lengths of stay are not intended to establish any minimum/maximum periods of treatment. Initial and continued eligibility for treatment is predicated on the patient meeting the criteria. The Standards for Reasonable Cost Control & Utilization Review for CD Treatment Centers (formerly TCADA) criteria can be found at the following site:

### Texas Health Steps Periodicity Schedule

**COMPREHENSIVE HEALTH SCREENING** - BIRTH THROUGH 10 YEARS

*Comprehensive Health Screening is defined as both objective screening with use of standardized procedures or screening tools and subjective screening of those components when a standardized procedure or screening tool is not required. For example, visits where a standardized hearing screening is done requires hearing screening to be age-appropriate and based on recognized national standards such as the National Center for Education in Maternal and Child Health (NCCEMCH) Bright Futures. The absence of a symbol indicates that subjective screening is appropriate unless the provider determines an objective score of test is necessary. Refer to the Texas Medicaid Provider Procedure Manual (TMPY) for further detail.*

<table>
<thead>
<tr>
<th>AGE</th>
<th>MEASUREMENTS</th>
<th>DEVELOPMENTAL SCREENING</th>
<th>LABORATORY TESTS</th>
<th>TB SCREENING</th>
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<tr>
<td></td>
<td>Weight</td>
<td>Height</td>
<td>BMI</td>
<td>Infant Vision Screening (objective)</td>
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<tr>
<td>Newborn</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-5 days</td>
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</tr>
<tr>
<td>7 weeks</td>
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<td></td>
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<tr>
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**LEGEND OF SYMBOLS**

- Indicates a component is mandatory to complete during the checkup. If a component is not completed at the required age, then the provider must complete it at the next checkup, if age-appropriate, or whenever medically necessary.

- TB screening. In counties designated as having a high incidence of TB, administer an intradermal skin test at ages 1 and 4 years of age and the DSHS approved questionnaire annually beginning at 2 years of age. In all other counties, administer the DSHS approved questionnaire annually beginning at 1 year of age.

---

Check regularly for updates to this schedule: dshs.state.tx.us/thsteps/providers_components.shtml

For free online provider education: txhealthsteps.com
## Comprehensive Health Screening* - 11 Through 20 Years

*Comprehensive Health Screening is defined as both objective screening with one of standardized procedures or screening tools and subjective screening of those components when a standardized procedure or screening test is not required, for example, visits when automated hearing screening is not required. Screening must be age-appropriate and based on recognized national standards such as the National Center for Education in Maternal and Child Health (NCCEMCH) Bright Futures. The absence of a symbol indicates that subjective screening is appropriate unless the provider determines an objective screen or test is necessary. Refer to the Texas Medicaid Provider Procedure Manual (TMPPM) for further detail.

### Measurements

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<th>AGE</th>
<th>History</th>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
<th>Blood Pressure</th>
<th>Vision Screening (refractive)</th>
<th>Hearing Screening (Objective)</th>
<th>Nutritional Screening</th>
<th>Mental Health Screening</th>
<th>Laboratory Tests (as indicated)</th>
<th>TB Screening</th>
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<td>(HIV, TB)</td>
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### Legend of Symbols

- ○ Indicates a component is mandatory to complete during the checkup. If a component is not completed at the required age, then the provider must complete at the next checkup, if age-appropriate, or whenever medically necessary.

- ▲ TB screening: In counties designated as having a high incidence of TB, administer an intradermal skin test at 11 years of age and the DSBS approved questionnaire annually thereafter. In all other counties administer the DSBS approved questionnaire annually.

---

Check regularly for updates to this schedule: [dshs.state.tx.us/thsteps/providers_components.shtml](dshs.state.tx.us/thsteps/providers_components.shtml)

For free online provider education: [txhealthsteps.com](txhealthsteps.com)

---

**Texas Health Steps**

03.13.15
June 2015

205
## Texas Referral/Authorization Form

Please fill out form completely in blue or black ink. Refer to instruction sheet.

*This referral does not guarantee payment. Please contact health plan to verify member eligibility and covered benefits.*

<table>
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<tr>
<th>Option</th>
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<td>OTHER</td>
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</table>

**HEALTH PLAN NAME:** __________________________ **DATE** __/__/____

**PATIENT INFO**

- **Patient name:** [Name]
- **DOB** __/__/____
- **Last Name:** [Last Name]
- **First Name:** [First Name]
- **Sex:** Male [M] Female [F]
- **Phone # (___):** (____) _______  [Optional]
- **Member ID #:** __________ [Optional]
- **Member Social Sec. #:** __________ [Optional]

**REFERRED BY**

- **Physician name:** [Name]
- **Last Name:** [Last Name]
- **First Name:** [First Name]
- **PCP:** [Yes/No]
- **SCP:** [Yes/No]
- **HOSPITAL:** [Yes/No]
- **Fax #: (___):** (____) _______
- **Contact name:** [Name]
- **Phone #: (___):** (____) _______

**REFERRED TO**

- **Provider name:** [Name]
- **Last Name:** [Last Name]
- **First Name:** [First Name]
- **Provider/Facility #:** __________
- **Fax #: (___):** (____) _______
- **Phone #: (___):** (____) _______
- **Provider City:** __________, Texas

**REFERRED TO LOCATION**

- **Office:** [Yes/No]
- **Outpatient facility:** [Yes/No]
- **Inpatient:** [Yes/No]
- **24 Hour observation:** [Yes/No]
- **ER/Post Stabilization:** [Yes/No]
- **Other:** [Yes/No]
- **Date of service:** __/__/____

**Facility name:** [Name]

**Facility #:** [Number]* Required for ER/UCC, Therapy and Outpatient services.

**COMMENTS/CLINICAL HISTORY**

________________________________________________________________________

**PHYSICIAN SIGNATURE:**

The information contained in this form is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

**HEALTH SERVICES RESPONSE**

- **Approved as requested**
- **Authorization #:** [Number]
- **Expiration date:** __/__/____
- **Days authorized:**
- **Medical Director Review:** [Yes/No]
- **Pending Info.:** [Yes/No]
- **No referral needed:** [Yes/No]
- **Denied:** [Yes/No]
- **Approved with modification:**

**NOTES**

________________________________________________________________________

Signature __________ Date: __/__/____

**SPECIFIC SERVICES REQUESTED**

**SPECIFIC SERVICES REQUESTED**

- **Routine:** [Yes/No]
- **Urgent:** [Yes/No]
- **Emergency:** [Yes/No]
- **Out of Network:** [Yes/No]
- **Revised Referral:** [Yes/No]
- **Notification Only:** [Yes/No]

**Requested**

- **Start date:** __/__/____
- **Requested End date:** __/__/____

**ICD-9/DSM/ Diagnosis:** [Number]

**Scope of referral**

- **Consultation:** [Yes/No]
- **Diagnostic Testing:** [Yes/No]
- **Follow-up:** [Yes/No]
- **Number of visits:**

**Maternity Services:**

- **EDC**
- **Vaginal**
- **C-Section**

---

**TO AUTHORIZE ONLY (OR OTHER) SPECIFIC SERVICES, INCLUDE CPT/4 MEDICAID LOCAL OR HCPCS CODES HERE.**

---

**Assistant Surgeon:**

---

## Appendix E – Request for initial outpatient therapy

### B.50 Request for Initial Outpatient Therapy (Form TP-1)

<table>
<thead>
<tr>
<th>Category of Therapy Being Requested</th>
<th>Date of onset:</th>
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<tbody>
<tr>
<td>Occupational Therapy (OT)</td>
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<td>Physical Therapy (PT)</td>
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<td>Speech Therapy (SLP)</td>
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<tr>
<td>Orthotics and Prosthetics</td>
<td></td>
</tr>
<tr>
<td>Medical Equipment, Appliances</td>
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</tr>
<tr>
<td>Contact Lens, Cochlear Implant</td>
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<tr>
<td>ASN</td>
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<tr>
<td>Home Program</td>
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<tr>
<td>Speciality Clinic</td>
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<tr>
<td>Home Health</td>
<td></td>
</tr>
<tr>
<td>ADL (Activities of daily living)</td>
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</tr>
<tr>
<td>Family and Community Services</td>
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<table>
<thead>
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<th>Service Type</th>
<th>Service Date(s)</th>
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<td>OT</td>
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**Medicaid Identifying Information**

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<th>TP</th>
<th>NPI</th>
<th>Taxonomy</th>
<th>Benefit Code</th>
</tr>
</thead>
</table>

**Cancer Identifying Information**

<table>
<thead>
<tr>
<th>TP</th>
<th>NPI</th>
<th>Taxonomy</th>
<th>Benefit Code</th>
</tr>
</thead>
</table>

*Effective Date: 07/30/2007 (Revision Date: 09/01/2007)*

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Appendix F – Request for extension of outpatient therapy

<table>
<thead>
<tr>
<th>Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Name:</strong></td>
</tr>
<tr>
<td><strong>Date of birth:</strong></td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
</tr>
<tr>
<td><strong>Client Address:</strong></td>
</tr>
<tr>
<td><strong>Date of Initial Evaluation:</strong></td>
</tr>
<tr>
<td><strong>PT/OT:</strong></td>
</tr>
<tr>
<td><strong>Date Removed:</strong></td>
</tr>
<tr>
<td><strong>Serial Casting:</strong></td>
</tr>
<tr>
<td><strong>CP/OT:</strong></td>
</tr>
<tr>
<td><strong>Speech for:</strong></td>
</tr>
<tr>
<td><strong>Category of Therapy Being Requested:</strong></td>
</tr>
<tr>
<td><strong>PT/OT:</strong></td>
</tr>
<tr>
<td><strong>Frequency per month:</strong></td>
</tr>
<tr>
<td><strong>Frequency per week:</strong></td>
</tr>
<tr>
<td><strong>Service Type:</strong></td>
</tr>
<tr>
<td><strong>Date Signed:</strong></td>
</tr>
<tr>
<td><strong>Specialist Name:</strong></td>
</tr>
<tr>
<td><strong>Signature:</strong></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
</tr>
<tr>
<td><strong>TP:</strong></td>
</tr>
<tr>
<td><strong>NPI:</strong></td>
</tr>
<tr>
<td><strong>Taxonomy:</strong></td>
</tr>
<tr>
<td><strong>Benefit Code:</strong></td>
</tr>
<tr>
<td><strong>NPI:</strong></td>
</tr>
<tr>
<td><strong>Taxonomy:</strong></td>
</tr>
<tr>
<td><strong>Benefit Code:</strong></td>
</tr>
</tbody>
</table>

*Forms*
### B.20 Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): □ Requesting Physician □ Supplier

- Client name: 
- Client Medical number: 
- Is client under 21 years of age? □ YES □ NO
- Supplier name: 
- Supplier address: 
- Supplier phone: 
- Supplier fax: 
- Supplier NPI: 
- Supplier taxonomy: 
- Supplier benefit code: 
- Physician name: 
- Physician phone: 
- Physician fax: 

I certify that the services being supplied under this order are necessary and consistent with the physician’s determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client’s home when used as prescribed.

<table>
<thead>
<tr>
<th>Item</th>
<th>HPCS Code</th>
<th>Description of DME/medical supplies</th>
<th>Quantity</th>
<th>Quantity limit?</th>
<th>Reason for denial?</th>
<th>Reason for denial?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

- □ Check if additional documentation is attached as outlined in the MMFP.
- Is the DME Provider Medicare certified? □ YES □ NO
- If yes, indicate Medicare number: 

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

<table>
<thead>
<tr>
<th>Item</th>
<th>ICD-9</th>
<th>Brief Diagnosis Description</th>
<th>Complete justification for determination of medical necessity for requested item(s)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Refer to Section A, Section B)</td>
</tr>
</tbody>
</table>

2. Each item requested in Section A must have a corresponding diagnosis and medical necessity justification. Enter all item numbers from the table in Section A that pertain to each diagnosis.

- If applicable, include height, weight, wound status, dimensions, and functional/mobility status in table below.

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Wound status/dimensions</th>
<th>Functionality/mobility status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The "Date last seen" and "Duration of need" items below must be filled in.

- Date last seen by physician: / / 
- Duration of need for DME: / / month(s) 
- Duration of need for supplies: / / month(s)

By signing this form, I hereby attest that the information completed in Section A is consistent with the determination of the client’s current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client’s home when used as prescribed.

Signature and attestation of prescribing physician: 
Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician’s license number: 
Prescribing provider’s NPI: 

- □ Check if all of the information in Section A was complete at the time of the prescribing provider's signature.

---

Appendix G – Request for Durable Medical Equipment
Appendix H – Medical record criteria

Primary Care Physician – Medical record criteria
Providers using electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

Organization
a. Each page has patient’s name or ID*
b. Personal data: gender, date of birth, address, occupation, home/work phone numbers, marital status is recorded*
c. All entries in the record contain author's signature or initials or electronic identifier*
d. All entries are dated*
e. All entries are legible to someone other than the writer
f. Medication list is completed including dosages and date of initial or refill prescription
g. Medication allergy or lack thereof and adverse reactions are prominently noted.*
h. Problem list is completed including significant illnesses and medical and psychological conditions*
i. Past medical history is completed (for patients seen 3 or more times) is easily identified and included serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
j. For patients 14 years and up, there is a note concerning cigarettes, alcohol and substances (for patients seen 3 or more times, query substance abuse history).
k. HandP documents have subjective/objective information for presenting problem.
l. Note regarding follow-up care, calls, visits. Specific time of return is noted in weeks, months or as needed.
m. Unresolved problems from previous visits are addressed in subsequent visits.
n. An immunization record has been initiated for children or history for adults*
o. Preventive screening and services offered according to Aetna guidelines
p. A uniform prenatal record form (Ob/Gyn and FP OB charts only)*
q. Information about Advance Directives is noted (Members over 18 years old)*
r. Identification of all providers participating in the Member’s care and information on services provided by these providers
s. Treatment plan is documented
t. Prescribed medications including dosages and dates of initial prescription or refill
u. Possible risk factors for patient relevant to particular treatment are noted

Examination
v. Blood pressure measured/recorded on the first visit (patients xx years old and older)
w. Weight measured/recorded on first visit

Studies
x. Lab and other studies are ordered, as appropriate
y. Evidence that physician has reviewed lab, X-ray, or biopsy results (signed or initialed reports) and Member has been notified of results before filing report.*

Communication
z. Copies of letters/notes or documentation of telephone contacts from referred specialists
aa. Phone instructions/communications with patients are documented*
bb. A system to document missed appointments
cc. Hospital Discharge Summary or Emergency Room Report or Summary Sheet

Storage
dd. Medical records protected from public access*
ee. Each patient has an individual medical record*
ff. All documents in medical record are securely placed in the record
gg. All documents in medical records should be retained and produced for review according to regulatory requirements of Texas Medicaid and CHIP programs.

Specialist Physician Medical Record Criteria
Providers using electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

Organization
a. Each page has patient’s name or ID*
b. Personal data: gender, date of birth, address, occupation, home/work phone numbers, marital status is recorded*
c. All entries in the record contain author’s signature or initials or electronic identifier*
d. All entries are dated*
e. All entries are legible to someone other than the writer
f. Medication list is completed including dosages and date of initial or refill prescription
g. Medication allergy or lack thereof and adverse reactions are prominently noted.*
h. Problem list is completed including significant illnesses and medical and psychological conditions*
i. Past medical history is completed.
j. For patients 14 years and up, there is a note concerning cigarettes, alcohol and substances (for patients seen 3 or more times, query substance abuse history).
k. HandP documents have subjective/objective information for presenting problem.
l. Note regarding follow-up care, calls, visits. Specific time of return is noted in weeks, months or as needed.
m. Unresolved problems from previous visits are addressed in subsequent visits.
n. A uniform prenatal record form (Ob/Gyn and FP OB charts only)*
o. Information about Advance Directives is noted (Members over 18 years old)*
p. Identification of all providers participating in the Member’s care and information on services provided by
q. these providers
r. Treatment plan is documented
s. Prescribed medications including dosages and dates of initial prescription or refill
t. Possible risk factors for patient relevant to particular treatment are noted

Examination
a. Blood pressure measured/recorded on the first visit (patient xx years old and older)
b. Weight measured/recorded on first visit

Studies
a. Lab and other studies are ordered, as appropriate
b. Evidence that physician has reviewed lab, X-ray, or biopsy results (signed or initialed reports) and Member has been notified of results before filing report.*
Communication
   a. Copies of letters/notes or documentation of telephone contacts from referring physician
   b. Phone instructions/communications with patients are documented*
   c. A system to document missed appointments
      d. Hospital Discharge Summary or Emergency Room Report or Summary Sheet

Storage
   hh. Medical records protected from public access*
   ii. Each patient has an individual medical record*
   jj. All documents in medical record are securely placed in the record
   kk. All documents in medical records should be retained and produced for review according to regulatory
      requirements of Texas Medicaid and CHIP programs.

*Indicates items assessed for Medical Record Keeping Practices during Office Assessments
Appendix I – Private Pay Agreement

Private Pay Agreement

Private Pay Agreement
Example Form

I understand __________________ is accepting me, __________________,  
(Provider Name) (Member Name)
as private pay patient for the period of _________________, and I will  
be responsible for paying for any services I receive. The provider will not  
file a claim to Medicaid for services provided to me.

Patient Signature ____________________________ Date ____________________
Appendix J – Member Acknowledgement

Member Acknowledgement

Member Acknowledgement

Example Form

I, ____________________, am agreeing to receive services from
(Member Name)
_________________________, that may not have been authorized or
(Provider Name)
may not be a covered benefit. I will be responsible for paying for any
services I receive. The provider will not file a claim to Medicaid for
services provided to me.

_________________________________________  ________________
Patient Signature                        Date
Appendix K – Consent for Disclosure of Confidential Information

I hereby authorize Aetna Better Health and any of its parents, subsidiaries, or other affiliates and their respective agents and subcontractors, to disclose confidential information about the member/insured listed below.

Please Print All Responses

If you do not fill out all of this form, Aetna Better Health may be unable to process your request. Incomplete authorization requests will be returned to the member.

I UNDERSTAND THIS AUTHORIZATION IS VOLUNTARY and the information to be disclosed may be protected by law.

Member Name _______________________________ ID Number _______________________________ Date of Birth _______________________________

Street Address _______________________________ City/State/Zip Code _______________________________ (______) _______ - _______ Daytime Phone Number _______________________________

I authorize the individual or company identified below to receive confidential information pertaining to the member/insured named above.

________________________________________________________
Individual or company authorized to receive confidential information

________________________________________________________
Street Address

________________________________________________________
City, State, and Zip Code

________________________________________________________
Daytime Area Code and Phone Number

Information to be disclosed to this individual or company includes application or enrollment information, eligibility information, claims records, claim status, and patient management records.

Disclosure requested will include otherwise confidential medical information. If our records include claims or other information pertaining to chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information, these records will be included in the information we will make available to the individual or company designated above.
IMPORTANT: Your signature below means you understand and agree to the following:

- You understand your eligibility for benefits and payment for services covered by Aetna Better Health under your plan will not be affected if you do not sign this form. (However, without your signature, your request to release the information described above to a third party will not be honored.)

- The confidential information provided to the authorized individual or company upon their request, may include diagnosis and treatment information, including information on chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.

- You understand you may receive a copy of this form if you ask for it by writing to the address listed at the bottom of this page.

- You understand this authorization will expire one year from the date you sign this authorization. You also understand if you sign this form, you may revoke the authorization at any time by notifying Aetna Better Health in writing, but if you do, it will not have any effect on actions Aetna Better Health took before we received the notification.

- You agree to hold Aetna Better Health and its affiliates harmless from any claim or liability, including, but not limited to, any claim brought under a confidentiality or privacy law, in connection with the release at your request of information and records described above.

Signature of member or legal representative                        Date

Print name of member legal representative (if applicable)            Relationship to member/insured

If this authorization is being requested by member/insured’s legal representative, you must furnish a copy of the power of attorney, or other relevant document designating you as the representative.

(Important note: the witness below may not be the person authorized to receive the information to be disclosed.)

Witnessed by:

Printed Name of Witness                                           Date

Signature of Witness
Consent for Disclosure of Confidential Information - Spanish

Autorización para Divulgar Información Personal y Confidencial a Terceras Personas

Por medio de la presente autorizo a Aetna Better Health así como también a cualesquiera de sus casas matrices, subsidiarias, u otras afiliaciones y sus agentes respectivos y subcontratistas, a divulgar información confidencial acerca del miembro/asegurado indicado más abajo.

Favor de Escribir las Respuestas con Letra de Molde

Si esta forma no se llena en su totalidad, Aetna Better Health podría no procesar su solicitud. Las solicitudes para autorización incompletas serán regresadas al afiliado/miembro correspondiente.

ENTIENDO QUE ESTA AUTORIZACIÓN ES DE CARÁCTER VOLUNTARIO y la información a ser divulgada estará protegida por la ley.

<table>
<thead>
<tr>
<th>Nombre del Miembro</th>
<th>Número Identificación</th>
<th>Fecha de Nacimiento</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domicilio Particular</td>
<td>Ciudad/Estado/C. Postal</td>
<td>No. de Teléfono Diurno</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mediante este documento autorizo a la persona o a la compañía que se identifica aquí debajo para recibir información confidencial acerca del miembro/asegurado indicado anteriormente.

Persona o compañía autorizada para recibir información confidencial

Domicilio Particular

Ciudad, Estado, Código Postal

Número de Teléfono Diurno incluyendo Número de Area

La información a ser divulgada a la persona o compañía indicada, incluye información sobre la solicitud de membresía y registro, información sobre elegibilidad, registro de reclamaciones, estado de reclamaciones y registros sobre el manejo del paciente.

La divulgación solicitada incluirá información médica confidencial. Si nuestros registros incluyen reclamaciones u otra información perteneciente a enfermedades crónicas, condiciones de la salud relacionadas con el comportamiento, incluyendo el abuso del alcohol u otras substancias, enfermedades contagiosas, incluyendo HIV/SIDA, y/o información de índole genética, dichos registros serán incluidos en el grupo de información que entregaremos a la persona o a la compañía arriba indicada.
IMPORTANTE: Su firma al calce indicará su entendimiento y su acuerdo a lo siguiente:

- Si usted no firma esta forma, usted entiende que su derecho de obtener beneficios y pago por servicios cubiertos por Aetna Better Health bajo su plan de cobertura, no se verá afectado. (Sin embargo, si usted no firma esta forma, su solicitud para divulgar la información descrita anteriormente a terceras personas, no podrá cumplirse.)

- La información confidencial entregada a la persona autorizada o compañía que haya hecho la solicitud, podría contener información sobre diagnósticos y tratamiento, incluyendo información sobre enfermedades crónicas, condiciones de la salud relacionadas con el comportamiento, incluyendo el abuso del alcohol y otras sustancias, enfermedades contagiosas, incluyendo HIV/SIDA, y/o información de índole genética.

- Usted entiende que podrá obtener una copia de esta forma a solicitud suya, pidiéndola por escrito a la dirección indicada al calce.

- Usted entiende que esta autorización tendrá vigencia durante un año a partir de la fecha que usted firme la misma. También entiende que si usted firma esta forma, usted tendrá el derecho de revocar su autorización en cualquier momento mediante una notificación por escrito a Aetna Better Health, en el entendimiento de que, si lo hiciere, su revocación no tendrá efecto sobre las acciones adoptadas por Aetna Better Health antes de recibir dicha notificación por escrito.

- Usted acuerda de no hacer responsable a Aetna Better Health y a sus afiliadas por reclamaciones o daños incluyendo, más no limitado a, cualesquiera reclamaciones presentadas bajo alguna ley de confidencialidad o privacidad relacionada con la divulgación, a solicitud suya, de información y registros descritos anteriormente.

Firma del miembro o representante legal

Fecha

Nombre del representante legal del miembro con letra de molde
(sí fuera aplicable)

Relación con el miembro/asegurado

Si esta autorización está siendo solicitada por el representante legal del miembro/asegurado, éste deberá presentar copia del poder notarial u otro documento legal que lo autorice como el representante.

(Nota Importante: el testigo firmante no podrá ser la misma persona autorizada para recibir la información a ser divulgada.)

Testigo:

Nombre del Testigo con Letra de Molde

Fecha

Firma del Testigo
# Texas Health Steps Quick Reference Guide

## THSteps Medical Checkups Billing Procedure Codes

<table>
<thead>
<tr>
<th>THSteps Medical Checkups</th>
<th>Procedure Codes</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90724</td>
<td>90725</td>
<td>DTaP, Hb</td>
</tr>
<tr>
<td>90726</td>
<td>90727</td>
<td>DTaP, Hb, IPV</td>
</tr>
<tr>
<td>90732</td>
<td>90733</td>
<td>PPV23</td>
</tr>
<tr>
<td>90734</td>
<td>90735</td>
<td>Meningococcal</td>
</tr>
<tr>
<td>90743</td>
<td>90744</td>
<td>Hep B</td>
</tr>
<tr>
<td>90745</td>
<td>90746</td>
<td>Hib, Hep B</td>
</tr>
</tbody>
</table>

*Indicates a vaccine distributed by TVFC*

## Immunizations Administered

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90698</td>
<td>Hep A</td>
</tr>
<tr>
<td>90699</td>
<td>Hep A, Hep B</td>
</tr>
<tr>
<td>90700</td>
<td>Hib</td>
</tr>
<tr>
<td>90701</td>
<td>HPV</td>
</tr>
<tr>
<td>90702</td>
<td>Influenza</td>
</tr>
<tr>
<td>90703</td>
<td>PCV7, PCV13</td>
</tr>
<tr>
<td>90704</td>
<td>Rotavirus</td>
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<tr>
<td>90705</td>
<td>MMRI</td>
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<tr>
<td>90706</td>
<td>IPV</td>
</tr>
<tr>
<td>90707</td>
<td>Tetanus</td>
</tr>
<tr>
<td>90708</td>
<td>MMR</td>
</tr>
<tr>
<td>90709</td>
<td>IPV</td>
</tr>
<tr>
<td>90710</td>
<td>Td</td>
</tr>
<tr>
<td>90711</td>
<td>Varicella</td>
</tr>
</tbody>
</table>

*Indicates a vaccine distributed by TVFC*

## Modifiers

**Performing Provider**

Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.

<table>
<thead>
<tr>
<th>AM</th>
<th>SA</th>
<th>TD</th>
<th>U7</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>32</td>
<td>SC</td>
<td></td>
</tr>
</tbody>
</table>

## Exception to Periodicity

Use with THSteps medical checkups procedure codes to indicate the reason for an exception to periodicity.

- U1
  - Vaccine/toxoid not available through TVFC and the number of state defined components administered per vaccine.
  - Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available.

## Condition Indicator Codes

Use one of the indicators below if a referral was made.

<table>
<thead>
<tr>
<th>Condition Indicator</th>
<th>Condition Indicator Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>NU</td>
<td>Not used (no referral)</td>
</tr>
<tr>
<td>Y</td>
<td>ST</td>
<td>New services requested</td>
</tr>
<tr>
<td>Y</td>
<td>S2</td>
<td>Under treatment</td>
</tr>
</tbody>
</table>

## TB Skin Test

Be sure to include a charge of at least $0.01 for procedure code 86580, even though this procedure code is not reimbursed separately.

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