AETNA BETTER HEALTH®
Doing the right thing for the right reason
AETNA BETTER HEALTH®

Provider Training

Presenter Name
Month DD, YYYY
<table>
<thead>
<tr>
<th>Counties:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tarrant Service Area:</td>
</tr>
<tr>
<td>Denton</td>
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<tr>
<td>Hood</td>
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<tr>
<td>Johnson</td>
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<tr>
<td>Parker</td>
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<tr>
<td>Tarrant</td>
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<td>Wise</td>
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</tbody>
</table>
Eligibility

To be eligible for Texas Medicaid, a person must:

• Be a resident of Texas, be a U.S. Citizen, or qualified alien (most immigrants who arrive after August 22, 1996 are barred from Medicaid for five years, but could be eligible for Texas FamilyCare and certain programs for pregnant women)
• Meet specific standards for financial income and resources

In addition, a person must fall into one of the following categories to participate in STAR Kids:

• Children and young adults age 20 or younger.
• Who receive Supplemental Security Income (SSI) and SSI-related Medicaid.
• Who receive SSI and Medicare.
• Who receive Medically Dependent Children Program (MDCP) wavier services.
Verification of Eligibility

Providers can verify member eligibility by:

• Calling Member Services at 1-844-787-5437

• Use Aetna Provider Web Portal which is found at https://medicaid.aetna.com/MWP/landing/home.
Provider Secure Web Portal
Sample ID Cards

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Mental Health/Substance Abuse (MH/SA)

In order to meet the behavioral health needs of our members, we will provide a continuum of services to members at risk of or suffering from mental, addictive, or other behavioral disorders.

We endorse early identification of mental health issues so that timely intervention, including treatment and patient education, can occur. To that end, 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 primary care providers’ scope of practice
• Inform members how and where to obtain behavioral health services
• Understand that members may self-refer to an in-network behavioral health care provider without a referral from the member’s PCP.

Whenever a PCP is concerned about an member who may have a MH/SA problem, it can be very helpful to have designated screening tools to help the PCP decide whether to take further action. Please refer to the Provider Manual about the tools we use to screen members with possible MH/SA concerns.
Covered Services

The benefits in the **Provider Manual** show what services Aetna Better Health of Texas and Medicaid Fee-for-Service (FFS) covers.

Members under Texas FamilyCare C or D, may have to pay a copayment at during their visit.

All services must be medically necessary and the provider may have to ask for a prior approval before some services can be provided.
Provider Responsibilities in Providing EPSDT Services

Participating providers will be contractually required to do the following in providing EPSDT services:

• Provide EPSDT screenings and immunizations to children aged birth to twenty-one (21) years of age in accordance with Texas’ periodicity schedule, including federal and State laws standards and national guidelines (i.e., American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care: http://brightfutures.aap.org/clinical_practice.html) and as federally mandated.

• Avoid delays in pediatric screenings and services by taking advantage of opportunities (for instance, provide an immunization, or screening during a visit for a mild acute illness or injury or during a sibling’s visit).

• Participate in the Department of State Health Services (DSHS) Vaccines for Children (VFC aka TVFC) Program, the federally funded, state-operated vaccine supply program that provides pediatric vaccines at no cost to doctors who serve children who might not otherwise be vaccinated because of inability to pay.

• Participate in the statewide immunization registry database, the Texas Immunization Information System (TIIS).

• Fully document all elements of each EPSDT assessment, including anticipatory guidance and follow-up activities on the state-required standard encounter documentation form and ensure that the record is completed and readable.

• Comply with Aetna Better Health of Texas’ Minimum Medical Record Standards for Quality Management, EPSDT Guidelines and other requirements under the law.
Pharmacy Coverage

CVS Caremark administers the prescription drug benefit for our members.

- Please review the Provider Manual for copay information
- Pharmacies are required to follow federal and state guidelines surrounding dispensing emergency medications.
- The following documents are available online:
  - Preferred Drug List (PDL)
  - Over-the-Counter Drug List
  - Prior Authorization Form
  - Mail Order Form
**Medical Prior Authorization**

You may submit prior authorization requests to us 24-hours-a-day, 7-days-a-week through one of the options below:

- Fax
- Phone

Please submit the following with each authorization request:

- Member Information, e.g., correct and legible spelling of name, ID number, date of birth, etc.
- Diagnosis Code(s)
- Treatment or Procedure Codes
- Anticipated start and end dates of service(s) if known
- All supporting relevant clinical documentation to support the medical necessity
- Include an office/department contact name, telephone and fax number
## Prior Authorization Decision Timeframes

<table>
<thead>
<tr>
<th>Decision</th>
<th>Decision/Notification Timeframe</th>
<th>Notification to Practitioner / Provider</th>
<th>Notification Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent pre-service approval</td>
<td>Within 24 hours of receipt of necessary information, but no later than 72 hours from receipt of request</td>
<td></td>
<td>Telephone and in writing</td>
</tr>
<tr>
<td>Non-urgent pre-service approval</td>
<td>Within 14 calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed decision</td>
<td></td>
<td>Telephone and in writing</td>
</tr>
<tr>
<td>Continued / extended services approval (non-ED/acute inpatient)</td>
<td>1 business day of receipt of necessary information</td>
<td></td>
<td>Telephone and in writing</td>
</tr>
<tr>
<td>Post-service approval of a service for which no pre-service request was received.</td>
<td>30 calendar days from receipt of the necessary information</td>
<td></td>
<td>Telephone and in writing</td>
</tr>
</tbody>
</table>
Member Care Secure Web Portal

Provider View

Welcome RA

My patients
Manage my patients

Messages
View and send non-urgent messages about my patients

Gaps in care
Identify gaps in care and other alerts

My practice information
View and update my practice’s demographic data and contact information

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Clearinghouse & Clean Claims

- We accept both paper and electronic claims
- Emdeon is preferred clearinghouse for electronic claims
  - EDI claims received directly from Emdeon
  - Processed through pre-import edits to:
    - Evaluate data validity
    - Ensure HIPAA compliance
    - Validate member enrollment
    - Facilitate daily upload to Aetna Better Health system
Claim Submission

Aetna Better Health encourages participating providers to electronically submit claims through Emdeon. You can submit claims by visiting Emdeon at http://www.emdeon.com/. Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Emdeon.

Please use the following Payer ID when submitting claims to Aetna Better Health:

- 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.
Claim Submission (cont.)

• 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 Better Health of Texas
Attention: Claims Department
P.O. Box 60938
Phoenix, AZ 85082
Clearinghouse & Clean Claims (cont.)

We process clean claims according to the following timeframes:

- 90% of all claims (the totality of claims received whether contested or uncontested) submitted electronically by medical providers within 30 days of receipt
- 90% of all claims filed manually within 30 days of receipt
- 99% of all claims, whether submitted electronically or manually, within 30 days of receipt
- 99.5% of claims within 30 days of receipt.

A “clean claim” is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.
Claim Submission

Please note that we follow Texas billing practices, (i.e., required diagnosis codes, CPT, HCPCs and associated modifiers), and Texas’ fee schedule methodologies. We also follow Texas’ timely filing requirements along with the claim dispute processes and timeframes.

**Common Barriers**

- 5010 Requirements *(Rendering NPI and pay-to NPI; Both are required)*
- NDC Codes Missing or Incomplete
- Lack of Prior Authorization

**Resubmissions**

- Electronic and paper resubmitted claims are accepted, however, we prefer electronic claims. Resubmitted claims must be labeled appropriately.
Claim Submission

Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.

- How to fill out a CMS 1500 Form:

- Sample CMS 1500 Form:
  [Link](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf)

- How to fill out a CMS UB-04/1450 Form:
Claim Submission (HIPPA 5010 & ICD10)

Our website includes detailed information about HIPPA and ICD10 resources.

HIPPA 5010 and ICD10

On January 15, 2009 the US Department of Health & Human Services issued two final rules for adoption:

- An updated HIPAA X12 standard version 5010 for electronic transactions, with a compliance date of January 1, 2012. The updated format has more than 1300 changes to the 4010 standard (with 600+ just for claims).
- Adoption of the ICD-10 Code Sets with a compliance date in October 2015 (version 5010 accommodates the ICD-10 code structure; 4010 does not).

Aetna Better Health met the compliance requirements for the federally mandated HIPAA 5010 version transactions for 1/1/2012 and is on track to be able to accept ICD-10-CM & PCS Codes for dates of service for October 2015.

Online ICD-10 Resources

- Road to 10: The Centers for Medicare and Medicaid Services (CMS) has created a website that's a great resource for small physician practices and specialty practices.
- Crosswalks for the Top 50 Codes by Specialty at the AAPC website
- 100 Tips for ICD-10-PCS Coding at icd10monitor.com
- Free code conversion tool from icd10monitor.com

For your convenience, Aetna Better Health has added additional information, updates and links available for 5010 in the document library.
Provider Services Department

• **Contact (Phone/Email)**: 1-800-306-8612 (Tarrant) or TXProviderEnrollment@AETNA.com

• **Provider Services Manager:**
  • Responsible for Provider Services Representatives
  • Responsible for training Provider Services Reps in all areas (i.e., provider questions, provider complaints, provider responsibilities, claim submission, prior authorization requirements and member eligibility).

• **Provider Services Representatives:**
  • Educate network providers on our policy and procedures & claim submission.
  • Inform providers of changes through face-to-face visits, provider forums, webinars
  • Provide written or electronic communication including the Provider Manual, Periodic Provider Newsletters, and fax/email blasts.

• If you’re interested in participating in our EFT program and/or would like electronic 835 remits, please email us at the above email address for additional information.
Provider Communications

Provider Newsletters
We publish Periodic Provider Newsletters to all participating network providers. The purpose of periodic newsletters is to provide a consistent and reliable method of communication with participating network providers. The Network Newsletter will also be posted on our web page.

Special Provider Communications
Special provider communications are used to distribute information updates to our provider practices, when the distribution and implementation timeline for the information (e.g., new evidence-based practice guidelines) precedes the next regularly scheduled provider communication.
Member Rights & Responsibilities

It is our policy not to discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of member rights and responsibilities in the Provider Manual. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

In the event that we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.

For a complete list of member’s right and responsibilities, please review the Provider Manual.
Americans with Disabilities Act (ADA)

The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.

- Our providers are obligated to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities (e.g., physical locations, waiting areas, examination space, furniture, bathroom facilities, and diagnostic equipment must be accessible)
- Offer waiting room and exam room furniture must meet needs the needs of all members, including those with physical and non-physical disabilities.
- Be accessible along public transportation routes and/or provides enough parking.
- Have clear signage and “way” finding (e.g., color and symbol signage) throughout doctors offices/facilities.

Resources:
http://www.ada.gov/reg3a.html
Cultural Competency

Full Document in Packet

To improve patient health and build health communities, providers need to recognize and address the unique culture, language and health literacy of diverse patients and communities.

Aetna Better Health promotes cultural competency and offers education and e-newsletters in an effort to help eliminate health care inequalities.

To access Aetna Better Health’s online courses, visit: www.aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html

Available course:
- Health Literacy Universal Precautions Toolkit

Quality Interactions Quarterly E-Newsletters
In these newsletters, you’ll find updates on the latest research and policies related to cross-cultural care and disparities. Each issue includes a feature article and policy/literature updates. You’ll get practical tips, learn new research findings and read

To train providers to care for diverse populations, the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) has commissioned the Cultural Competency Curriculum Modules (CCCMs). The modules, encompassed in “A Physician’s Practical Guide to Culturally Competent Care,” will equip providers with competencies that will enable them to better treat the increasingly diverse U.S. population.

WHAT IS CULTURAL COMPETENCY?
### Welcome!
We designed this training to assist you in helping Aetna Better Health of Texas detect, report, and prevent fraud, waste, and abuse.

Following these requirements protects our members from harm and helps to keep health care costs down.

### Definitions

**Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**Waste:** Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

**Abuse:** Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

### First you are required to comply with all applicable statutory, regulatory, including adopting and implementing an effective compliance program.

### Second you have a duty to the program to report any violations of laws that you may be aware of.

### Third you have a duty to follow your organization’s Code of Conduct that articulates your and your organization’s commitment to standards of conduct and ethical rules of behavior.

- A provider’s best practice for preventing fraud, waste, and abuse is to (also applies to laboratories as mandated by 42 CFR 493):
  - Develop a compliance program
  - Monitor claims for accuracy - ensure coding reflects services provided
  - Monitor medical records — ensure documentation supports services rendered
  - Perform regular internal audits
  - Establish effective lines of communication with colleagues and members
Member Abuse and Neglect

Please pull out your hand-out.

<table>
<thead>
<tr>
<th>IDENTIFYING &amp; REPORTING ABUSE, NEGLECT &amp; EXPLOITATION OF A MEMBER</th>
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</thead>
</table>

Aetna Better Health’s policy is to promote the education of network providers including long term care facilities on the identification and reporting of actual and suspected abuse, neglect, and exploitation of our members.

### Definitions

**Neglect** means intentional or unintentional failure to fulfill a caregiver’s obligation or duty to an elderly person. “Self neglect” can also occur when an elderly person is unable or unwilling to make provision for proper care for themselves.

**Abuse** constitutes the intentional infliction of physical harm, causing injury as a result of negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault of an individual 18 years of age or older who is unable to protect himself or herself from abuse, neglect or exploitation by others because of a physical or mental impairment.

### Neglect

#### Types of Neglect

- The intentional withholding of basic necessities and care
- Not providing basic necessities an care because of lack of experience, information, or ability

#### Signs of Neglect

- Malnutrition or dehydration
- Unkempt appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

### Examples of Neglect

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

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# Provider Appointment Standards

*Please check the 6100 45 provider appointment policy template*

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Emergency Services</th>
<th>Urgent Care</th>
<th>Non-Urgent</th>
<th>Preventative &amp; Routine Care</th>
<th>Wait Time in Office Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider (PCP)</td>
<td>Same day</td>
<td>Within 24 hours</td>
<td>Within 72 hours</td>
<td>Within 28 14* days (1)</td>
<td>No more than 45 minutes</td>
</tr>
<tr>
<td>Specialty Referral</td>
<td>Within 24 hours</td>
<td>Within 24 hours of referral</td>
<td>Within 72 hours</td>
<td>Within 4 weeks</td>
<td>No more than 45 minutes</td>
</tr>
<tr>
<td>Dental Care</td>
<td>Within 48 hours (2)</td>
<td>Within 3 days of referral</td>
<td></td>
<td></td>
<td>No more than 45 minutes</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse (MH/SA)</td>
<td>Same day</td>
<td>Within 24 hours</td>
<td></td>
<td>Within 10 14* days</td>
<td>No more than 45 minutes</td>
</tr>
<tr>
<td>Lab and Radiology Services</td>
<td>N/A</td>
<td>Within 48 hours</td>
<td>N/A</td>
<td>Within 3 weeks</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Provider Appointment Standards Cont.

<table>
<thead>
<tr>
<th>Commitments</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline Physicals for New Adult Members:</strong></td>
<td>Within 180 calendar days of initial enrollment.</td>
</tr>
<tr>
<td><strong>Baseline Physicals for New Children Members</strong></td>
<td>Within 90 days of initial enrollment, or in accordance with EPSDT guidelines.</td>
</tr>
<tr>
<td>and Adult Clients of DDD:</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Physicals:</strong></td>
<td>Within 4 weeks for routine physicals needed for school, camp, work, or similar.</td>
</tr>
</tbody>
</table>

- **Physicals:**

  - **Baseline Physicals for New Adult Members:** Within 180 calendar days of initial enrollment.
  - **Baseline Physicals for New Children Members and Adult Clients of DDD:** Within 90 days of initial enrollment, or in accordance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.
  - **Routine Physicals:** Within 4 weeks for routine physicals needed for school, camp, work, or similar.
<table>
<thead>
<tr>
<th>Prenatal Care: Members shall be seen within the following timeframes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 weeks of a positive pregnancy test (home or laboratory)</td>
</tr>
<tr>
<td>3 days of identification of high-risk</td>
</tr>
<tr>
<td>7 days of request in first and second trimester</td>
</tr>
<tr>
<td>3 days of first request in third trimester</td>
</tr>
</tbody>
</table>
## Provider Appointment Standards Cont.

### Initial:

<table>
<thead>
<tr>
<th>Initial Pediatric Appointments:</th>
<th>Within 3 months of enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Security Income (SSI) and Texas Care (ABD &amp; Disabled Members):</td>
<td>Each new member will be contacted within 45 days of enrollment and offered an appointment date according to the needs of the member, except that each member who has been identified through the enrollment process as having special needs will be contacted within 10 business days of enrollment and offered an expedited appointment.</td>
</tr>
</tbody>
</table>

**Maximum number of Intermediate/Limited Patient Encounters.** 4 per hour for adults and 4 per hour for children.
Medical Records - Standards

Laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to a members or their contract with Aetna Better Health of Texas for inspection, evaluation, and audit for the longer of:

• A period of 5 years from the date of service; or 3 years after final payment is made under the provider contract/subcontract and all pending matters are closed.

Additional Information:

• Providers must maintain member records in either a paper or electronic format.

• Providers must also comply with HIPAA security and confidentiality of records standards.

Our standards for medical records have been adopted from NCQA and the Medicaid Managed Care Quality Assurance Reform Initiative (QARI). For a complete list of minimum acceptable standards, please review the Provider Manual.
Provider Complaints, Grievance & Appeals

Provider Payment Disputes:
Network providers may file a payment dispute verbally or in writing direct to Aetna Better Health of Texas to resolve billing, payment and other administrative disputes.

Provider Complaints:
Both network and out-of-network providers may file a verbal complaint with Aetna Better Health of Texas. Provider complaints are an expression of dissatisfaction filed with Aetna Better Health of Texas that can be resolved outside of the formal appeal and grievance process.

Provider Grievances:
Both network and out-of-network providers may file a formal grievance in writing directly with Aetna Better Health of Texas in regard to our policies, procedures or any aspect of our administrative functions including dissatisfaction with the resolution of a payment dispute or provider complaint that is not requesting review of an action.

Provider Appeal:
A provider may file a formal appeal in writing, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with Aetna Better Health of Texas within 90 calendar days from the Aetna Better Health of Texas Notice of Action.
Additional Information & Important Requirements

• Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with the Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

• Accommodating members with special needs, which includes but is not limited to: offering extended office hours to include night and weekend appointments, promoting practices offering extended hours, and offering flexible appointment scheduling systems.

• Ensuring that hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured or public fee-for-service individuals (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals) All services are available 24 hours a day, 7 days a week when medically necessary.
Long Term Services and Supports (LTSS)

Services – All services in Service Package 1 (Medical) and Service Package II (LTSS or Non Traditional Medical) which includes

- Nursing Facility Services
- Supported Living Facilities
- Home and Community Based Services provided through the Home and Community Based Services waivers
- **Does Not Include** those waivers serving individuals with developmental disabilities.

**Cost Sharing**

- Members in Nursing Homes will continue to pay their Share of Cost. This may also be known as Patient Pay, Member Contribution, or Resident Trust Fund. This amount is determined by the State and provided to both the NF and the Plan.
- Members in Supported Living will contribute their income minus $90 toward the cost of their stay in the SLF.
Information on the Aetna Better Health of Texas website:

• Prior Authorization List

• Secure Web Portal

• Provider Manual

• Contracted provider look-up

www.aetnabetterhealth.com/Texas
Thank you!